Violent Adolescents: Psychiatry, Philosophy, and Politics

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Historically, the American Academy of Psychiatry and the Law (AAPL) has not engaged in debates on public policy. In its unique position at the interface of law and medicine, AAPL is able to make important contributions to social policy involving management of violent youths. In the 1990s, increasing rates of violence among adolescents spawned a new era of research into the causes and correlates of violence in youths. The resultant data on risk factors have provided opportunities for establishing empirical assessments and risk-focused treatment programs. Community treatment programs that demonstrate a moderate effect in reducing violence have renewed optimism about the benefit of treatment over punishment. The ongoing development of methodology to assess risk for violence presents opportunities for advancement of rehabilitation. Current social policies that limit the ability to provide treatment and rehabilitation in juvenile settings should be challenged by organized psychiatry.

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Psychiatrists working with juvenile courts or corrections face unique clinical challenges due to the wide-ranging developmental capabilities, psychological sophistication, social and family backgrounds, socioeconomic status, and education of presenting youths. Young offenders engage in an array of criminal behavior of varying severity and frequency. While most adolescents charged with criminal offenses commit minor and nonviolent crimes, there is a sizable subgroup of offenders who commit serious or violent offenses. These youths challenge society's ability to protect itself from harm while providing the rehabilitation and treatment that may assist the youth in establishing a pro-social lifestyle to reduce the future risk of violence. A brief overview of the changing, and at times conflicting, values within juvenile justice that clash with medical values of beneficence is presented, and the empirical research on risk factors for juvenile violence, treatment programs with proven efficacy, and prevalence rates of psychiatric illness among juvenile offenders are reviewed. Current controversies in juvenile forensic psychiatry, including assessment of risk for future violence and assessment of "psychopathy" and the advocacy role for rehabilitation within juvenile justice that AAPL could assume, are discussed.

Juvenile courts have always ambivalently approached adolescents who come into conflict with the law. Rutter *et al.*[1] described the changes, in European philosophy of justice for juvenile offenders, from a welfare model in the 1950s, emphasizing rehabilitation, to a "just desserts" model in the 1970s, emphasizing civil rights. Rutter coined the term "populist punitiveness" to describe a political process that has developed over the past 20 years, in which the argument that punishment would reduce crime through general deterrence and incapacitation appealed to the electorate as a solution to juvenile crime.

Grisso[2] noted a similar trend in the United States. Traditionally, the courts have seen adolescents as being developmentally immature, less culpable than adults, and deserving of separate treatment. Rehabilitation, guidance, and training of young offenders were given greater emphasis than punishment. Unfortunately, efforts at rehabilitation at times led to lengthy periods of incarceration that were longer than those given to adult offenders convicted of sim-

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ilar crimes. He described the "rights reform" beginning in the 1960s, emphasizing establishment of due process rights for young offenders similar to those afforded adult offenders. The courts, however, still insisted on the obligation to rehabilitate juvenile offenders. Grisso described the "punishment reform" beginning in the 1980s in response to increasing rates of adolescent violence. The catchphrase "adult crime-adult time" signaled the trend to treat adolescents as if they were adults, despite the substantial developmental differences. This phase increased the likelihood and severity of punishment for young offenders, increased the number of juveniles transferred to adult courts, and emphasized public safety over rehabilitation.[3]

The latest review of juvenile court statistics in the United States provides data from 1998.[4] Most states have multiple pathways to determine which juveniles will be tried in adult court. All states have maintained the traditional juvenile court waiver procedures in which a juvenile judge may decide to transfer a youth to ordinary court, following a full hearing. By 1999, 29 states had enacted statutory transfer provisions in which commission of certain offenses, usually violent, resulted in automatic transfer to adult court. In 13 states, the upper age of juvenile court jurisdiction was reduced to 15 or 16 years from 17 or 18. In 15 states, concurrent jurisdiction provisions gave prosecutors discretion regarding which juveniles should be tried as adult offenders. There are no data on the number of juveniles who are tried under concurrent jurisdiction provisions. In Florida, a state with broad provisions, prosecutors sent 4,000 juveniles to adult court in 1998 and 1999. This compares with an estimated 8,100 cases annually nationwide that were transferred by juvenile court judges after waiver hearings. Among felons sentenced to prison, transferred juveniles were more likely to receive prison sentences for the same crime than defendants who were adults at the time of the offense.

In the United Kingdom, youth justice reforms in the past three years have focused on reduction of use of custody for young offenders, with greater emphasis on community management.[5] England is proceeding with restorative justice programs, family programs, and intensive supervision programs (ISSPs) as alternatives to custody. The ISSP, designed for persistent young offenders, provides intense supervision with education, vocational training, and programs to reduce offending, as well as reparation for victims. Intensive noncustodial programs cost less than one-third of a custodial sentence.

Canada's 1984 Young Offender Act[6] paralleled other legislation, emphasizing civil rights and community protection. It was replaced in 2003 by the Youth Criminal Justice Act[7] that returned emphasis to rehabilitation. In the Declaration of Principle, the Act sets out the intent to prevent crime by addressing factors underlying criminal behavior, providing rehabilitation while also ensuring measured consequences for criminal conduct consistent with the youth's immaturity. Intensive rehabilitation custody and supervision programs for violent offenders were established and funded as an alternative to adult sentences. Parliament intended to reduce the number of youths in custody and the length of sentences given to individual offenders. Arguably, the Act places greater faith in rehabilitation than may be justified by empirical data. While it is too early to estimate the public's overall reaction to the new legislation, it is anticipated that there will be public outcry when young offenders who commit particularly heinous crimes receive only modest punishment. The emphasis on rehabilitation over punishment may well result in loss of confidence in the justice system.

The tension between the goals of rehabilitation and protection of the public has resulted in a pendulum-like approach to young offenders. Evident from the review of juvenile justice legislation in Western nations is a harsh approach to controlling a young offender that is beginning to swing back to a more rehabilitative model in some jurisdictions. The renewed interest in rehabilitation of young offenders has in large measure stemmed from longitudinal research identifying risk factors and potential treatment options conducted in a number of countries in the last decade.

Psychiatric Disorders in Young Offenders

In the past five years, there has been increasing attention paid to the prevalence of psychiatric illness in young offenders.[8] In the United States, this arose from a growing recognition of the unmet mental health needs of young persons in general coupled with studies documenting the inadequacy of mental health services in juvenile correctional facilities. The empirical literature is limited, but the research data suggest high rates of psychiatric illness in young offenders.[9]

Similar findings emerged in the United Kingdom.[10] Prevalence estimations derived from limited studies suggested rates of mental health problems in 46 to 81 percent of young offenders. The report by The Mental Health Foundation concluded that existing mental health services failed to meet the needs of this population and called upon the government to increase psychiatric services under the National Health Service.

In a recent prevalence study by Teplin,[11] substantial rates of psychiatric morbidity were found in juvenile detainees in Chicago. Even after excluding the diagnosis of Conduct Disorder, 60 percent of males and 67 percent of females met diagnostic criteria for one or more psychiatric disorders. Bearing in mind the limitations of the research, the rates of psychiatric disorder in young offenders are far greater than previously estimated and exceed the capabilities of community and institutional mental health services.

Risk Factors for Adolescent Violence

In the past 15 years, there has been a surge in research into child conduct problems.[1,12,13] Longitudinal and cross-sectional studies in different countries and cultures have examined multiple factors to determine their association with subsequent offending and violence. There is a convergence of findings in different studies that confirms the multifactorial nature of serious offending behavior and violence. This has resulted in a wealth of data that can now be used to formulate prevention and treatment interventions for children and youths at different developmental levels.

Self-report rates of criminal behavior and violence by adolescents in England demonstrate high frequency of behavior that would, if discovered, result in criminal charges.[14] In the United States, the Monitoring the Future project has demonstrated stable levels of self-reported violent behavior over the past 25 years, with approximately 30 percent of adolescents affirming at least one violent act in the previous year.[15] Given the high rates of antisocial and assault behavior, one could consider this almost normative in adolescence. Most adolescents, however, discontinue antisocial or violent behavior by late adolescence, and only a small percentage of them go on to become chronic adult offenders.

Youths who exhibit serious violent behavior usually also commit other serious nonviolent crimes, so that it is difficult to separate violent offenders from other chronic severe delinquents. Violent adolescents are a heterogeneous group with variable social and psychological profiles. Despite the variability of traits, certain patterns of behavior help identify those youths at higher risk for violence. The characterization by Moffitt[16] of the "life course persistent offender" versus "the adolescent limited offender" identifies a group of offenders who carry a higher risk of violent behavior. The life course persistent offender usually demonstrates conduct problems in early childhood, with more than 50 percent continuing to demonstrate antisocial behavior that escalates during adolescence and the adult years. Although they make up only approximately 5 percent of the population, such persons commit a disproportionate number of offenses. They have higher rates of difficulties in temperament, social alienation, and poor parenting, as well as difficulties with cognitive deficits, hyperactivity, and attention problems, impulsivity, and aggressiveness. They present a higher risk of continued antisocial behavior than the adolescent limited group. The fact that many desist in their antisocial behavior in adolescence, however, highlights the complexity of predicting violent behavior during the rapid shifts in psychological development inherent in adolescence. Predicting violent behavior is further complicated by the fact that youths who begin and are likely to discontinue their antisocial behavior in adolescence are a far larger group and commit an overall higher number of violent offenses. Although adolescent-limited offenders are more likely to discontinue antisocial behavior in young adult years, they are often caught in the web of mandatory waiver to adult court, resulting in potentially lengthy adult sentences that are not necessary to assure public safety.

In response to increased violence among adolescents, The Surgeon General of the United States examined youth violence from a public health perspective.[17] Results from Lipsey's meta-analysis of longitudinal studies[18] were augmented by longitudinal studies from the United States. Risk factors were defined as anything that increased the probability for violence, with the condition that there was an underlying theoretical rationale to support the factor. Factors were categorized into early-onset and late-onset and divided into individual, family, peer, community, and school factors. Risk factors were demonstrated to have different effects at different ages of development. By adolescence, each factor had only a

small individual effect, but the cumulative effect was substantial.

The report cautioned that no individual factor or group of risk factors was powerful enough to predict which individual would become violent. Most youths with evidence of some risk factors would never become violent, but risk factors could be used to predict rates of violence in groups with certain characteristics.

In 1998, the National Institute of Mental Health initiated a process to identify risk factors for children and youths exhibiting externalizing behavior problems and to identify further research needed in the field.[19] A group of experts reached consensus on factors supported by key research studies. Factors were divided into "correlates," "predictive risk factors," and "causal risk factors." A critical review of the literature identified a number of significant causal risk factors, including children's hostile attribution processes, parental engagement and discipline patterns, and peer rejection and association with delinquent peers. The need to move beyond examination of simple risk factors to develop a more complex view of how these factors interact within a developmental and contextual perspective was emphasized. As an example, a child's temperament interacts with parenting style in a bidirectional relationship, so that each affects the other. Similar findings can be seen in other interactions. For example, Moffitt found in the Dunedin study[20] that the aggression in youths with low neuropsychological functioning coupled with family adversity was four times higher than in boys with either factor alone.

Treatment Approaches for Violent Adolescents

In the modern history of juvenile justice, there have been multiple failed attempts at treatment and rehabilitation of juvenile delinquents that led to a sense of therapeutic nihilism by the 1980s. In the past decade, however, there has been renewed optimism in the efficacy of treatment and rehabilitation of juvenile delinquents. In a comprehensive meta-analysis of 200 treatment studies, Lipsey and Wilson[21] concluded that there was statistically significant overall treatment effect with some approaches showing great promise. Within the meta-analysis, the best treatment outcomes had a 30 percent recidivism rate in the first year, compared with a 50 percent rate of recidivism in control groups. Treatment programs focusing on interpersonal skills, cognitive behavioral techniques, individual counseling, and multiple services were the most effective for community groups. Although a modest treatment effect could be demonstrated, the authors concluded that given the array of treatment program combinations, even 200 studies were insufficient to derive any firm conclusions.

The report of the Surgeon General on youth violence reviewed proven programs.[17] Level 1 programs demonstrated reduction of violence or serious delinquent behavior, and Level 2 programs demonstrated reduction of known risk factors for violent behavior. Determinations were based on rigorous experimental designs, evidence of significant deterrent effects, and replication of results at multisite or clinical trials. Programs were divided into primary, secondary, or tertiary prevention. Tertiary prevention programs were aimed at adolescents who were already demonstrating violent or serious delinquent behavior. The review reached two major conclusions. First, treatment could divert a significant proportion of violent youths from future violent behavior. Second, there was marked variability in the effectiveness of different types of programs.

The Surgeon General's Report outlined "model programs" that employed rigorous experimental design and resulted in significant and replicated deterrent effects on violence. Tertiary prevention model programs aimed at youths who were already demonstrating antisocial or violent behavior included "functional family therapy," "multisystemic therapy," and multidimensional foster care. Ineffective tertiary programs were also identified. These included "boot camps," residential programs, and social casework. In contrast to the stated goals of reducing crime, waiving adolescents to adult court was shown to increase subsequent recidivism among those youths who had been waived, while exposing them to increased rates of physical harm by other adult prison inmates. Waived youths had much higher rates of attempted and successful suicide in custody than did adult defendants.

Empirical studies of psychosocial programs demonstrate only a moderate treatment effect for violent adolescents; however, progress in pediatric psychopharmacology is likely to increase treatment effectiveness by targeting specific risk factors, including impulsivity, attention deficits, and underlying psychiatric disorders associated with violence. Con-

nor[13] summarizes the pharmacological approaches to adolescent aggression. There is strong empirical support for the use of neuroleptic drugs for disruptive behavior disorders and psychotic disorders and for the use of stimulants in Conduct Disorder and Attention Deficit Hyperactivity Disorder. Promising results have also been obtained for mood stabilizers. While it would be reductionistic to believe pharmacological treatments by themselves would have a profound effect on individual aggression, there is reason to expect that combining psychosocial treatments with targeted pharmacological interventions will lead to improved compliance and ultimate efficacy.

Current Controversies

Juvenile justice legislation is the measure of our approach to dealing with violent adolescents. Within different jurisdictions, there is different emphasis placed on the goals of rehabilitation versus protection of the public. As a result, there are marked differences in the way violent juveniles are managed. In some jurisdictions, adolescents convicted of a violent crime are exposed to harsh penalties that in other jurisdictions would merit comparatively limited incarceration or intensive supervision and treatment. Accordingly, different jurisdictions place variable ethics and clinical demands on forensic psychiatrists. Central to ethics concerns are determinations of which adolescents meet statutory criteria for waiver to adult court. Courts generally apply the "public safety standard" and the "amenability to treatment standard"[2] that demand assessments for risk of future violent behavior and potential to reduce that risk through specific treatment and rehabilitation.

The assessment of risk of violent behavior in adult offenders has been the subject of extensive debate.[22,23] Despite many legitimate concerns regarding the methodology, process, and accuracy of the probability assessments and the purposes for which they are used, empirical data, at least, have been developed to guide the process. Assessment of risk of violence among adolescents shares the same concerns but lacks validated risk assessment instruments and must also account for the fluid state of adolescent development. Grisso[2] described the assessment as employing known risk factors, actuarial factors, base rates of violent behavior, and assessments of the social context in which the violence occurred. Conditional short-term risk estimates are possible with some degree of accuracy, but estimates of long-term risk are more problematic. While it is reasonable to assume that youths exhibiting the extremes of either few or many risk factors would be more likely to be assessed accurately, we are currently unable to predict accurately future violent behavior in the larger middle group. At this point, the forensic psychiatrist is able to give to the court a generic description and analysis of proven risk factors and protective factors in a specific situation and guide the court as to the significance of the information.[24] Definitive statements as to an individual's risk for future violence should only be offered in broad statements that highlight the limitations of the research.

At the current time, specific structured risk assessments of youth violence[25,26] are being tested in offender populations. The Structured Assessment of Violence Risk in Youth (SAVRY) is a work in progress, utilizing a structured professional judgment approach.[26] The SAVRY was created by employing risk and protective factors derived from existing research, operationalizing them, and scoring each of them on a scale from zero to two, based on the extent of fit with the description. Preliminary research in adolescent offenders showed moderate ability to predict which youths would reoffend in the 12 month follow-up period.[27] While preliminary results are encouraging, there is insufficient research at this time to affirm use of this instrument for court purposes. The structured professional judgment approach, however, has much to offer as a general guideline in the clinical assessment of violent offenders and serves as an *aide-mémoire* in ensuring that relevant factors are considered in the assessment. It also focuses the assessment process on those areas that may be amenable to intervention and thus guides treatment planning.

In adult forensic settings, the Psychopathy Checklist-Revised (PCL-R),[28] used to predict psychopathy, has become a well-established instrument for predicting risk of future violent behavior. Groups of individuals with high psychopathy scores have higher rates of violent offenses than offenders with lower scores. Like all instruments used for assessment of risk, the PCL-R is unable to establish the specific risk for a given individual.[29] Psychopathy has been defined as a specific form of personality disorder. Psychopaths are arrogant, superficial, and manipulative, with shallow and labile affects, and are unable to form strong emotional bonds. Behaviorally, they are irresponsible, impulsive, and sensation seeking and

are prone to criminal behavior.[30] Generally, these traits are evident in adolescence and continue through the adult years. The diagnosis of psychopathy commonly has severe consequences for offenders and may affect their classification within correctional settings and limit their opportunities for parole. To date, there has been no proven treatment for adult psychopathy, although the literature is characterized by significant methodological weaknesses.

Personality traits consistent with psychopathy are recognized in adolescent offenders, but there is heated debate as to whether psychopathy is an appropriate concept for adolescents. The first measurement of psychopathy in adolescents utilized a modified PCL-R that eliminated two items and modified two further items.[31] High psychopathy scores were able to predict reconvictions for violent offenses. Subsequent studies utilizing the Psychopathy Checklist-Youth Version (PCL-YV)[32] have found good internal consistency and inter-rater reliability in adolescent populations.[33] High psychopathy scores correlated with age of first arrest, seriousness of offense, and number of convictions,[34,35] reoffense rates in adolescent sexual offenders,[36] and reoffense rates in violent offenders treated in the community.[27]

Other measurements of psychopathy in children and adolescents include the Psychopathy Screening Device[37] and the Childhood Psychopathy Scale (CPS).[38] Limited research is available on these instruments. The CPS was used in the middle group of the Pittsburgh Youth Study.[39] Youths with high scores demonstrated the most impulsive, severe, frequent, and aggressive conduct difficulties and provided incremental accuracy in predicting antisocial behavior over and above other known risk factors. Lynam[40] argued that youths with conduct problems combined with hyperactivity, impulsivity, and attention difficulties are "fledgling psychopaths."

Early identification of psychopathy may have profound impact if treatment and support resources can be applied to these youths and their families early in their development. Childhood personality traits interact with the environment in a manner that may perpetuate or exacerbate their development.[41] Disruptive youths may evoke harsher discipline or reaction from parents or teachers that may serve as a rationalization for subsequent oppositional or antisocial behavior. These disruptive individuals often associate with other youths with similar behavioral problems that predictably reinforce the antisocial traits. Early intervention may disrupt this reinforcement resulting in amelioration of the development of adult "psychopathy."

While recognizing the potential benefits of early identification and intervention, a number of critics have recognized problems regarding the use of the construct of "psychopathy" in adolescents. Seagrave and Grisso[41] raised concerns that psychopathy may be diagnosed in adolescents who may be going through a transient developmental phase that mimics similar traits—for example, self-centeredness or rule-breaking behavior, resulting in false positive diagnoses. The temporal stability of psychopathy from adolescence into adulthood has not been demonstrated empirically, thus limiting its predictive ability. The lack of certainty regarding base rates of psychopathy, cutoff scores used to determine psychopathy, and the potential for examiners to fail to consider temporal and contextual information were cited as potential problems. Ultimately, the authors feared that a psychopathy diagnosis would be used as a screening device to transfer youths to adult court.

Other authors[43] wondered whether juvenile psychopathy actually exists, and if it does, whether it is the same as adult psychopathy, given the lack of longitudinal research on the temporal stability of the construct. The same group of researchers, however, agreed that there is good inter-rater reliability in measures of psychopathy and that the same traits are found in both adolescents and adults.[29]

Existing research findings on risk assessment and juvenile psychopathy have potential for great benefit and great harm. In large measure, the harm versus benefit is determined by the context and purposes of the assessment. In those jurisdictions emphasizing a retribution and punishment approach, one could easily envision a youth given the label of "psychopath" or the designation "high risk" to be summarily transferred to adult court and denied any opportunity for rehabilitation. Given the current state of research, such summary determinations would not be justified. In adults, the diagnosis of psychopathy connotes the image of a ruthless, callous, and dangerous individual who is not amenable to treatment. It is easy to understand how courts would perceive an adolescent psychopath in a similar vein and react with a punitive response to protect the public. This would be inappropriate on two grounds. First is the lack of empirical support for the temporal stability of

adolescent psychopathy. Second, research into specific treatment aimed at the core features of adolescent psychopathy has not yet been conducted. In a recent preliminary study of treated versus untreated youths with high PCL-YV scores, treated youths showed significantly lower recidivism rates than untreated youths.[44]

In research and treatment settings, assessment of adolescent psychopathy adds an important element to the evaluation process. This subgroup of offenders can be reasonably identified with good inter-rater reliability, and comparisons across different treatment settings are reasonable. Adolescents with high PCL scores are identified as high-risk youths who should receive increased treatment and supervision services. At this point, no definitive treatment has yet been developed, and development of such a treatment must be a priority for future research. Whether we can significantly alter the trajectory of adolescent psychopathic-like traits and behavior into adult psychopathy remains to be determined.

Advocacy in Juvenile Justice

In an ideal world, juvenile offenders with psychiatric difficulties would receive appropriate treatment and resources in a juvenile setting. In the real world, resources are limited, and many juveniles are transferred to adult court and prisons where no treatment is available and they are exposed to abuse and violence. Many youths transferred to adult court are indeed violent and dangerous and may not be amenable to intervention or treatment. While far from perfect, the comprehensive risk focused assessment process is able to identify within reason those youths who present the highest risk from those who are less likely to continue offending. The civil rights of the accused are protected through the due process of the waiver hearing and the evaluation of the forensic psychiatrist or psychologist is open to cross-examination. The process is designed to be fair and transparent.

In contrast to the waiver hearing are automatic transfer provisions in which the nature of the crime or the opinion of the prosecutor determines whether a youth will be tried in adult court. While no doubt many of these offenders pose a significant risk to reoffend, we have no way of determining which of these youths share the risk factors that indicate a likelihood of future violent offending. Adolescents who may have committed a violent offense, but who would not be evaluated as a high-risk offender on a comprehensive assessment, are exposed to a process that has been demonstrated to be likely to cause harm without necessarily reducing the risk of subsequent recidivism. The genesis of this legal doctrine was in part driven by rising levels of youth violence that shocked communities, coupled with the lack of knowledge about prevention and treatment of violent behavior in adolescents. It was fueled by a political process that overstated the public peril. These factors are no longer as relevant. The rates of youth violence, as measured by crime statistics, have declined in virtually all Western countries. We are now at a point where we can offer moderate abilities to predict higher-risk youths and construct prevention and treatment programs. While these programs are far from ideal, the public health prevention and treatment approach is superior public policy to automatic transfer provisions that incarcerate without rehabilitating.

Forensic psychiatrists are accustomed to working within the legal system in a narrow manner by applying psychiatric knowledge to the specific legal situation faced by an examinee. Some forensic psychiatrists become involved in public policy consultation through work on *amicus* briefs or consulting to lawmakers. As an organization, AAPL has been reluctant to be involved in public legal policy issues, generally for very sound reasons. Some public policy issues raised in annual meetings are not specifically medical or psychiatric in nature, but rather are based on moral value judgments. Engaging in public policy debate can be a costly and time-consuming undertaking that may commit resources that are better spent in educational forums consistent with the mandate. Further, members have expressed concerns that their individual views may be in conflict with the AAPL position, placing them in a potentially awkward situation when testifying.

In contrast, the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) regularly develop position statements on legislation that impacts psychiatric practice. In 2001, the AACAP established a task force on juvenile justice reform that included many AAPL members. Their recommendations focused primarily on advocacy for medical and psychiatric care of juvenile offenders.

The AAPL has recently set up task forces to develop guidelines for insanity defense and competency

to stand trial evaluations. These are primarily education documents in keeping with the mandate and the definition of forensic psychiatry as applying psychiatric knowledge to specific problems of law. As the AAPL edges into public positions on forensic matters, the questions become focused on what limits are set on the process. While position statements based on scientific evidence may be of great assistance to policy makers, they may also be used for unintended purposes, resulting in potential embarrassment for the organization or individual members. Accordingly, there must be careful oversight of the process and resultant product. Any position statements should reflect the core values of medicine and psychiatry, while also addressing the potential value conflicts among medicine, law, and social policy. Appelbaum,[45] in his presidential address and subsequent article, noted that a profession's ethics are shaped by the broader social acceptance and support of its activities. While forming public policy is beyond the scope of our abilities, it is reasonable to assume that positions promoting assessment and treatment of psychiatrically disturbed adolescents within the juvenile justice system would fall comfortably within the public expectation of our role. Although advocacy on the part of an expert witness is undesirable, advocacy for scientifically supported interventions for violent youths should be seen as a priority for organized psychiatry.

The existing research supports a number of conclusions that are central to public policy issues in juvenile justice. Treatment and rehabilitation of young offenders demonstrate moderate benefit, with the promise of improvement with further research. Most youths can be managed safely in juvenile justice settings that provide the opportunity for treatment and rehabilitation. While far from perfect, forensic psychiatrists and psychologists have the skills to assist the court in identifying high-risk youths and those who may have committed a violent crime but are not at high risk for a violent lifestyle.

Psychiatric and medical issues are but one small part of the much larger legal, philosophical, and political debate in juvenile justice policy. Since assessment and treatment are so central to the management of violent youths, it is difficult to understand how policy makers can form sound law without this clinical input. The AAPL has a unique position at the interface of law and psychiatry. The AAPL can utilize the expertise at its disposal to contribute to public debate. Now is the time for the Academy to establish a task force to create a public position on psychiatric intervention for violent youths.

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