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SPECIAL ARTICLE

Progress and Perils in the Juvenile Justice and Mental Health Movement

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► Abstract

The juvenile justice system in the United States is experiencing a social movement aimed at responding to the mental and emotional problems of delinquent youths. Ironically, this movement arose in the wake of a decade of reform in juvenile justice that had set aside the system's 100-year tradition of rehabilitation for delinquents in the interests of their punishment and a primary emphasis on public safety. This article describes the recent juvenile justice and mental health movement, discusses the circumstances that motivated it, and provides examples of its progress. Now that the movement has taken hold, however, its future is threatened by several unintended consequences of the motives and strategies of those who succeeded in promoting the movement. Those potential perils are described with an eye to reducing their impact, thereby sustaining the movement and its potentially positive effects.

More than at any other time in its history, the juvenile justice system is the focus of extraordinary nationwide efforts to address concerns about the mental health needs of delinquent youths. The purpose of this article is to identify this phenomenon as a social movement, to describe how it developed, and to examine its progress and its perils.

In 1995, whether one was reading newspapers or articles in criminology journals, the portrayal of delinquent youths was frightening. Homicide and aggravated assaults among teenagers had more than doubled between the late 1980s and early 1995.¹ Projections by one leading criminologist predicted "a blood bath" by 2005.² The prevailing image of the new delinquent was that of a ruthless "super-

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Later, this movement's evolution and some of its positive outcomes are described. But not all of its consequences have been salutary. The image of the delinquent as super-predator has been replaced by the troubled delinquent—a youth who meets criteria for one or more mental disorders and who is in need of treatment. Many will see this as progressive, but it has its risks as a foundation for juvenile justice reform. Zealous advocacy to respond to youths' mental health needs is important to improve mental health services for youths in juvenile justice custody, an objective that almost everyone now agrees must be met. But zeal without the balancing effect of careful thought about how to accomplish that objective can do more harm than good. The potential perils of this movement, therefore, must be recognized and studied, to avoid them and to steer a careful course toward effective mental health services for delinquent youths. After recounting the movement's successful start, this article describes three types of peril that threaten its future. The following description of the progress and perils of the juvenile justice and mental health movement is offered from a U.S. perspective. The movement apparently has not arisen with as much force in other countries, although researchers in Great Britain, the Netherlands, and Belgium have begun to identify similar trends and issues in juvenile justice settings in their countries.

► The Progress

The first signs of change arose in the late 1990s and grew rapidly in the recent half-decade. An early benchmark for the movement was a monograph published in 1992 by the National Coalition for the Mentally Ill in the Criminal Justice System.¹⁰

Edited by Joseph Coccozza, this collection of writings by researchers and clinicians summarized what we knew at that time, which was very little, regarding the

prevalence, identification, and treatment of mental disorders among youths in juvenile justice settings. The work stimulated some key people who later helped to fuel the movement and has been widely cited in recent years as an early call to arms. Unfortunately, it came at a time when youth violence statistics were beginning to soar, and therefore it had to compete with the strong voices of policy makers bent on simply locking youths away.

Social Context of the Movement

Several coincidental social circumstances of the 1990s contributed to the start of the movement. One was the practical effects of the recent punitive legal reform. It was becoming apparent that the nation's get tough policies were creating substantial overpopulation of juvenile justice facilities. In addition, staff of those facilities began reporting what they thought was an alarming increase in the influx of youths with behavior that looked to them like mental health problems, contributing further to chaotic conditions for youths and staff in secure facilities. By then it was also apparent that during the early 1990s there had been a nationwide deterioration in state funding for child community mental health systems. State after state had experienced the collapse of its public mental health services for youths, some states having closed all of their residential facilities for seriously disturbed adolescents (e.g., Ref. 11). Together, these circumstances raised suspicions that the new punitive laws, coupled with inadequate public mental health resources for youths, were beginning to turn the juvenile justice system into a place to deposit youths who could no longer get help in the community.

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The third ingredient was financial incentive. Late in the 1990s, the Department of Justice began a series of investigations of several states focused on conditions of juveniles' confinement. (For examples of Department of Justice investigations of juvenile justice programs of the late 1990s and early 2000s, see the information pertaining to Arizona, Louisiana, Georgia, and Florida in Ref. 25.) They found facilities overcrowded as the result of the get-tough policies of the 1990s and understaffed by private companies that ran juvenile facilities as though they were adult prisons. Litigation in these states often resulted in consent agreements requiring the investment of millions of dollars and a promise of continuing effort for improvement, often targeted in part for responses to delinquent youths' mental health needs.

In addition, the federal government developed a program of juvenile justice block grants for which states could apply if they developed and proposed plans for improvements in their response to youths' health and mental health needs.²⁶ Each state was required to develop a State Advisory Group to steer the use of block grant funds, and often those advisory groups targeted screening, assessment, and mental health responsiveness in juvenile facilities. Added to this were substantial sums of money earmarked for juvenile justice reform that began to be available to states through private organizations such as the MacArthur Foundation and the Casey Foundation. By 2000, it was not unusual to find states with juvenile justice agencies that suddenly had many millions of dollars added to their budgets annually, much of that for improving the mental health care of juveniles in their custody.

Thus, by 2000, it was clear that change was under way and was progressing with a sense of urgency. Juvenile justice systems were required to reform, and the money available to do it offered them a rare opportunity for system improvement if they could respond to the challenge. The research that began in the 1990s was ready to fuel the movement, providing evidence that up to two-thirds of youths in juvenile justice facilities met criteria for one or more mental disorders.¹⁴ Identifying those youths became a high priority for those reforming juvenile justice systems. Many new tools to screen and assess juvenile justice youths for mental health needs had just been made available, and the juvenile advocacy foundations were providing the energy and media attention. (For reviews of over 20 of those instruments, see Ref. 27.)

An example of the potent effects of this mix of research, advocacy, and funding can be seen in the rate of adoption of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), developed by Grisso and Barnum^{16,28} in the 1990s. The MAYSI-2 is a youth self-report tool designed specifically for use at the front door of juvenile pretrial detention centers or juvenile correctional programs. It is not diagnostic, but in a 10-minute procedure that does not require a clinician, it allows detention staff to identify whether youths are reporting clinically significant levels of symptoms on six dimensions, such as suicide ideation and depressed or anxious affective conditions. It signals the need for immediate emergency clinical consultation or further clinical assessment.

Development of the MAYSI-2 began in 1994, at a time when few administrators saw the need for a mental health screening tool. With support from the William T. Grant Foundation, the instrument was developed, validated, and readied for release in 2000. Funding by the MacArthur Foundation provided technical assistance to states willing to adopt and implement the tool routinely with every youth entering

the long run. Perhaps most social movements in their early stages are, like many youths themselves, motivated more by immediate gains than by careful attention to longer-range risks. This drawback may explain some disturbing things observed by this author and other consultants while advising juvenile justice facilities nationwide regarding their adoption of mental health screening for youths in custody. What they have observed are unanticipated effects of the efforts to increase identification of youths with mental health needs that may not be in the best interests of the youths. The remainder of the article presents observations of the author during clinical and research consultation with juvenile justice programs in recent years, as well as concepts developed in an earlier work.²⁶

► The Perils

The present juvenile justice and mental health movement bears the marks of three types of potential risks of negative consequences: translational risks involving overinterpretation of the message, economic risks of bandwagon incentives, and systemic risks that may result in iatrogenic injustice.

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Overinterpreting the Message

The movement was energized by empirical evidence offered by many reliable studies that provided data about the prevalence of mental disorders among youths in juvenile justice settings. Those studies announced that a large proportion of these youths—as many as two-thirds—met DSM criteria for one or more mental disorders (i.e., mood, anxiety, substance use, conduct, or developmental disorders). This was an alarming message for many juvenile justice administrators. Federal government and juvenile advocates called for the juvenile justice system to respond and many presumed that this meant that they had to find a way to provide treatment for most of the youths in their care.

This presumption, of course, is simplistic. The fact that two-thirds of youths in detention centers meet criteria for a psychiatric disorder does not mean that they are seriously in need of psychiatric treatment. Youths with a particular disorder vary in the severity of their symptoms. Some function relatively well in everyday life and others very poorly. Youths' psychological conditions are more labile than those of adults. Compared with adults, there are greater risks that youths with symptoms of one disorder at one point may, within another year, meet criteria for a different disorder or no disorder at all. Moreover, prevalence rates for mental disorder depend on what one defines as mental disorder. Shall we leave in or take out conduct disorder? How about substance use disorders? Thus, most experts recognize that it is not necessary and is probably unwise for the juvenile justice system to translate the published prevalence rates into a policy that seeks treatment for two-thirds of the youths in its custody.

Juvenile justice personnel, however, often did not recognize the difference between diagnosis and treatment need. There were at least two negative reactions by juvenile justice personnel to these overwhelming statistics. One was paralysis. The thought of providing treatment for such a large number of youths seemed to some so daunting that they failed to respond at all. The perceived magnitude of the problem seemed to defy the development of a plan. The other reaction was resistance to the use of

something, but to do it immediately. Political pressure to comply sometimes caused administrators to take quick action that sacrificed the details for the deadline. For example, regarding mental health screening for juvenile justice facilities, sometimes administrators did not carefully consider what methods were appropriate; what decisions should and should not be based on those methods; whether the information should or should not be shared with others inside or outside their agencies; whether a pilot process might be helpful; or how, when, and by whom mental health screening tools should be administered.

Observations of juvenile justice systems' implementation of the MAYSI-2 provided several examples of the effects of haste or lack of attention on the integrity of the tool for mental health screening in detention centers. Sometimes this gave rise to practices that completely invalidated the instrument's use. For example: Seeking greater efficiency, one state developed a new MAYSI-2 answer form. It eliminated the "no" answer column and reorganized the standardized random appearance of the items so that they were grouped according to scale, then labeled the groupings on the answer form (so, for example, the youth read "Depressed-Anxious" before answering the items that contributed to that scale).

Given the instructions that "every youth must be screened at admission," a detention center administered the MAYSI-2 to youths every time they re-entered the unit—after court appearances, doctor's appointments, and visits with parents. Some youths were receiving the MAYSI-2 several times a week and simply began circling all the "no's" on the screening tool. Whereas "all no" responding on the MAYSI-2 is less than 10 percent in most facilities, it was 40 percent in this one.

In one site, a pilot study showed that the proportion of youths above cutoff was higher in that facility than the average for facilities nationwide. The administrators changed the cutoff scores to bring their institution's proportion more in line with the national average.

Some juvenile courts were using MAYSI-2 scores or other 10-minute screening measures as their primary source of data for making long-range treatment decisions after youths were found delinquent, despite clear warnings on these instruments that they are neither diagnostic nor valid for deciding youths' long-range needs.

It is quite likely that these inappropriate practices arose because juvenile justice administrators, many of whom were not accustomed to employing standardized methods, were pressed to make decisions about implementation of mental health screening too quickly. Getting on the national bandwagon to meet the demand to implement screening may have overridden careful thought or consultation on proper practices. In the case of the MAYSI-2, the availability of free consultation and technical assistance (through a clearinghouse supported by the MacArthur Foundation) was advertised and often known by juvenile justice programs that implemented MAYSI-2. Many programs availed themselves of those services and implemented mental health screening appropriately. But some agencies simply acquired the tool and, within a few weeks, put it in place under pressure to get it done.

The most obvious lesson in this experience is that the transfer of technologies—in this case, offering mental health measures to juvenile justice programs—must be accompanied not merely by incentives to

creative solutions to the problem need to be examined carefully in this regard. For example, within the past two years, we have seen the development of a new kind of juvenile court called the "juvenile mental health court," with special features designed to deal more therapeutically with young offenders who have mental disorders.⁴⁰ If we do not proceed carefully with this innovation, might it merely become a magnet that draws those youths into the juvenile justice system, increasing their arrests and frequency of detention and adding to their delinquency records?⁴¹

The second risk of iatrogenic injustice is raised by competing roles of juvenile justice. Juvenile courts have an obligation to care for the health and mental health of youths in their custody, but they also have an obligation to prosecute juveniles, satisfy their victims, protect the community from offenders, and assure that they are punished. Beneficence and retribution have presented difficult, competing, objectives for the juvenile justice system throughout its history. The juvenile justice and mental health movement offers the latest variation on that theme.

For example, when mental health screening tools such as the MAYSI-2 are used at detention intake, typically the screening tool asks youths to self-report their behavior and feelings, such as their use of illegal substances, their angry feelings toward others, and various symptoms that increase the risk of aggression. That information is necessary to provide for youths' emergency mental health needs and immediate safety. But what are the risks that this same information might be used to increase the likelihood of their transfer to criminal court, to prosecute them, or to increase their sentences? The circumstance arises in the treatment arena as well. Urged to meet youths' treatment needs, some pretrial detention centers have implemented anger management programs and group counseling activities. But by what authority does the juvenile justice system engage individuals in intrusive psychological treatment before adjudication, or acquire information in an unprivileged relationship in the guise of therapy, which may be subject to subpoena and used to convict them?

These are not hypothetical questions. As mental health screening has been implemented nationwide, detention centers sometimes have been asked by juvenile courts to send mental health screening results to the prosecutor's office as a routine procedure. Defense attorneys sometimes have objected to mental health screening of youths for fear that youths' responses could provide self-incriminating information for their prosecution.

These threats of iatrogenic injustice, creating legal jeopardy for youths in the name of beneficence, can be avoided if they are recognized early in a system's reform efforts and made the focus of preventive policy. For example, judges can establish court policies that prohibit the use of mental health screening information for purposes of adjudication. Screening can be used to divert youths from the juvenile system rather than encouraging their further penetration of it. Most of the dangers are avoidable if we recognize and confront them thoughtfully. But history is replete with examples of beneficent intentions that create injustice, a danger we face if we respond to juveniles' mental health needs by turning juvenile justice facilities into psychiatric units. Elsewhere, I have provided an analysis of ways to limit the treatment obligation of the juvenile justice system, while strengthening the obligation within those narrower boundaries (Ref. 36, pp 127-60).

If someday we look back and see that these broader advances in developmental science stimulated a substantial repeal of some of the more punitive laws of the third era, then we may conclude that the "mental health and juvenile justice movement" was not merely an adjustment to existing policies. We may view it, instead, as having been one component in a broader, developmentally sensitive reform that led to a fourth era in the history of the juvenile justice system.

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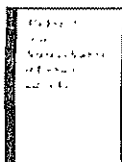
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