In 33 states, juvenile detention centers hold mentally ill youth without charges. A majority of detention centers report holding children aged 12 and under; and 117 centers reported jailing children 10 and under. Increasing awareness of the number of detained youth with serious unmet mental health needs raises questions regarding how best to identify and treat these youth. Youth-serving systems should divert youth with mental illness away from the juvenile justice system into community-based mental health treatment whenever it is safe and appropriate to do so. Juvenile mental health courts (JMHCs) do just that.

In recent years, JMHCs have gained recognition for linking young people with appropriate mental health services and returning them to their communities. Based on a model of “therapeutic jurisprudence,” JMHCs are designed to help provide individualized, community-based mental health services to youth in the juvenile justice system under the close supervision of a judge and other court administrators. Through collaborative and nonadversarial efforts among all professionals in the process, JMHCs attempt to identify the underlying psychological, educational, and social needs that contribute to youthful offending. These needs are then addressed by linking the youth with services and supports in the community. Together, professionals from various disciplines use a strengths-based problem-solving approach, with the ultimate goal of assisting youth safely and successfully remain in, or reenter, their communities and avoid detention.

What is a Collaborative Court?
The first JMHC in the country was established in Santa Clara County, California in 2001. Today more than 40 JMHCs operate nationwide. While all JMHCs may not operate identically, they share an intensive case management approach in dealing with delinquent youth with unmet mental health needs. This approach embraces the idea that treatment, rather than punishment alone, is the most effective strategy to help youth avoid future involvement in the juvenile justice system. In addition to emphasizing treatment, JMHCs share several other foundational principles:

- Youth should not become tangled in the juvenile justice system solely because of their

Continued on page 102
Civil Advocacy

Many young people in the juvenile justice system face barriers to needed services or have ancillary needs that directly impact their likelihood of succeeding at home. Civil legal advocates can be instrumental in addressing these unmet needs. While not all JMHCs include civil advocacy as a component of their services, those that do can increase substantially the array of services and resources available to participating youth and their families.

Civil advocates ensure that qualified youth have access to public benefits such as Medicaid, Supplemental Security Income, and special educational services. In addition, civil advocates can help stabilize a youth’s home and family by providing legal assistance related to housing, consumer protection, or unemployment matters. A civil advocacy coordinator may also contribute to the day-to-day functioning and continuing development of the court’s program and practices.

Civil advocates can provide technical assistance to the court by drafting legal forms such as standing orders, waivers and consents, and memorandum of understanding for court partners. Additionally, civil advocates can educate the court and collaborators on the law of privacy and consent, which helps to eliminate barriers to coordination that frequently arise from misunderstandings about the confidentiality of medical and juvenile justice records.

In a model JMHC, the civil legal advocates are committed to and involved with the entire collaborative court process from a youth’s initial screening to graduation.

Who Does a Juvenile Mental Health Court Serve?

Diagnostic Eligibility

Each JMHC may define eligibility criteria differently based on its policy goals and the potential mental illness or need to access mental health services.

- Young people with mental illness should be diverted from the traditional juvenile justice system into evidence-based treatments in their communities whenever possible and appropriate, consistent with public safety concerns.
- Youth should reside in the least-restrictive setting possible.
- Information obtained in mental health screening or treatment should not jeopardize a youth’s legal interests.
- Treatment should be culturally appropriate and consider gender, ethnicity, race, age, sexual orientation, socioeconomic status, and faith.
- Mental health diagnoses and treatment should take into account developmental differences between young people and adults that may affect behavior.

- The JMHC should engage and treat the youth’s family and community supports as partners in developing service goals, probation supervision, and transition plans.
- Multiple agencies and systems share responsibility for caring for youth; all should work collaboratively to develop service plans.

JMHCs seek to fulfill these principles by bringing together professionals from different disciplines and interests to collaborate in providing these youth with intensive case management and services. When qualifying youth first enter a JMHC, they are screened for their strengths and needs. The members of the JMHC, along with the youth, their families, and potentially other individuals from the community, create a service plan to provide this support. The JMHC then connects the youth to treatment and service providers in their communities, while providing ongoing case management. This continuing supervision ensures youth receive needed services, and that conflicting or duplicative services are avoided. Existing JMHCs have adopted various innovative features to improve outcomes, including:

- Treatments based in the home or community (e.g., wraparound services)
- The use of evidence-based treatment modalities (e.g., Multi-Systemic Therapy)
- The use of evidence-based assessment/screening tools (e.g., Massachusetts Youth Screening Instrument—MAYSI, DISC assessment)
- Close collaboration with schools and community providers (e.g., including school liaisons as members of the JMHC’s multidisciplinary team)
- Preadjudicatory screening and treatment (whereby youth who successfully complete the mental health court program are never adjudicated delinquent)
- Dismissal of petitions (or automatic record expungement) upon successful completion of the program
- Inclusion of civil advocates to assist youth and families with legal issues other than criminal prosecution, such as housing and public benefits.

(Continued from front page)
Quick Look: Alameda County’s Juvenile Mental Health Court

Do juvenile mental health courts work? The evidence is positive for one California court. The National Center for Youth Law (NCYL) spent three years studying the Alameda County Juvenile Collaborative Court (ACJC). This court opened its doors in 2007 to enhance public safety, reduce recidivism, and support youth with mental health needs by connecting them and their families to mental health services.

NCYL’s review focused on how well the ACJC met these goals. NCYL collected data about court outcomes by reviewing court procedures and records. It also interviewed youth and families involved in the court, as well as court members and community collaborators. Highlights from its findings appear below.

Number of youth participants (2007-09): 34

Ethnicity:
- African American (50%)
- Caucasian (20%)
- Hispanic (15%)
- Asian (9%)

Ages: 12 to 18 years

Avg. length of involvement: 13 months

Mental health history: All youth had some prior involvement with the mental health system. Most had at least two mental health diagnoses upon entering the court.

Juvenile justice system involvement:
Youth had an average of four prior detentions each, ranging from 0 to 15. Detainment periods averaged 147 days.

Positive impacts:
Overall, Alameda County’s juvenile mental health court had a positive impact on the youth and families served and was meeting its goals.

- Detentions declined among youth who left the ACJC before 2010:
  - Detentions declined 76%
  - # youth detained declined 52%
  - Total # detention days declined 63%
  - New law violations decreased 68%

- Mental health services for youth increased in all categories (inpatient, outpatient, day treatment).
- Psychiatric crises among youth decreased.
- Youths’ access to other resources and supports (e.g., disability benefits, special education services, health insurance, housing) increased.

- Youth benefitted from receiving community-based services and remaining in their homes instead of in institutions.
- Civil advocates played a key role securing benefits for families leading to educational services, safe housing, and financial stability.
- The court benefitted the larger community, in addition to the youth and families and the professionals involved.
- Communication between youth and their families improved.
- Youths’ behavior, school attendance, self-esteem, mental health, and access to medication improved.

Improvement areas:
NCYL’s review uncovered these areas for improvement:

- Youth spent 1,800 total days in juvenile hall while participating in the court.
- Mental health service use declined significantly once youth left the court.
- Communication by the ACJC with youth and caregivers was not frequent enough.
- Community service providers did not always have sufficient resources to provide prompt services to youth and families.
- Some caregivers desired more translators and mental health support during and after court involvement.

Learn more
For detailed information about Alameda County’s mental health court, see NCYL’s report, *Improving Outcomes for Youth in the Juvenile Justice System*, available at www.youthlaw.org/fileadmin/ncyl/youthlaw/health/ACCCFinal.pdf
services, supports, and resources available in the community.

Existing JMHCs have included the following mental health conditions as potentially qualifying diagnoses:11

- Brain conditions with a genetic component (e.g., major depression, bipolar disorders, schizophrenia, schizoaffective disorders, severe anxiety disorders, and ADHD with significant functional impairment)
- Developmental disabilities (pervasive developmental disorder, mental retardation, and autism spectrum disorders)
- Organic brain syndromes (severe head injuries, severe cognitive deficit, and degenerative diseases of the brain)
- Fetal Alcohol Spectrum Disorder
- Severe Post Traumatic Stress Disorder
- Co-occurring mental illness and substance abuse
- Conduct disorder, oppositional defiant disorder, impulse control disorder, adjustment reactions, or personality disorders

Many existing JMHCs also have a list of disqualifying mental health conditions. For example, JMHCs may exclude adjustment disorder, oppositional defiant disorder, conduct disorder, personality disorder, and sexual offending behavior if unaccompanied by a qualifying mental illness.

Core Purposes and Approach

Collaborative Approach

One of the JMHC’s greatest strengths is the multidisciplinary, collaborative court team. This group, comprised of juvenile justice and behavioral health professionals works by consensus, admitting youth into the court and acting as a case manager to admitted youth. The team plans for and supervises individualized mental health treatment services, including pharmacological interventions, individual counseling, family counseling, and special educational planning and services.

In addition, the team members engage and recruit the youth’s family and extended supports, as well as interested community members and agencies, to assist in problem-solving, treatment planning, and service delivery. Generally speaking, the court team members, the youth and their families, and the community partners are involved in a court process in ways they have never before experienced.

United by a shared goal of diverting youth with mental illness from the traditional juvenile justice system, JMHC team members work together to decide what approach will produce the best outcome for both the young people and the community. Having a team of dedicated professionals from a variety of disciplines creates an atmosphere that is more supportive for youth than that found in the traditional juvenile justice system,12 and allows participants to marshal a range of available resources to meet the youths’ and community’s interests.

Treatment Not Punishment

Many young people with mental illnesses are unable to respond to the traditional juvenile justice model, either because their mental illnesses make it difficult to make appropriate decisions or to conform their behavior to required norms, or because traditional punishments may be counterproductive to their needs or treatment goals.

Consider the example of a child who, but for his untreated schizophrenia, may not have shoplifted. Alternatively, placing a teenager with depression on house arrest may intensify his depression rather than teach him not to commit the subject crime. Employing a multidisciplinary team structure, JMHCs attempt to reach a common understanding of how the best interests of a youth with mental illness, his or her family, and the community

One of the JMHC’s greatest strengths is the multidisciplinary, collaborative court team.
Improves the efficacy of the juvenile justice system by conserving limited resources.

Case Management and Linking to Mental Health Services
To improve outcomes for youth, including disentanglement from the juvenile justice system, diversion must be supported by links to intensive, individualized, community-based mental health services. Participants enter the JMHC with a wide variety of mental health needs. Some youth require only routine outpatient mental health treatment but need the court’s assistance connecting to appropriate service providers or applying for government entitlements.

Others need more intensive mental health treatment, such as psychiatric stabilization, substance abuse counseling, or family therapy. The JMHC’s unique multidisciplinary team structure ensures that a youth is provided with a treatment/service coordinator who acts as a case manager and a liaison between different providers and who also provides progress reports to the JMHC team members. This coordination and ongoing evaluation increases the individualization of the services provided.

The JMHC focuses on intensive community-based services designed to maintain youth in their homes whenever possible. If secure confinement becomes necessary, the JMHC attempts to place youth in therapeutic settings, not detention facilities. In addition to using a community-based treatment approach, the JMHC provides services tailored to specific outcomes for the youth, including maintaining residential stability (reducing the number of placement moves), achieving success in school, living with their families, avoiding delinquency, and minimizing safety risks.

Patrick Gardner, JD, is deputy director of mental health at the National Center for Youth Law, Oakland CA. He served as the project director and principal author of the report from which this article is drawn.

This article was adapted and reprinted with permission from the National Center for Youth Law. It originally appeared in their new report, Improving Outcomes for Youth in the Juvenile Justice System: A Review of Alameda County’s Collaborative Mental Health Court, February 2011, available at www.youthlaw.org/fileadmin/ncl/youthlaw/health/ACCCFinal.pdf

Endnotes
2 Committee on Government Reform—Minority Staff Special Investigations Division, United States House of Representatives. Incarceration of Youth who are Waiting for Community Mental Health Services in the United States, 2004, ii.
3 Ibid., 5.
4 Ibid., 6.
6 Therapeutic jurisprudence takes an interdisciplinary view of justice, employing both behavioral sciences and the law as complementary tools in analyzing and crafting sound law. Without trumping other judicial considerations, such as public safety or constitutional protections, therapeutic jurisprudence looks to the practical effects law has on individuals within the legal system and assumes that, all other things being equal, the law should be restructured to better accomplish therapeutic values. See Wexler, David B. “Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence.” Law & Human Behavior 16, 1992, 27, 32.
10 Ibid.
11 Ibid.
12 Ibid.
13 Skowyra and Powell, 2006.