

Mental Health Courts

A mental health court is a court with a specialized docket for certain defendants with mental illnesses (Almquist and Dodd 2009). Mental health courts divert select defendants away from the regular criminal courts into judicially supervised, community-based treatment to properly address their overwhelming health needs. In contrast to traditional courts, mental health courts have therapeutic goals, including increasing participants' adherence to treatment and decreasing future involvement in the justice system (McNiel and Binder 2007).

Mental health courts are problem-solving courts modeled after drug courts, which are voluntary in nature and concentrate on providing defendants with appropriate treatment through the use of graduated sanctions. Court staff and mental health professionals screen and assess individuals to develop appropriate treatment plans. Individuals who agree to the terms and conditions of supervised treatment must also attend regular status hearings to report to the judge on the adherence or nonadherence to the treatment plan. Adherence to court conditions may result in rewards and incentives, whereas nonadherence may result in sanctions. Treatment plans and conditions of supervision may be revised as needed.

Scope of the Problem

Mental illness in the juvenile justice system has become an increasingly obvious problem. A report from the National Center for Mental Health and Juvenile Justice found that 70 percent of youths in the juvenile justice system are afflicted with a mental health disorder, and 27 percent suffer from a disorder so severe it significantly impairs their ability to function (Cocozza and Shufelt 2006; Shufelt and Cocozza 2006). The true extent of the mental health needs of youth in the juvenile justice system is unclear, as most standardized screening instruments that diagnose such disorders are not administered until youth are adjudicated and put in an out-of-home placement.

The Survey of Youth in Residential Placement found that 51 percent of youths in placement reported symptoms of depression and anxiety. In addition, when asked specific questions from the MAYSI Depressed-Anxious Scale (which determines whether a youth requires mental health treatment for these problems), 48 percent of youths scored within the "caution" or "warning" range on the scale (Sedlak and McPherson 2010). One-fifth of youths reported two or more recent suicidal feelings, and nearly the same amount (22 percent) reported past suicide attempts, which is nearly 4 times the rate reported by national samples of youths in the general population. However, the survey also showed that mental health services provided to youth in custody fall short of recommended practices.

In response to the increasing population of defendants with mental illness, the popularity of mental health courts has grown in the last decade, despite little empirical evidence of these types of courts obtaining successful outcomes (Steadman and Redlich 2006). In 1997 there were four mental health courts in the United States. By 2009 there were some 250 courts in operation; however, most of them are for adults (Almquist and Dodd 2009). The first juvenile mental health court was established in 2001 in Santa Clara County, Calif. Today, there are more than a dozen courts operating in California, Florida, Ohio, and Washington, and several more are in development (Herman 2005).

Theoretical Foundation

Juvenile mental health courts, like juvenile drug courts, operate under a paradigm of therapeutic jurisprudence. The principles of therapeutic jurisprudence promote a nonadversarial, treatment-oriented approach when adjudicating juvenile offenders, while still upholding their due process rights (Winick and Wexler 2003; Porter, Rempel, and Mansky 2010). Operating under the paradigm of therapeutic jurisprudence, the main purpose of mental health courts is to treat and rehabilitate youth (i.e., treating mental health issues, reducing recidivism).

Juvenile mental health courts are designed to use a multidisciplinary team approach to develop and monitor treatment plans and compliance, as well as provide necessary treatment to youth. Team members could include district attorneys, public defenders, mental health providers, and case managers or probation officers (Cocozza and Shufelt 2006; Arredondo et al. 2001).

Characteristics of Juvenile Mental Health Courts

There is a lack of agreement regarding what constitutes a mental health court, leading to a difference among courts regarding several dimensions, including target population, accepted offenses, intensity of supervision, and program duration (Council of State Governments 2005; Behnken, Arredondo, and Packman 2009; National Center for Mental Health and Juvenile Justice 2005). The National Center for Mental Health and Juvenile Justice identified and surveyed 11 existing juvenile mental health courts to provide an overview of the current courts in operation (Cocozza and Shufelt 2006). Findings from the survey provide an overview of the everyday operation of mental health courts that serve juveniles.

Most of the surveyed juvenile mental health courts accepted youths with a range of charges, from misdemeanors to felonies. While the courts did not necessarily exclude youths based on current charges, the mental health eligibility criteria were more stringent. Half of the surveyed courts accepted only those youths suffering serious mental health illnesses, while other courts accepted youths who had any identified mental health issue.

The caseload of the courts also varied. Some juvenile mental health courts operated with small caseloads (usually fewer than 10), while other courts were able to serve up to 75 youths at a time. The size of the docket depended on a variety of factors, including the size of the jurisdiction, the amount of resources available, and whether the court provided direct services or relied on existing providers. The length of time youths were involved with the court also depended on the court. For youths who complete the program, the length of court involvement ranged from 3 to 6 months in one court to a 2-year minimum in another. The average length of involvement was between 10 and 18 months.

Most of the courts provided services to youths through relationships with existing community-based service providers. Therefore, services provided to youth mainly depended on the availability of services in a given community. Services provided to youth include individual, group, and family therapy; medications and medication management; case management services; and evidence-based services such as Multisystemic Therapy.

Concerns/Issues

There are several benefits to juvenile mental health courts, including the advantages of a multidisciplinary approach to treatment, increased dispositional alternatives for judges, monitoring strategies that can increase compliance with treatment plans, and an increased awareness of the problem of the lack of mental health services (Cocozza and Shufelt 2006). However, numerous concerns have been raised, as the number of mental health courts—and problem-solving courts—continues to increase across the country.

One main concern has to do with the problem of net widening. Juvenile mental health courts are designed to divert youths with mental health disorders from further processing in the juvenile justice system and provide them with appropriate and necessary treatment. But there is concern over the potential misuse of mental health courts. Parents or guardians may seek delinquency court jurisdiction for their children to receive services, even if their children are not delinquent. Law enforcement officials may be quick to arrest youths with mental health issues for minor, nonviolent offenses because they believe the specialized court will better address their issues (Behnken, Arredondo, and Packman 2009). This may lead to the inclusion of nondelinquent youth in the juvenile justice system. This in turn could lead to another concern over how to address youth with mental health issues in a specialized court. If jurisdictions rely on the courts to provide treatment to any youth with mental health issues, they risk criminalizing and stigmatizing youth who would not have been involved in the juvenile justice system to begin with. Involvement with the juvenile justice system should be seen as the last available option, instead of as an alternative method to ensuring that youth receive treatment services (Behnken, Arredondo, and Packman 2009).

Another concern is the issue of coercion. Participation in mental health courts, as with most problem-solving courts, is intended to be voluntary. However, concerns have been raised about the ability of youths with mental health issues to make informed and voluntary decisions about their participation. States continue to struggle with how to determine the competency of juvenile offenders to understand the adjudication process and make decisions in that process (Hammond 2007). This may also affect the capability of courts to use sanctions to compel youths to adhere to their treatment plans (Porter, Rempel, and Mansky 2010).

Finally, as with the development of other problem-solving courts, there is the unresolved argument whether mental health courts are really necessary. The juvenile justice system is oriented toward providing treatment and rehabilitation to juvenile offenders. Concerns have been raised whether specialized courts are needed in the juvenile justice system, given that youths are already provided with services (Cocozza and Shufelt 2006).

Outcome Evidence

Unfortunately, few studies have evaluated the effectiveness of juvenile mental health courts. The National Center for Mental Health and Juvenile Justice is currently undertaking a study of the Crossroad Program, which is a juvenile mental health court in Akron, Ohio.

The aforementioned Santa Clara County juvenile mental health court that was the first such court established in the United States is called the Court for the Individualized Treatment of Adolescents (CITA). The court functions from the premise that early and appropriate intervention allows mentally disordered juvenile offenders to receive humane and appropriate

treatment (Behnken, Arredondo, and Packman 2009). CITA has several goals, including increasing public safety, reducing recidivism, increasing treatment engagement, and increasing effective use of existing community resources (Cocozza and Shufelt 2006). The court accepts only youths who had not turned 14 at the time of their offense and have a serious mental illness, such as brain disorders or severe head injuries that may have contributed to their criminal activity. Youths who have committed certain violent felonies may be excluded from participating, as have been youths who had mental health diagnoses of conduct disorder, oppositional defiant disorder, impulse control disorder, personality disorder, or adjustment reactions.

The program evaluation looked at the effect of CITA to reduce recidivism rates in 64 study participants. The evaluation used a pretest/posttest design to compare the number and type of offenses committed by study participants during the 18 months preceding court admission with those committed during the 23 months following court admission. Data on youth from April 1996 to March 2008 was collected from the Santa Clara Mental Health and Probation Departments. The data included several factors, such as age, sex, race, sexual orientation, living situation, psychiatric disorder, mental health history, substance use history, and needs assessment upon CITA admission.

The data showed that before involvement with CITA, 99 percent of program graduates had recidivated at least once while on traditional probation. The sample had an average of two placements in a treatment facility, and 17 percent had been removed from parental care. Overall, the findings showed reductions in the frequency of serious, violent, and other delinquency behavior among youth who completed the CITA program. The outcome results showed significant reductions in the commission of violent offenses, such as assault or battery. There were also significant reductions in the thefts and vandalisms, including shoplifting, stealing, or destroying property. There were also reductions in vehicle theft, burglary, public disturbances, carjacking, and failing to appear in court, though the reductions were insignificant. However, there were minor increases in incidents of hit and run, running away from home, robbery, drug possession, and curfew violation, though the low baseline frequency of these events makes drawing statistically meaningful conclusions not possible.

Although the study did have several weaknesses—including a nonrandomized control group, a lack of a comparison or control group, and selection bias—it was the first evaluation of a juvenile mental health court. Overall, the evaluation found positive outcomes among CITA graduates. Future research should address the shortcomings of this study and look to explore further outcomes as well, such as rate of compliance with treatment plans or whether the program was implemented as designed.

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