

## EXECUTIVE SUMMARY

# Double Jeopardy: Adolescent Offenders with Mental Disorders

by Thomas Grisso

Over the past two decades, two converging social trends have jeopardized the welfare of some of the nation's most troubled—and vulnerable—youths. Beginning in the 1980s, a rising tide of teenage violence led virtually every state to pass laws mandating severe penalties for violent young offenders and reducing the discretion of juvenile court judges to screen out those with mental disorders. At the same time, state after state saw the collapse of public mental health services for children and the closing of residential facilities for disturbed youths.

The results were predictable: juvenile detention centers began to take the place of psychiatric emergency rooms, and juvenile correctional beds increasingly were occupied by youths who really needed hospital beds. In some cases, parents voluntarily gave custody of their children to the juvenile justice system, or managed to have their children arrested, simply to obtain the mental health services they could no longer find in their communities. As a consequence, today an estimated two-thirds of youths in juvenile justice custody meet the criteria for one or more mental disorders—two to three times the rate found in the community at large.

Youth advocates have called on the juvenile justice system to do more to meet the mental health needs of the young people in its care. But what can we reasonably expect the system to do? In *Double Jeopardy: Adolescent Offenders with Mental Disorders*, Thomas Grisso examines this question, along with the complex issues that underlie it: Who are these doubly-imperiled youths? What do we know about their mental health needs? What are the system's obligations to them? How can we identify them as they enter the system and respond to their needs in a way that also meets the nation's objectives for the juvenile justice system?

Grisso's analysis is informed by a growing body of knowledge in the fields of child development, psychology, psychiatry, criminology, and law. He examines the damage that results from criminalizing delinquent behavior, yet cautions against the other extreme: viewing mental illness as the cause of violence, and mental health interventions as the solution

to juvenile delinquency. Without settling for simple answers, Grisso charts a rational course of action and points to the research that still must be done if we are to fulfill our responsibilities to these youths and to the public.

### ***Understanding the challenges***

Two kinds of challenges face experts trying to develop policy and practice for dealing with disturbed youths in the juvenile justice system: the limits of our knowledge (what we can do) and the obligations of the system (what we should do).

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***What can we do?*** Science has made so much progress in dealing with adult mental health problems, it is natural to assume we know just as much about the mental health of adolescents. In fact, we don't. Adolescence is a unique developmental period, characterized by enormous variability and change. Virtually every behavior or emotion that in an adult would be a symptom of a mental disorder will be found, for a time, in almost every child or adolescent. At one age it may be adaptive and "normal," at another maladaptive and "abnormal." Diagnostic categories don't describe adolescents' problems very well, and disorders often overlap.

While hundreds of tools are available to assess the clinical conditions of adolescents, their usefulness within the juvenile justice system is limited. These instruments were developed in clinical and community settings; it's not at all clear that scores have the same meaning when they're based on what youths and parents say in the juvenile justice context. Moreover, the norms developed for the instruments too often are based on samples

that don't reflect the ethnic, racial, and cultural composition of youths in the juvenile justice system. And the tools themselves often don't live up to their potential in practice, when the system is forced to use them with inadequate staffing or financial support.

Despite these limitations, some available methods do allow us to identify and describe youths' mental health problems—if we have the will to commit adequate resources to the task and a clear view of why we need to do it.

*What* should *we* do? Even before we decide how to identify disturbed youths, we must decide which ones we need to identify, and to what end. The sad fact is, nearly all young offenders in the system will meet the criteria for some mental disorder, and most could benefit from treatment. But the juvenile justice system is not and should not become the nation's child mental health system; it has neither the financial nor the professional resources to assume that role. Treating every child who could benefit is not a reasonable objective.

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How, then, do we decide which youths to assess, what instruments to use, and whom to treat? The answer requires that we consider the seriousness and potential consequences of a youth's mental disorder in light of the juvenile justice system's three sociolegal obligations:

- **The custodial obligation**

While young people are in the care of the system, it has a responsibility to protect them—to identify and respond to their most critical needs.

- **The due process obligation**

The system must safeguard defendants' rights and protect youths from legal jeopardy stemming from their disorders.

- **The public safety obligation**

The system has a responsibility to reduce the likelihood that a youth in its custody will harm others, now and in the more distant future.

Whatever policy decisions we make, whatever laws and regulations we pass, whatever practices we institute, they must trace back to these responsibilities.

***Protecting the youth: the custodial obligation***

Because adolescents depend on adults—even more so when their liberty is restricted—public agencies have a legal and moral responsibility to attend to the needs of young people in their custody. This doesn't mean, however, that the system must treat each adolescent's mental disorder. That would require enormous resources and entail potential risks to liberty and self-determination. And in any case, not all youths with mental disorders are equally in need of clinical care; some of them will function better than others, even with the same mental disorder.

A more limited and realistic response is geared to very specific objectives. The first is safety: We need, first of all, to reduce the risk of immediate harm, such as suicide attempts or out-of-control aggressive behaviors, while the youth is in custody. The second is to improve the functioning of seriously impaired youths so that they can participate in juvenile rehabilitation programs—a basic mandate of the system—or to divert them from those programs if their impairment is so severe they require intensive psychiatric care. Finally, we need to decrease the risk that a youth's mental disorder will recur and lead to further delinquency.

Given these objectives, when intervention is needed, what sort of treatment should the system provide? Effective treatment, of course—but that proves to be another very challenging task. There is evidence that some treatments can reduce both symptoms and delinquency recidivism. Their effectiveness, however, depends not only on the type of treatment, but on who provides it, how, and where. Treatments that work very well in controlled studies often are much less effective in the real world, where the environment, the providers, and the manner of delivery may be very different. And badly delivered treatment can be worse than no treatment at all.

Protecting the child, then, means more than simply offering treatment. It means that wherever we require treatment, we must also provide the means—qualified personnel, appro-



appropriate training, and continuing quality control—to make the treatment effective.

### ***Protecting the youth's rights: the due process obligation***

Because of its emphasis on rehabilitation, the juvenile justice system in its early years did not focus on issues of due process; even the modern juvenile court typically has provided only a “junior version” of legal protections for young defendants. In the 1990s, however, many states passed legislation that placed public protection above rehabilitation. As the system became more punitive, it also became more important to protect young defendants’ rights—to determine, for example, whether a juvenile who gave a confession had “knowingly, intelligently, and voluntarily” waived her Miranda rights, or to assess whether a young offender was competent to participate meaningfully as a defendant in his own trial.

How do we define standards of competence for juveniles? We can’t simply apply the same standards used with adults. For one thing, adolescents tend not to have the specific mental disorders or symptoms that, among adults, are the most common basis for incompetence to stand trial. For another, their developmental status—teenagers’ neurological, cognitive, and social immaturity—can itself impair their competence, something that has not generally been a factor in deciding adults’ competence as trial defendants.

Research has shown that immaturity impairs youths’ decision-making abilities and capacities as defendants, but it has not examined the combined effects of immaturity and mental disorders. While we know that mental disorders influence cognitive abilities, there are no objective guidelines that make it clear whose confessions should be excluded or who is not competent to stand trial. It falls to the defense attorney to raise the question of competence, to press for an evaluation, and to ensure that information revealed in the evaluation is not used improperly against her client.

This is a lot to expect of lawyers who are usually court-appointed and paid with public funds, are sometimes inexperienced, and often have spent only a few minutes with their clients before the trial. To protect young defendants’ rights, then, one of the most important steps we can take is to provide them with competent defense attorneys—which means we must give defense attorneys the specialized training they need to represent children. We also need to develop legal definitions of competence that

recognize the roles of immaturity and childhood disorders in impaired functioning. And we must ensure that forensic mental health professionals have the training to evaluate youths’ legal competence in ways that are sensitive to the developmental differences between adolescents and adults.

### ***Protecting others: the public safety obligation***

The increase in mentally disturbed adolescents in the system is due, at least in part, to a concern for public safety. The system does have an obligation to reduce the likelihood that youths in its custody will harm others. But how can we identify which youths present an increased risk of violence? And where, in that obligation, do adolescents with mental disorders come in? Are they in fact more likely to be violent?

These turn out to be enormously complex questions. Research has shown a substantial relation between adolescents’ mental disorders and mental states such as anger and impulsivity. But this will not necessarily tell us which delinquent youths are likely to harm others. While we may be able to evaluate relative levels of risk, we are nowhere near being able to predict violence.

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It’s important to recognize that at different points in the juvenile justice process, we’re concerned with the potential for aggression over different timeframes; at each point, particular symptoms or mental states may carry different weights, require different forms of screening, and call for different responses. At the point of entry, for example, a decision must be made whether to send the youth home or to a secure detention facility (or hospital) during further processing; here the concern is primarily the short-term risk of harm to others and possible crisis intervention. At later stages—for example, in considering whether rehabilitation should take place in the community or a secure correctional center, or whether the youth should leave juvenile justice custody—a longer view is called for. In

these cases, however, judges must learn not to expect more certainty than science can support.

The public safety mandate can sometimes lead to a conflict between short- and long-range obligations. To protect the public in the short-term, it may be necessary to place a youth in a secure facility. If he has a mental disorder that is increasing his risk of aggression, the system needs to provide treatment that will reduce the risk when he is eventually released from custody. Yet the most effective treatments for young offenders require that they be treated in the context of their family and community—impossible in a secure facility.

The conflict points to an important concept in thinking about juvenile offenders, mental illness, and violence: Correctional facilities are necessary, but they are not a good setting for the rehabilitation of adolescents with mental illness. For those few young offenders who require round-the-clock psychiatric care, secure hospital units must be available. For the greater number who require treatment for rehabilitation to be successful, the goal should be to keep them in a secure correctional facility only until the level of risk is low enough that they can be treated in the community. This goal is not easily achieved in a system of mandatory sentencing.

### **Research questions and policy considerations**

Once we understand the obligations of the juvenile justice system toward youths with mental illness—and the extraordinary challenges they present—the question remains: What must we do in order to fulfill these obligations? There are many tasks ahead for science, law, and policy.

While science has made remarkable progress in both child mental health and developmental psychology, many questions central to juvenile justice remain unanswered. For example, we know very little about the variations in how mental disorders affect the risk of violence in young people of different ages, genders, and racial, ethnic, or cultural groups. Until we have that knowledge, it will be difficult to develop valid instruments for assessing a juvenile offender's risk of aggression. We also have little information on the effectiveness of different treatments for mental disorders in juvenile justice settings. Most of these interventions have been tested on very different population groups and in very different environments, with methods of delivery that may not be practical in the juvenile justice setting, and with different objectives. At this point, it

is impossible to say which treatments, if any, make a difference—either for the juvenile offender's ability to function, or for his threat to public safety.

In the law, perhaps the most urgent need is to clarify competence criteria for young offenders. The legal concepts of competence to stand trial and valid waiver of rights were developed for adults in the criminal justice system. For youths, we still need to identify the relevant abilities and how they are affected by mental disorders and immaturity. Then we need to educate defense counsel, prosecutors, judges, and forensic mental health professionals about adolescents' developmental capacities and mental disorders, and their relation to legal questions about competence and waiver of rights.

Finally, to fulfill our responsibilities to youths in double jeopardy, we must develop better models of interaction among the juvenile justice system, the child mental health system, and other child welfare agencies. Some jurisdictions have already begun to move in this direction, with collaborative programs such as juvenile mental health courts or treatment foster care. The next step might be joint ventures in inpatient and outpatient programs for seriously disturbed youths. The solutions will surely require innovative approaches to funding and the blurring of administrative boundaries. But it is clear that no single agency or program can protect the safety of society, the fairness of the system, and the emotional health of troubled adolescents.

### **Ordering Information:**

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