

Adolescent Offenders with Mental Disorders

Thomas Grisso

Summary

Thomas Grisso points out that youth with mental disorders make up a significant subgroup of youth who appear in U.S. juvenile courts. And he notes that juvenile justice systems today are struggling to determine how best to respond to those youths' needs, both to safeguard their own welfare and to reduce re-offending and its consequences for the community. In this article, Grisso examines research and clinical evidence that may help in shaping a public policy that addresses that question.

Clinical science, says Grisso, offers a perspective that explains why the symptoms of mental disorders in adolescence can increase the risk of impulsive and aggressive behaviors. Research on delinquent populations suggests that youth with mental disorders are, indeed, at increased risk for engaging in behaviors that bring them to the attention of the juvenile justice system. Nevertheless, evidence indicates that most youth arrested for delinquencies do not have serious mental disorders.

Grisso explains that a number of social phenomena of the past decade, such as changes in juvenile law and deficiencies in the child mental health system, appear to have been responsible for bringing far more youth with mental disorders into the juvenile justice system. Research shows that almost two-thirds of youth in juvenile justice detention centers and correctional facilities today meet criteria for one or more mental disorders.

Calls for a greater emphasis on mental health treatment services in juvenile justice, however, may not be the best answer. Increasing such services in juvenile justice could simply mean that youth would need to be arrested in order to get mental health services. Moreover, many of the most effective treatment methods work best when applied in the community, while youth are with their families rather than removed from them.

A more promising approach, argues Grisso, could be to develop community systems of care that create a network of services cutting across public child welfare agency boundaries. This would allow the juvenile justice system to play a more focused and limited treatment role. This role would include emergency mental health services for youth in its custody and more substantial mental health care only for the smaller share of youth who cannot be treated safely in the community.

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When adolescents face problems affecting their welfare, most communities in the United States have available at least four public systems with which to respond in the interests of society, families, and youth. These four systems specialize in education, child protection, juvenile justice, and mental health. Like a mall's storefronts, each offers a somewhat different type of product. Each of the four storefronts has its own door through which community members can pass when they have determined that an adolescent's needs fit the professions, skills, and objectives of the personnel and products within.

In recent years, however, communities have begun to recognize that this model of service delivery for adolescents—so logical in its organization around specific types of problems and services—is not consistent with the nature of adolescents' needs. The problems in which the separate systems specialize—learning problems, parental neglect, delinquent behavior, and mental disorders—are not like medical problems of teeth, eyes, bones, and skin, each of which arises independent of the other. Hundreds of thousands of youth need the services of all four of these public systems at once, often because their problems have interrelated causes. Communities whose policies organize behavioral and social services for youth according to a specialty-store logic often have difficulty addressing this reality. The storefronts themselves do not face each other and often do not even recognize that they are serving the same customers.

Nowhere has this difficulty been more evident in recent years than in society's responses to delinquent youth with mental disorders. The purposes of the juvenile justice system are

to protect youth in its custody, to protect the community, and to engage in interventions that reduce crime. The purpose of the mental health system is to treat mental disorders. What, then, is the appropriate public service response for youth with serious mental disorders who engage in troubling offenses that threaten the community?

In this article, I examine research and clinical evidence that may help in shaping a public policy that addresses that question. The first step in crafting such a policy is to determine how and to what extent delinquency and mental disorders co-occur. In the first two sections of the following review I address this question from two perspectives. From a clinical perspective, I first examine how symptoms of adolescent mental disorders are related to aggression. And then from an epidemiological perspective, I consider the proportion of youth with mental disorders who offend, the proportion of young offenders who have mental disorders, and the prevalence of mental disorders among youth in juvenile justice facilities.

The heavy presence of youth with mental disorders in the juvenile justice system might suggest that the solution is simply to improve the way the system provides mental health services to those in its custody. But entertaining this notion requires carefully considering the advantages and disadvantages of assigning the task of treatment to the system's juvenile pretrial detention centers and correctional facilities. What is known about the value of clinical treatment for reducing future delinquency? What is known about its value when delivered to youth in juvenile justice custody? What legal and practical consequences need to be considered regarding delivery of treatment in juvenile justice settings?

Based on existing knowledge, what recommendations can be offered for developing a community response to youthful offenders with mental disorders? What could be the meaningful roles for various child welfare agencies, and what role could the juvenile justice system best play within that context?

The Clinical Relation between Mental Disorders and Aggression

A number of comprehensive studies, reviewed later, indicate that certain types of mental disorders are common among youth who are arrested for delinquencies.¹ Indeed, many of the symptoms of these disorders themselves increase the risk of aggression and, therefore, the risk of behavior for which youth are arrested and receive delinquency charges.² But the picture that emerges from this research is complex, with some disorders decreasing the risk and others increasing it only in combination with other disorders. The following review captures the broader picture of what is known. Recent comprehensive reviews of the relation of mental disorder and aggression are available to provide greater detail.³

Risk of Aggression and Specific Disorders

Research has thoroughly documented an increased tendency toward anger, irritability, and hostility among youth with affective (mood) disorders.⁴ Such disorders, mostly various forms of clinical depression, are found in about 10 to 25 percent of youth in juvenile justice settings.⁵ Someone not familiar with childhood depression may consider this association odd, since depressed adults frequently appear sad and withdrawn, not angry. But so common is irritability and hostility among youth with depressive disorders that the formal psychiatric definition of childhood depression allows “irritable mood” to be substituted for “depressed mood” as one

of the criteria for diagnosing depression in youth.⁶ That depressed youth are often sullen and belligerent, rather than simply sad, has a number of implications for aggression in social situations. The irritable mood of such youth increases the likelihood that they will provoke angry responses from other youth (and adults), thus augmenting the risk of events that escalate to physical aggression and result in arrests. When these youth are in custody in juvenile justice facilities, their mood disorder may increase the risk of altercations with other youth. In addition, the connection between anger and depression can be directed toward themselves, so that they present an increased risk of engaging in self-injurious behaviors, including suicide.

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Anxiety disorders in children and adolescents usually involve fearfulness and a tendency to be withdrawn and to avoid confrontation. Many studies show that youth with anxiety disorders are *less* aggressive than the average for their peers.⁷ The exception is youth with posttraumatic stress disorder (PTSD), who are susceptible to responding to threats aggressively and unexpectedly.⁸ Youth with PTSD and conduct disorder (a disorder characterized by antisocial tendencies) have been found to be more impulsive and aggressive than youth with conduct disorder alone.⁹

Psychotic disorders such as schizophrenia are fairly rare before early adulthood and are not often seen in juvenile justice settings. Nevertheless, some youth have psychotic-like symptoms, possibly as early forms of the disorder, that include thought disturbances—that is, unusual and sometimes bizarre interpretations of events. The evidence that youth with “evolving” psychotic disorders present a greater threat of aggression than other youth is quite weak.¹⁰ But when youth with psychotic features engage in serious delinquencies, one frequently finds that their disturbed thought has played a role in their aggression.

In contrast, the evidence is quite clear that youth with disruptive behavior disorders, such as conduct disorder (CD) and attention-deficit hyperactivity disorder (ADHD), manifest substantially increased rates of physically aggressive behavior.¹¹ This finding is not surprising, given the features of these disorders. Aggressive and delinquent behaviors are part of the criteria for obtaining a CD diagnosis, and ADHD is diagnosed in part by impulsiveness, which can often lead a youth to respond to emotional situations without pausing to consider the consequences. We cannot simply dismiss conduct disorder as “not really a mental disorder, but merely bad character,” because there is considerable evidence that the great majority of youth in the juvenile justice system diagnosed with CD also meet diagnostic criteria for other clinical disorders.¹² Conduct disorder and ADHD also are important to consider because of their longer-range implications for criminal behavior. While only about one-third of adolescents with CD eventually develop antisocial personality disorder in adulthood, about two-thirds have nonviolent or violent offense records as adults.¹³

Finally, there is substantial evidence for a relation between substance use disorders and delinquent behavior, as well as continued aggression among substance-abusing youth with conduct disorder as they transition to adulthood.¹⁴ For example, in one study, substance use disorders were found in 40 to 50 percent of delinquent youth but only 15 percent of nondelinquent youth.¹⁵ Substance use disorder also has implications for the protection of youth in juvenile justice custody, because youth entering juvenile detention facilities straight off the street may engage in aggressive and self-injurious behaviors arising in the context of withdrawal symptoms.

Many specific mental disorders and their comorbidity increase the risk of aggression because their emotional symptoms (such as anger) and self-regulatory symptoms (such as impulsiveness) themselves increase the risk of aggression.

Complex Clinical Factors and Aggression

In considering the relation of aggression to symptoms in each of these disorders, it is important to recognize that not all youth with a given diagnosis are identical. Among those who meet criteria for a disorder, some may experience their symptoms more severely than others. Youth may also vary in their capacities to cope with their symptoms. Some have the disorder persistently across a significant period of time, while others meet

criteria for the disorder for only a short time. Among the latter, some will have recurring episodes of the disorder, while others will experience only one episode. Because of these complex individual differences, merely knowing a youth's diagnosis does not tell us everything we need to know about the risk of aggression in individual cases.

Two other complexities of child disorders have significant implications for policy and practice. The first is co-morbidity, or the presence of more than one mental disorder, which is very common among adolescents with mental disorders.¹⁶ Among youth in juvenile justice facilities who meet criteria for having any mental disorder, about two-thirds meet criteria for two or more disorders.¹⁷

Research has underscored the importance of co-morbidity for understanding the relation between adolescents' mental disorders and their aggressive behaviors. For example, many disorders that offer only a modestly increased risk of aggression appear to augment the risk when they are found in combination with other disorders. Co-morbidity of CD and ADHD has been identified as increasing the likelihood of chronic and repeated offending during adolescence.¹⁸ Co-morbidity recently was examined in a study addressing how mental disorders in adolescence relate to later offending in young adulthood.¹⁹ Depression or anxiety (and even the two together) during adolescence only slightly increased the odds of adult offending, and adolescent substance use disorder had a modestly greater relation to adult offending. But either depression or anxiety in combination with substance use disorder during adolescence greatly increased the odds of serious and violent adult offending and was far more predictive than substance use alone.

The second type of clinical complexity with implications for policy and practice involves a class of youth often called "seriously emotionally disturbed." Such youth have multiple mental disorders, manifested from before adolescence, that persist throughout their adolescence and into adulthood. They account for a relatively small proportion of youth in the community with mental disorders (estimated at 10 percent). But the extent of their disabilities is such that they consume nearly half of the community's mental health resources.²⁰ Almost all of them have juvenile justice contact during their adolescence, and a majority continues to have criminal justice contact—for both minor and serious offenses—as they transition into adulthood.²¹ They have been estimated to account for about 15 to 20 percent of youth in juvenile justice facilities.²² Seriously emotionally disturbed youth typically have acquired a significant number of diagnoses consecutively or together in adolescence.

In summary, research confirms that many specific mental disorders and their co-morbidity increase the risk of aggression because their emotional symptoms (such as anger) and self-regulatory symptoms (such as impulsiveness) themselves increase the risk of aggression. The increased risk of aggression, in turn, increases the risk that youth with these symptoms will be arrested, charged, and convicted of delinquencies and may have continued criminal justice contact as they move into adulthood.

What is not clear from the clinical research itself is how much the mental disorders of adolescents contribute to a community's delinquency or to the burden on its juvenile justice system and other child welfare agencies. Answering this question requires examining a different type of research, focused on

the prevalence of mental disorders among delinquent youth.

The Prevalence of Mental Disorders among Adolescent Offenders

Two kinds of studies address questions about the social consequences of the links between mental disorders and delinquency. One type examines the degree of “overlap” between a community’s population of youth with mental disorders and its population of youthful offenders. Knowing this overlap gives some notion of the risk of official delinquency for youth with mental disorders and the degree to which mental disorders of youth contribute to a community’s overall delinquency. The second type of study examines the proportion of youth with mental disorders within juvenile justice facilities or programs. These studies provide information with which to formulate policy about treating and managing youth with mental disorders in juvenile justice custody.

It is important to recognize that these two types of research begin with very different populations, even though they both address the relation between mental disorder and delinquency. The first typically focuses on all delinquent youth in the community, while the second examines only delinquent youth placed in juvenile pretrial detention centers when they are arrested or in juvenile correctional facilities when they are adjudicated. This distinction is further complicated, as discussed later, by the fact that not all youth in juvenile justice facilities are necessarily delinquent.

Epidemiologic Studies of Mental Disorder and Delinquency

Some studies have identified a significant overlap between the populations of youth served by community mental health agencies

and youth in contact with the community’s juvenile court.²³ These studies are few in number, but they have found that the risk of juvenile court involvement among a community’s young mental health clients is substantial. For example, a study in one city found that adolescents in contact with the community’s mental health system during a nine-month period were two to three times more likely to have a referral to the juvenile justice system during that period than were youth in the city’s general population.²⁴ Youth in contact with a mental health system’s services, however, are not the sum of a community’s youth with mental health needs because many receive no services. The results of the study above probably represent the proportion of more seriously disturbed youth who have juvenile justice contact. Even so, merely knowing that youth “have contact” with the juvenile justice system tells us little about their offenses or even whether they offended at all.

Very few studies have used samples that make it possible to identify both the proportion of delinquent youth in a community who have mental disorders and the proportion of youth with mental disorders who have been delinquent. The few that have, however, are large studies with careful designs.

One examined a community population (drawn from several cities) that identified youth with persistent serious delinquency (repeat offending) and youth with persistent mental health problems (manifested multiple times).²⁵ About 30 percent of youth with persistent mental health problems were persistently delinquent. But among all persistently delinquent youth, only about 15 percent had persistent mental health problems.

Another recent study examined the relation between mental disorders during adolescence

and criminal behavior when those youth became adults.²⁶ Delinquencies and adult criminal arrests were recorded for a sample of youth in a large geographic region aged nine through twenty-one. The youth were also assessed for mental disorders three times between the ages of nine and sixteen. A diagnosis at any one of these three points identified the youth as having a mental disorder “sometime during childhood or adolescence.”

In this study, youth who were arrested between the ages of sixteen and twenty-one included a considerably greater share of youth who had had mental disorders in adolescence than those who were not arrested—for males, 51 percent as against 33 percent. This finding does not mean that 51 percent of the arrested group had mental disorders at the time of their arrest, but that they had had a mental disorder sometime in adolescence. It also does not mean that the majority of youth who had mental disorders in adolescence were arrested in adulthood. A different statistical procedure in this study, called “population attributable risk,” addressed that question. It showed that the risk of adult arrest among individuals who had mental disorders at some time during adolescence was about 21 percent for women and 15 percent for men.

These few studies suggest the following conclusions, all of which need further confirmation. First, consistent with the clinical research reviewed earlier, youth who have mental disorders are at greater risk of engaging in offenses than youth without mental disorders. It is possible that treating their disorders would reduce that risk. But most youth with mental disorders do not engage in offenses that involve them in juvenile or criminal justice systems. Second, youth with mental disorders represent only a minority of all youth who engage in delinquent behavior,

although the share is somewhat disproportionately greater than their prevalence in the general community. If those youth received treatment that reduced their delinquency, it is possible that overall rates of delinquency in the community would fall somewhat, but the majority of delinquencies are not related to mental disorders.

Third, rates of delinquency are higher among youth with certain types of emotional disorders—for example, depression or anxiety co-morbid with substance use disorders—and among youth with chronic and multiple disorders (seriously emotionally disturbed youth). Finally, a few studies have suggested that youth with mental disorders make up a somewhat greater proportion (although still a minority) of youth who were arrested for more serious and violent delinquencies or crimes.²⁷

Mental Disorder in Juvenile Justice Settings

Research on the subset of delinquent youth who enter juvenile pretrial detention centers and correctional programs cannot tell us the relation between mental disorder and delinquency, because most youth who engage in delinquencies are not placed in secure juvenile justice programs. Such studies, however, are extremely important for public policy, because they identify the scope and nature of mental disorder among youth for whom the juvenile justice system has custodial responsibility.

Until recently the precise prevalence of mental disorders among youth in juvenile justice custody was unknown. Estimates varied widely from study to study, largely because of inadequate research methods or differences from one study site to another.²⁸ In the past decade, however, well-designed studies executed in a variety of sites have

provided a reliable and consistent picture. Those studies have found that among youth in various types of juvenile justice settings—for example, pretrial detention centers where youth are taken soon after arrest—about one-half to two-thirds meet criteria for one or more mental disorders.²⁹ The prevalence of mental disorders is much higher in juvenile justice settings than it is among youth in the U.S. general population, which is about 15 to 25 percent.³⁰

During the 1990s, most states saw a reduction in the availability of public mental health services for children. Many communities began using the juvenile justice system to try to fill the gap caused by decreased availability of mental health services.

Across these studies, the rate is higher for girls than for boys.³¹ The overall prevalence rate does not vary greatly between younger and older adolescents or for youth with various ethnic and racial characteristics, although age and race differences are sometimes found for specific types of disorders and symptoms.³² As described in the earlier clinical review, about two-thirds of youth in juvenile justice custody who meet criteria for a mental disorder (that is, about one-third to one-half of youth in custody) meet criteria for more than one disorder.³³

I will focus later on the implications of these statistics for the juvenile justice system's best

response to mental disorders among youth in its custody. The high prevalence of mental disorder in juvenile justice facilities does not necessarily define the need for treatment. Some youth who meet criteria for mental disorders are experiencing their disorders temporarily and need only emergency services, while a smaller share—about one in ten—represents a core group of youth with chronic mental illness who can be expected to continue to need clinical services into adulthood.³⁴ Some are functioning fairly well despite their symptoms, while others are barely able to function at all. And some have mental health needs, such as learning disabilities, that were not even included in the recent studies of prevalence among youth in juvenile justice settings.

Reasons for the High Prevalence of Mental Disorders in Juvenile Justice Programs

Why are mental disorders so prevalent among adolescent offenders in juvenile justice settings? Three perspectives—clinical, socio-legal, and inter-systemic—help to explain. They are not competing explanations. All probably play a role, and no evidence suggests that one is more important than the others.

From a clinical perspective, it is likely that the same symptoms of mental disorder that increase the risk of aggression also increase the likelihood that youth will be placed in secure juvenile justice facilities for any significant period of time. When police officers arrest youth, usually those youth are not placed in pretrial detention. Nor is detention reserved for the most serious offenders—in fact, youth arrested for very violent offenses typically do not make up the majority of youth in detention. Those youth who are detained more than a few hours are

those who have been more unruly or unmanageable at the time of their arrest, which satisfies detention criteria regarding a risk that they will be endangered, or might endanger others, if not detained.

Youth with mental disorders frequently have symptoms involving impulsiveness, anger, and cognitive confusion that can make them less manageable and a greater risk to themselves or others, especially under the stress associated with their offense and arrest. Thus, among youth who are detained, a significant share is likely to have mental disorders that create unmanageable behavior—more so than for youth without mental disorders and more so than their peers with less severe mental disorders. This likelihood makes it no surprise that youth with mental disorders contribute disproportionately to detention populations.

From a socio-legal perspective, recent changes in laws applied to youths' delinquencies may have increased the likelihood that youth with mental disorders will enter the juvenile justice system. Before the 1990s, law enforcement officers, juvenile probation departments, prosecutors, and judges typically had some discretion regarding whether they would arrest or prosecute youth with mental disorders when they engaged in illegal behaviors, especially if those behaviors involved minor offenses committed by younger adolescents without offense histories. But a wave of serious juvenile violence during the late 1980s caused virtually all states to revise their juvenile justice statutes during the 1990s to rein in this discretion.³⁵ Under the new laws, certain charges or offenses required legal responses based on the nature of the offense alone, not the characteristics or needs of the individual youth. Penalties more often involved custody

in secure juvenile facilities, thus reducing the likelihood that youth could receive mental health services in the community after their adjudication. An unintended consequence of these changes in law, therefore, was an increase in the share of youth with mental disorders coming into the system rather than being diverted on the basis of the juvenile court's discretion.

A final, inter-systemic, explanation involves the dynamic relation between systems that serve youth. During the 1990s, most states saw a reduction in the availability of public mental health services for children, especially inpatient services.³⁶ It is possible that less adequate treatment contributed to increased delinquencies among youth with mental disorders. But it is certain that many communities began using the juvenile justice system to try to fill the gap caused by decreased availability of mental health services.

This phenomenon was documented in media articles, the observations of juvenile justice personnel, and government reports beginning in the mid-1990s and continuing into the early 2000s.³⁷ Some parents of children with serious mental disorders began urging police to arrest their children, knowing that courts could “order” mental health services that were becoming nearly impossible for parents to get on their own. Soon the local juvenile pretrial detention center was becoming the community's *de facto* mental health center that provided emergency mental health services or simply acted as a holding place for seriously disturbed youth who had nowhere to go.

In summary, these three factors—clinical, socio-legal, and inter-systemic—may together produce a prevalence of mental disorder in juvenile justice settings that does not

represent the actual relation between adolescent mental disorder and delinquency. That high prevalence does, however, represent a demand on the juvenile justice system to respond to youth in custody who have mental disorders, and the demand is almost overwhelming. Some of those youth are in secure custody because they have committed serious crimes, others because the legal system has widened the door to juvenile justice processing, and many because their symptoms make them difficult to handle and they have no place else to go.

The problem requires a solution, and the multiple causes of the problem as well as the various types of youth involved suggest that the solution will be complex. What have clinicians and researchers learned that can help us determine the appropriate response?³⁸

A Community Response

Typically, the call for a response to the needs of youth in juvenile justice with mental disorders focuses on “more treatment.” Yet treatment often is left undefined. Moreover, the need for “more treatment” often has been presumed to refer to the need for more services within the juvenile justice system. Research evidence, however, suggests the need both to define carefully what is meant by treatment and to avoid depending on the juvenile justice system to respond to the broader question of adolescent mental disorders and crime. Certainly the juvenile justice system has a treatment responsibility for youth in its care. But research and current logic suggest that this role should be focused, limited, and based on collaboration with the broader community in meeting that responsibility.

Before explaining those conclusions, I first examine evidence regarding whether

treatment for mental disorders will reduce delinquency. Then I consider how well juvenile justice can manage that treatment. Finally I look at the evidence for broader community-based alternative treatment strategies.

This discussion presumes two things about the purposes of public child welfare agencies. First, all such agencies, including the juvenile justice system, are responsible for dealing with mental health crises of youth who are in their custody. Mental health agencies are responsible specifically for meeting the mental health needs of youth, but all agencies must respond to acute needs that threaten youths’ safety. Second, all public child welfare agencies are responsible for reducing delinquency, but that is the primary mandate for the juvenile justice system, consistent with its responsibilities for community safety. This mandate will come to bear especially when community safety would be increased by treatment of mental disorders among youth who have been identified as delinquent.

The Values and Limits of Clinical Treatment

Ample research evidence attests to the benefits of treatment for youth in acute distress because of mental disorders. Among the most common and effective treatments are professional clinical care, psychopharmacological intervention when necessary, and structuring the environment to protect the youth and to reduce stress during a crisis.

The literature on the effectiveness of psychopharmacological options for treating mental disorders in adolescents is remarkably mixed, depending on the specific disorder.³⁹ There is no doubt that youth with some types of mental disorders can benefit from certain medications. But studies that test the effects

of a medication under highly controlled research conditions (called studies of “efficacy”) often have not been followed by tests of the effects of the medication when used by clinicians in everyday practice (called studies of “effectiveness”). The benefits of a medication “in the lab” cannot automatically be presumed to be the same “in the field,” given the possibility that doctors might not follow prescription guidelines or may err in diagnoses when prescribing.

Research shows that certain treatments can reduce symptoms and that certain interventions can reduce delinquency in youth with mental disorders.

Among the many types of psychotherapy and other psychosocial interventions available for youth with mental disorders, several have focused on youth with both mental disorders and delinquent behaviors. Evidence for both the efficacy and effectiveness of some of these approaches is substantial. Cognitive-behavioral therapy (CBT) teaches youth better awareness of social cues and promotes strategies for delay, problem solving and non-aggressive responding. Several studies have demonstrated CBT’s effectiveness for reducing future delinquency with a broad range of youth, including youth with depression and anxiety disorders.⁴⁰ Functional Family Therapy, Treatment Foster Care, and Multi-systemic Therapy have also demonstrated delinquency-reducing benefits for youth with a wide range of mental disorders.⁴¹ These therapies involve families and youth, within

their communities, dealing with problem behaviors and stresses as a systemic family unit. Although there are hundreds of existing interventions for delinquent youth, the successful ones described here are among the fairly small number that have demonstrably reduced the recidivism of delinquent youth with mental disorders.

A few studies have examined the effects of community mental health services in general on later arrests for delinquencies. In one study, youth in foster care who received such services in the community had lower subsequent rates of admission to pretrial detention centers.⁴² In another, adjudicated youth with mental disorders who were diverted from institutional placement and received services in the community had significantly fewer subsequent arrests than similar youth who had not received treatment.⁴³

In summary, research shows that certain treatments can reduce symptoms and that certain interventions can reduce delinquency in youth with mental disorders. Interestingly, most of this research has focused on whether or not youth received treatment, not on the degree to which their decreased delinquency was accompanied by reduced symptoms of mental disorders. Moreover, the research suggests that the most effective methods for reducing delinquency among youth with mental disorders do not involve traditional individual psychotherapy or psychiatric inpatient care. Those interventions are certainly appropriate for a minority of delinquent youth who need them. But for most delinquent youth with mental disorders, the most successful methods involve community-based interventions that assist them in the context of their everyday social interactions while they live in the community.

Should Juvenile Justice Be Responsible for Treatment?

Because effective treatments exist to reduce delinquency in youth with mental disorders, and because the primary mandate for juvenile justice is to reduce delinquency, it seems logical that the juvenile justice system should be the focus of society's efforts to treat delinquent youth with mental disorders. Yet there are several arguments against relying primarily on the juvenile justice system and far fewer arguments to the contrary. The issue is not informed by much research, but what evidence there is suggests the value of a limited rather than broad role for juvenile justice in treating delinquent youth with mental disorders.

First, committing the community's scarce mental health resources to juvenile justice programs invites criminalizing youth with mental disorders. Public funds for mental health services for children are limited, and allocating them to juvenile justice is likely to reduce the community's ability to develop community-based services. As experience has shown, reducing community-based services means that more youth are referred to juvenile justice, often by parents in search of services they cannot find in the community.⁴⁴ Such youth must carry the burden of a delinquency record to get basic mental health services, and that burden increases the likelihood of their future delinquency, criminal behavior, and arrest as adults.⁴⁵

Second, legal considerations restrict treatment options when youth are arrested and detained. Pretrial detention centers must respond to emergency mental health needs of youth. But until a youth is adjudicated and comes under its full custody, the juvenile justice system has no legal authority to impose rehabilitative or longer-range mental health interventions on youth.

Finally, clinical considerations suggest that the juvenile justice system will not be the most effective place to treat delinquent youth with mental disorders. The role of the state in relation to youth in its custody is basically adversarial, even when its interests are benevolent. Youth are not in custody voluntarily. It is certainly possible that some delinquent youth with mental disorders might be rehabilitated within the structure and guidance of properly operated, secure juvenile justice programs. But trust and caring are basic components of almost every effective therapy for youth with mental disorders. These conditions between youth and therapist often are difficult to maintain in secure juvenile facilities when the therapist is part of the system that restricts the youth's liberty.

Some treatments performed in secure juvenile justice settings can even be anti-therapeutic. For example, group therapies involving antisocial youth sometimes have a negative effect on less-antisocial peers.⁴⁶ Considerable evidence indicates that rehabilitation methods in secure settings, such as behavior modification, effectively change behavior within the setting but do not retain their effect when youth return to the community.⁴⁷

Evidence for the Value of Shared Community Responsibility

In recent years, thinking about how best to respond to delinquent youth with mental disorders has begun to focus on a community system of care that integrates services across child mental health, child protection, education, and juvenile justice agencies. Many youth have multiple needs that do not fit the boundaries of individual agencies. They may receive services from various agencies, but lack of coordination between agencies creates conflict, inefficiency, frustration for the family,

and sometimes harm when agencies work at cross purposes. A community system of care seeks to improve cross-agency referrals and collaboration, sometimes even to the extent of cost-sharing in developing unique services.

Methods for designing and implementing a community system of care have been developed and used in many communities nationwide.⁴⁸ In these systems, treatment of delinquent youth with mental disorders becomes the collective responsibility of all agencies, not the juvenile justice system alone. Collaboration between juvenile justice and community mental health services often allows juvenile justice to divert many youth from entering detention centers by referring them to community programs and to develop more effective aftercare plans for youth returning to the community from correctional placements. Thus treatment dollars can be allocated to community services with which juvenile justice programs can collaborate, rather than investing heavily in mental health services within its own system. Research has documented the benefits of a community system of care with regard to both economic and child welfare outcomes, including reductions in recidivism of delinquent youth.⁴⁹

Developing a community system of care, however, poses major challenges. Several studies have suggested that tradition and bureaucracy are the main barriers to change.⁵⁰ Juvenile justice systems are sometimes reluctant to run the risk of community-based treatment of youth in light of their public safety mandate, and mental health systems sometimes refuse to accept juvenile justice referrals on the grounds that “those youth” will disrupt their services.

The solution is not as simple as improving referral networks or establishing agreements

between two agencies. As described by experts who implement community systems of care, their development requires a comprehensive and often complex process involving community planning boards, buy-in by all child welfare agencies and services, the development of networking protocols and interagency councils, and creative blending of financial resources.⁵¹

The Role of Juvenile Justice

Given the involvement of a community’s juvenile justice system in a community system of care, what would be its responsibility for responding to delinquent youth with mental disorders? Logic and research suggest that its role would still be considerable, but much more focused and limited than if it were the sole provider of mental health services for youth in its custody.⁵² Moreover, its primary roles would be somewhat different at various stages in juvenile justice processing.

Identification and Diversion to Community Mental Health Services

The first stage in juvenile justice processing is the youth’s arrest and referral to the juvenile court. Once arrested, some youth are immediately placed in a secure pretrial detention facility. Others remain at home but are ordered to appear for intake interviewing. In either case, intake probation officers must decide whether a youth should proceed to trial or whether the case should be handled more informally. In addition, some youth will await trial in pretrial detention, while others will not.

A primary role of the juvenile justice system at this stage should be to identify youth with mental disorders who can be diverted from juvenile justice processing, so that they can continue to be in the community where treatment services are based rather than remaining in pretrial detention or

proceeding to full juvenile justice processing. Often this diversion is feasible because some youth are initially referred to juvenile detention centers for minor offenses or present no danger to others that requires secure containment. If their mental health problems were identified at this early stage, and if policies and system-of-care options (including foster and shelter care services if they cannot return home) were in place, then many youth with mental disorders could be diverted from formal juvenile justice processing. Substantial evidence suggests that systematic, well-functioning diversion programs have reduced the census of juvenile pretrial detention centers in many communities, often by half.⁵³

Diversion first requires identifying youth with mental health problems. That, in turn, requires a procedure called screening soon after youth are apprehended by police or are otherwise referred to juvenile court. Screening has two purposes. One is to determine the imminent risk of harm to self or others. Some youth truly need the structure of pretrial detention to provide temporary protection for themselves and the community, and diverting youth at high risk may jeopardize them, the community, and the effectiveness of the system-of-care collaborative model. The other purpose of screening is to identify youth who have current mental health needs—such as serious depression or anxiety, suicidal thoughts, or risk of substance use withdrawal—that might require immediate attention.

Youth may be screened at a special “juvenile assessment center” where all youth are taken when they are apprehended by law enforcement, immediately upon entry to a pretrial detention center (where appropriate diversion can occur within a few hours), or by

intake probation officers at first contact with youth. Research suggests that until recent years mental health screening was conducted in about two-thirds of detention centers but typically involved a few informal questions, rather than standardized tools.⁵⁴ In recent years, however, policymakers have urged juvenile justice intake programs to employ “evidence-based” screening tools—standardized methods for which research has demonstrated their validity.

Research has documented the benefits of a community system of care with regard to both economic and child welfare outcomes, including reductions in recidivism of delinquent youth.

In the past few years, procedures and technology for mental health and aggression risk screening in juvenile justice intake have been highly refined, and several well-validated screening tools (requiring no clinical expertise) designed specifically for use in juvenile justice settings have been made available.⁵⁵ Typically this type of screening is brief—usually requiring ten to fifteen minutes—and can be performed by specialized detention staff rather than mental health professionals. The purpose is neither to diagnose nor to develop treatment plans, but rather to classify youth simply as high or low risk (to assess whether they should remain in the community) and as highly likely or not likely to have mental health needs that require clinical attention as soon as possible.

Although the validity of screening methods has been well researched, less is known about whether screening helps improve outcomes for youth with mental disorders. For example, little is known about whether mental health screening disproportionately diverts youth of various races or ethnicities to mental health services instead of juvenile justice processing. Screening might reduce such disparities if it decreases errors related to discretionary decisions of juvenile justice personnel, or it might increase such disparities if the prevalence of mental disorders differs for various racial and ethnic groups of youth referred to the juvenile justice system.⁵⁶

Nor has research shown that mental health screening reduces mental health problems for youth diverted from the juvenile justice system. In fact, mental health screening by itself will not lead to better outcomes unless there are effective community mental health services to which screened youth can be diverted. Again, the emphasis must be on “evidence-based” services. It does no good to divert youth to community programs that can show no evidence of their value. Fortunately, evidence-based treatment programs do exist, as does some evidence that the best community-based programs for preventing delinquency recidivism also work well for youth with mental disorders.⁵⁷

Emergency Mental Health Services in Pretrial Detention

During the pretrial stage of juvenile justice processing, juvenile detention centers have special obligations regarding youth in their custody awaiting trial. Their treatment obligations, however, should be limited. They cannot provide long-term treatment for youth (for example, treatments designed to reduce delinquency), because the juvenile justice system is limited in its authority to exercise

such interventions until it has established its jurisdiction over the youth—that is, has found the youth delinquent after a hearing on the evidence. Detention centers are obligated to meet the immediate needs of youth in temporary custody, including their mental health needs that present as conditions that would pose harm to the youth if they were not addressed immediately.

Thus all detention centers should have the capacity to respond to mental health emergencies, such as suicide risks and escalation of symptoms to an extent that creates a threat to youth or others. Having that capacity does not mean that mental health professionals would always need to be on staff (although in large detention centers they often are). But facilities would need clear staff procedures for responding to youths’ emergency mental health needs, as well as access to outside clinical consultants and arrangements for rapid transfer to psychiatric facilities when necessary.

Some research suggests that despite the high prevalence of mental disorders among youth in pretrial detention centers, only about 15 to 30 percent of detention youth who meet criteria for a mental disorder receive treatment while in detention.⁵⁸ It is difficult to apply these findings to policy or planning, however. The shortfall is great if one presumes that every youth with a diagnosed mental disorder needs immediate treatment. But that presumption may be faulty, given that many youth with mental disorders might not need immediate treatment or might need effective treatment that could only be provided outside of detention, such as family-based treatments. Much more research is required to determine the level of need in detention centers based on symptom levels of youths’ mental conditions rather than on a diagnosis alone.

Assessment for Dispositional Treatment Planning

When youth are adjudicated delinquent, courts then determine the placement most appropriate for managing their rehabilitation. As it does in detention settings, screening at this point requires identifying mental health needs, but at this stage the purpose is not to identify youth who need emergency intervention but rather those whose rehabilitation plans should include specific types of longer-term mental health treatment. Such screening requires comprehensive and individualized assessment methods.

The information produced by that screening is typically provided to judges by specially trained probation officers, who should be using standardized tools that have recently been made available to assist them in collecting data on youths' needs, including mental health problems.⁵⁹ Some youth, however, need assessments by clinical professionals as a follow-up to probation assessments. Models for clinical evaluation services in juvenile courts are available, but little research has examined their efficiency and effectiveness in providing relevant information for the courts.⁶⁰ Assessments at this stage should help the juvenile court identify youth with mental disorders who, although adjudicated, might best be rehabilitated in non-secure community placements where they can benefit from a range of mental health services that typically are not available in secure correctional facilities.

Secure Care Mental Health Services and Aftercare

Different mental health service issues arise when certain youth, after having been adjudicated delinquent, must be sent to secure correctional facilities outside the community for reasons of public safety. In these cases, mental health services should be made

available within the secure facility itself. For some youth, the system can meet this need by buying psychiatric consultation services from outside the facility and by hiring mental health professionals to provide psychosocial interventions, such as individual psychotherapy. But a small percentage of delinquent youth—those with serious, chronic, and persistent mental disorders—will be too disturbed to be able to function within the routine programming of most correctional programs for youth.

There is as yet little research to guide the development of appropriate services for these youth. Some juvenile justice systems have identified certain secure facilities as “clinical units” where youth with serious, disruptive mental disorders are separated from the general youth correctional population and where they receive specialized clinical services from full-time mental health professionals on staff. A model that blends the resources of the juvenile justice system and the child mental health system to operate and staff such facilities would seem to offer various advantages. Such facilities exist in some states, but they have not been “modeled” or studied in a way that would allow for their systematic development nationwide.

Finally, new issues may arise when youth are released from secure residential programs back into the community. Typical “aftercare” programs involve close monitoring by probation officers when youth re-enter the community and often include educational and social plans for their re-integration. For youth with serious mental disorders, the most effective way to deliver those services is likely to involve the juvenile justice system’s continuing jurisdiction over youth during aftercare, but with primary interventions based in a community system of care.⁶¹

The Recommendations for Policy

Youth with mental disorders commit only a minority of a community's delinquencies, but they are at far greater risk of offending and re-offending than youth, on average, in their communities. A good deal more research is needed to make it possible to speak confidently about the best policies for responding to these circumstances, but certain directions for appropriate policies seem evident.

Perhaps most important, all stages in the processing of youth in juvenile justice must adopt practices that will improve the identification of youth with mental health needs—at court intake, detention admission, court decisions about disposition, and entry into secure juvenile justice programs. This broad policy should drive three specific ones. First, evidence-based screening and assessment tools should be used universally at these decision points to identify youth who might have emergency or long-term mental health needs. Second, every juvenile justice intake and detention program should document and archive screening and assessment results to provide data needed for system planning and resource development. And, third, all juvenile justice programs should make it a priority to educate personnel about the mental health problems of youth, thus improving the system's ability to identify and respond appropriately to such youth.

In addition, a community's child welfare agencies and juvenile justice agency should develop collaborations that will use mental health services in the community whenever possible to meet the mental health needs

of youth in contact with, or in the custody of, the juvenile justice system. Two specific policy recommendations are related to this general one. First, whenever possible, when youth are identified at intake as having long-term needs for mental health services, diverting such youth from processing should become a priority. Second, when youth with serious mental disorders are adjudicated delinquent, dispositions as well as aftercare should be coordinated with the community's mental health and juvenile justice services.

Finally, when safety considerations require that youth be confined in secure juvenile justice facilities removed from the community, the juvenile justice system should provide special mental health services for youth who have serious and chronic mental disorders. Providing such services may require developing small psychiatric inpatient programs, ideally blending the resources and objectives of the juvenile justice system and the mental health system.

All these policies are united by an overarching approach that reduces the political distance and boundaries among existing child welfare systems. Taking this approach might involve blending these agencies' resources and services or restructuring child welfare systems altogether so that separate agencies no longer exist. It is not two populations of youth—one delinquent, the other with mental disorders—that require attention. More often than not they are the same youth, and a child welfare system to meet their needs should be structured accordingly.

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