Juvenile Mental Health Courts and Therapeutic Jurisprudence: Facing the Challenges Posed by Youth with Mental Disabilities in the Juvenile Justice System

Patrick Geary

Follow this and additional works at: https://digitalcommons.law.yale.edu/yjhple

Part of the Health Law and Policy Commons, and the Legal Ethics and Professional Responsibility Commons

Recommended Citation
Available at: https://digitalcommons.law.yale.edu/yjhple/vol5/iss2/3

This Article is brought to you for free and open access by Yale Law School Legal Scholarship Repository. It has been accepted for inclusion in Yale Journal of Health Policy, Law, and Ethics by an authorized editor of Yale Law School Legal Scholarship Repository. For more information, please contact julian.aiken@yale.edu.
NOTE

Juvenile Mental Health Courts and Therapeutic Jurisprudence: Facing the Challenges Posed by Youth with Mental Disabilities in the Juvenile Justice System

Patrick Geary*

INTRODUCTION

Ever-increasing numbers of children struggle to live and develop under the burden of mental disability. Yet the juvenile justice system—an institution created in large part to look after these very children—has often failed to meet, address, or fully realize their mental health needs. As children’s mental health issues have entered the spotlight in recent years, the juvenile court’s gross inadequacy as a guardian of child development and gatekeeper of treatment services has become clearer. Indeed, many have concluded that “the inadequate and uneven delivery of mental health services to children and families in the juvenile justice system is a national crisis.”

The ideas behind the juvenile mental health court movement, however, may

* J.D. candidate, Yale Law School.
2. See CONFERENCE, supra note 1.
offer the juvenile justice system new hope. This movement advocates the creation of separate juvenile courts for youth with pronounced mental health needs and brings renewed attention to the rehabilitative goals of the juvenile justice system. While the aims of the juvenile mental health court movement are laudable, its greatest influence may lie beyond the formation of specialized juvenile courts that serve only a limited number of youthful offenders. Raising awareness of mental health needs in the broader juvenile justice system presents a wider opportunity to improve the treatment of youth with mental disabilities in all juvenile courts.

As outlined in Part I of this Note, the progressive foundation of the juvenile court serves as a uniquely appropriate base from which to address the needs of youth suffering from mental disabilities. Part II highlights the diverse and expanding nature of these needs and outlines the scope of the issues facing the juvenile justice system today. Part III follows the proliferation of specialty “problem-solving” courts in the adult and juvenile justice systems and describes the principles of therapeutic jurisprudence that encourage increased sensitivity to youth’s mental health needs in courtroom procedures. Given the extraordinary prevalence of mental health needs among youthful offenders, Part IV suggests that it would be impractical to address these needs through smaller, specialized courts and argues that it would be better to apply the approach adopted in juvenile mental health courts throughout the entire juvenile court system. The details of potential mental health oriented reforms are described in Part V, and both existing and potential funding initiatives designed to support these reforms are discussed in Part VI.

Dealing with youthful offenders plagued by mental disabilities will always be difficult. The juvenile justice system may not be the ideal place to address these children’s mental health needs, but we should not overlook the contributions that it can make. Rehabilitative treatment remains a fundamental tenet of the juvenile court, and youthful offenders must not be denied access to mental health services in the name of retribution or inadequate funding. The allocation of additional resources to juvenile mental health needs today would not only fulfill the original mandate of the juvenile court to provide treatment, rather than punishment; it would also save society money in the long run by reducing the need to expend resources on these juveniles later in their lives. The time for juvenile justice reform is now, and the present support for juvenile mental health courts demonstrates a public and judicial readiness to recognize the importance of mental health concerns and rediscover individualized treatment in

JUVENILE MENTAL HEALTH COURTS AND THERAPEUTIC JURISPRUDENCE

juvenile court dispositions. This rediscovery may be just the answer for a juvenile court under fire. By embracing young offenders and their mental health needs, the flailing juvenile justice system could complete a return to its legitimate roots in the rehabilitative ideal.

I. A BRIEF HISTORY OF JUVENILE JUSTICE

The first juvenile court opened its doors to wayward children just over a century ago. Under the state’s parens patriae power, the juvenile court had wide discretion to “rescue” young offenders and further the “best interests” of these children. The leaders of the juvenile justice revolution saw youth as developmentally sensitive and largely amenable to intervention and treatment and, accordingly, rejected the adult system’s emphasis on accountability and culpability. Progressive criminal justice reformers sought to create “a space to protect, to rehabilitate and to heal children, a site of nurturance and guidance, understanding and compassion.” A separate juvenile justice system provided the opportunity to eliminate the harms of contact with the adult criminal courts and to improve offenders’ well-being. Juvenile court dispositions focused on the child’s need for specialized treatment, rather than her culpability. Informal, paternalistic, and non-adversarial courtroom procedures facilitated expedient


8. Bilchik, supra note 7, at 1; Feld, supra note 7, at 833.

9. David C. Anderson, When Should Kids Go to Jail?, AM. PROSPECT, May-June 1998, at 72, 72-73 (citation omitted). Indeed, “the role of the juvenile court judge was to strengthen the child’s belief in himself and make available to him all of the support and encouragement from outside the court that the judge could harness on his behalf.” Id. at 73 (citation omitted).

10. Bilchik, supra note 7, at 1; Feld, supra note 7, at 833; Rhonda Gay Hartman, Adolescent Autonomy: Clarifying an Ageless Conundrum, 51 HASTINGS L.J. 1265, 1274 (2000) (noting that the juvenile court meant not to stigmatize and later reform children, but to shield them from stigma altogether).
delivery of the best-suited rehabilitative services.\textsuperscript{11}

Unfortunately, the traditional juvenile court failed to maintain its rehabilitative aspirations. The courts had been given extensive judicial discretion to tailor proceedings to the needs of individual offenders, but by the 1960s this discretion was often abused.\textsuperscript{12} In the Supreme Court's landmark decision \textit{In re Gault},\textsuperscript{13} the Court scaled back the juvenile court's dispositive and procedural flexibility. Responding to the arbitrariness of juvenile court dispositions and "an absence of the rehabilitation that the system had promised,"\textsuperscript{14} the Court granted juvenile defendants certain safeguards available in the more formalized adult criminal courts.\textsuperscript{15} In the years following \textit{Gault}, the increasing procedural convergence of juvenile and adult criminal courts began to erode the juvenile court's focus on rehabilitation.\textsuperscript{16} The juvenile justice system's trademark individualized treatment plans gave way to a focus on young offenders' culpability.\textsuperscript{17} These changes were reinforced by public dissatisfaction with the perceived leniency of the traditional juvenile court, a sentiment fueled by rising juvenile crime rates and a growing public fear of adolescent criminality.\textsuperscript{18}

Public support for a separate justice system for children continues to wane today, and as many jurisdictions begin "to shift more resources into monitoring

\begin{itemize}
\item \textsuperscript{11} Loren M. Warboys & Shannan Wilber, \textit{Mental Health Issues in Juvenile Justice, in Law, Mental Health, and Mental Disorder} 503 (Bruce D. Sales & Daniel W. Shuman eds., 1996).
\item \textsuperscript{12} Melissa Moon et al., \textit{Is Child Saving Dead? Public Support for Juvenile Rehabilitation}, 46 \textit{Crime & Delinq.} 38, 39 (2000); see also \textit{FRANKLIN E. ZIMRING, THE CHANGING LEGAL WORLD OF ADOLESCENCE} 128 (1982) (noting that "[t]he tyranny of unguided discretion is why we have retreated from the lawlessness of the original juvenile court"); N. Dickon Reppucci, \textit{Adolescent Development and Juvenile Justice}, 27 \textit{Am. J. Community Psychol.} 307, 313 (1999).
\item \textsuperscript{13} 387 U.S. 1 (1967).
\item \textsuperscript{15} The \textit{Gault} Court held that juveniles have the right to notice of charges, a fair and impartial hearing, assistance of counsel, and to protection against self-incrimination. 387 U.S. 1.
\item \textsuperscript{17} Feld, \textit{supra} note 7, at 830; see also Thomas et al., \textit{supra} note 1, at 621.
\item \textsuperscript{18} Bilchik, \textit{supra} note 7, at 3; see also \textit{ZIMRING, supra} note 12, at 1-8 (1998). Zimring notes both that "[J]uvenile violence in the United States is frequently depicted as a difficult current problem that will inevitably get worse," \textit{id.} at 4, and that "lenient treatment by the juvenile justice system [is seen as] a major cause of high rates of youth crime," \textit{id.} at 7.

674
and incarcerating the most serious juvenile offenders for longer periods of time[...]. Fewer resources are left to deal with... those youth most amenable to rehabilitation." 19 Legislatures—responding to the calls to “crack down” on juvenile crime—brought punitive reforms to the juvenile courts through much of the 1970s, 1980s, and 1990s. 20 Statutes enabling juvenile transfer to adult court, 21 mandatory minimum sentences, 22 and reduced confidentiality provisions 23 have continued to move the juvenile court farther away from the rehabilitative ideal. 24 Some scholars have even called for the abolition of the juvenile justice system altogether. 25


20. Anderson, supra note 9, at 73-74.

21. Indeed, prosecutorial discretion (concurrent jurisdiction over serious offenders in both the adult and juvenile courts), legislative offense exclusion (exclusive criminal court jurisdiction for serious offenses committed by juveniles of a certain age), and judicial waiver (automatic, presumptive, or discretionary transfer of juveniles into adult criminal court) have all but stripped today’s juvenile courts of their broad jurisdiction. Id. at 74; see also Feld, supra note 16, at 701-08; Grisso, supra note 14, at 173 (“For judicial transfer to criminal court, offense-based criteria were broadened, age-based criteria were lowered, transfer hearings were mandated, relevant criteria were expanded, burdens of proof were shifted to the defense, and standards of proof for transfer were reduced.”); Earl F. Martin & Marsha Kline Pruett, The Juvenile Sex Offender and the Juvenile Justice System, 35 AM. CRIM. L. REV. 279, 326-27 (1998).

22. Feld, supra note 7, at 717; Grisso, supra note 14, at 171.

23. Bilchik, supra note 7, at 5.

24. Over a quarter of the states have tolled the death knell for the rehabilitative ideal by amending juvenile court purpose clauses to include language “emphasizing offender accountability, public safety, and competency development.” Bilchik, supra note 7, at 3; see also Feld, supra note 16, at 709 (“These amendments de-emphasize rehabilitation and the child’s ‘best interests,’ and emphasize the importance of protecting public safety, enforcing children’s obligations to society, applying sanctions consistent with the seriousness of the offense, and rendering appropriate punishment to offenders.”).

25. Feld, supra note 16, at 723-24. Feld favors “an adult criminal court that administers justice for young offenders[,]... provid[ing] children with all the procedural safeguards already available
Any consideration of children’s mental health needs in the contemporary juvenile justice system must occur against the background of these uneasy circumstances. At the inception of the juvenile court, the focus on rehabilitative treatment programs for individual children led founders to look beyond young offenders’ delinquent acts. Juvenile court judges examined all probable causes of delinquency, and the mental health needs of the children before them figured prominently in their decision-making. While today’s juvenile courts operate on dramatically different terms than did their century-old predecessors, the juvenile justice system continues to face the challenges associated with handling youthful offenders with mental disabilities. Even if these challenges must ultimately be resolved in the adult criminal justice system, “we will always need a special legal mechanism to respond to children in need of services . . .”

II. THE SCOPE OF THE PROBLEM: MENTAL DISABILITY IN THE JUVENILE JUSTICE SYSTEM

Despite the early juvenile courts’ focus on rehabilitative treatment programs, these courts were strongly criticized for the way in which they handled youths with mental disabilities. Surprisingly little has changed. In the past century, the mental health field has made dramatic advances, yet many of the mental health problems of young offenders in today’s juvenile courts remain undiagnosed and to adult defendants and additional enhanced protections because of the children’s vulnerability and immaturity.” Id. Although no states to date have elected to merge the juvenile and adult courts into a unitary criminal justice system, such a move is certainly not beyond the realm of possibility: “The legal response to juvenile crime is undergoing revolutionary change, and its ultimate shape is uncertain.” Scott & Grisso, supra note 19, at 137.

26. Monrad G. Paulsen, Children’s Court: Gateway or Last Resort?, 10 COLUM. U.F. 4 (1967). Court dispositions were fashioned to poison the roots of delinquency and thereby foster maturity into productive adulthood by encouraging youths’ continuing stability. Id.

27. The juvenile court often invoked progressive guidance to mandate that these needs be met through ordering and applying “[p]sychological techniques . . . to the mentally disturbed.” Id. at 5.


29. See Thomas et al., supra note 1, at 616 (“‘Many of these Juvenile Offenders need the services of a good physician more than they do those of the jailor.’” (quoting WILLIAM MACDONALD, A STORY OF JUVENILE COURTS FROM THEIR INCEPTION TO THE PRESENT DAY, WITH COMMENTS UPON THE EXTENSION OF THE PROBATION SYSTEM AND A HISTORY OF THE JUVENILE COURT MOVEMENT 27 (1912))).

30. COALITION FOR JUV. JUST., HANDLE WITH CARE: SERVING THE MENTAL HEALTH NEEDS OF YOUNG OFFENDERS, 2000 ANNUAL REPORT 40 (2000) [hereinafter HANDLE WITH CARE] (remarking that we continue to move “towards a clearer and more sophisticated understanding of the underlying causes [of delinquency]”).
Untreated. Concern with the increasingly punitive nature of the juvenile justice system has prompted many juvenile and mental health professionals to decry what they view as an insufficient emphasis on treatment and rehabilitation. Critics—although substantially ignored in the present juvenile justice system—maintain that there is a strong nexus between delinquency, mental illness, and the overall need for mental health treatment to prevent recidivism.

Youths in contact with the juvenile justice system are significantly more likely than other youths to have mental disabilities. The juvenile justice system has in some ways become a "dumping ground" for mentally ill, learning disabled, [and] behaviorally disordered juveniles. Many juvenile offenders have a history of involvement with the mental health system but migrate to the juvenile justice system because the mental health system has failed to serve their needs. Although many delinquents are deemed simply socially maladjusted by the juvenile justice system, a considerable portion of these children have serious, diagnosable emotional disturbances. While estimates of these disturbances in the general population of children and adolescents range from two to seven percent, estimates for the delinquent population range from sixteen to fifty percent.


34. More specifically, Scott and Grisso list emotional disturbances and learning and attention deficit disorders among those disabilities more prevalent in the delinquent population. Scott & Grisso, supra note 19, at 169.


[A] youth is generally considered to be seriously emotionally disturbed when:

- Emotional and/or social impairment disrupts his or her academic and/or developmental progress; [such impairment] [d]isrupts family and/or other interpersonal relationships;
- [s]uch impairment of functioning has continued for a period of at least one year; or
- such impairment is of short duration and high severity.

HANDLE WITH CARE, supra note 30, at 8-9.
percent. Among delinquent youth, between one and six percent suffer from psychotic disorders, and at least twenty percent are estimated to suffer from serious mental disorders generally (including schizophrenia, major depression, and bipolar disorder). In addition, fifty-five percent of youth in the juvenile justice system show symptoms of clinical depression, and up to nineteen percent of youth may be suicidal.

Overall, the prevalence of psychiatric disorders among those detained in the juvenile justice system is between fifty and seventy-five percent. Put simply, “a far greater proportion of children in the juvenile justice system suffer from a serious emotional disturbance than in the general population.” If not only serious emotional disturbances but also other mental disabilities—attention deficit disorder, attention deficit hyperactivity disorder, substance abuse and dependence, learning disabilities, mental retardation, anxiety disorders, and conduct disorders—are considered, an even higher proportion of children before the juvenile court present substantial mental health needs. For many of these less severe conditions, the estimated prevalence among youthful offenders exceeds eighty percent. Among this population, the number of children with

37. NAT'L MENTAL HEALTH ASS'N, ALL SYSTEMS FAILURE (1993); Warboys & Wilber, supra note 11, at 506 (citing N.A. Brandenburg et al., The Epidemiology of Childhood Psychiatric Disorders: Recent Prevalence Findings and Methodological Issues, 29 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 76 (1990)); see also Dana Royce Baerger et al., Responding to Juvenile Delinquency: Mental Health Service Needs of Male and Female Juvenile Detainees, 3 J. CENTER FOR FAM. CHILD. & CTS. 21, 21 (2001) (finding that more than one-third of adolescents arrested and adjudicated within the juvenile justice system exhibit symptoms of major affective disorders).


40. HANDLE WITH CARE, supra note 30, at 10-11.


42. Warboys & Wilber, supra note 11, at 506.

43. Otto et al., supra note 39. Roughly half of the youth in contact with the juvenile system have conduct disorders, and up to forty-five percent have attention deficit hyperactivity disorder. HANDLE WITH CARE, supra note 30, at 11.

44. Daniel P. Mears et al., Critical Challenges in Addressing the Mental Health Needs of
multiple diagnoses is substantial, and at least half of adolescents with mental illnesses in the juvenile justice system have co-occurring substance abuse disorders.

Moreover, the rates of admission to mental health facilities for juveniles not in contact with the court system have rapidly escalated over the past several decades as well. More youth today have experienced child abuse or neglect, family dysfunction, or a host of other factors that might call for mental health intervention. Not surprisingly, then, the overall prevalence of psychosocial problems among youth seem to be increasing, and the demand for mental health services by some estimates nearly doubles each year. As these troubled youth begin to make contact with the juvenile justice system, it will become increasingly clear that this system must find a way to address these youths’ mental health needs in an appropriate manner.

III. THERAPEUTIC JURISPRUDENCE AND PROBLEM-SOLVING COURTS

Therapeutic jurisprudence—defined by one scholar as “the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects”—offers a publicly acceptable vehicle for juvenile justice reform. This approach sits at the
nexus of mental health and law, and its adherents look optimistically for opportunities to apply recent developments in the clinical behavioral sciences in the legal field.\textsuperscript{52} Therapeutic jurisprudence principles emphasize the ways in which legal rules and processes may further the psychological health and emotional well-being of those in contact with the justice system. Therapeutic jurisprudence models examine the role of law as a therapeutic agent, with a mental health-focused approach to the law compatible with existing legal values.\textsuperscript{53} While in many circumstances other legal considerations may trump therapeutic ones,\textsuperscript{54} therapeutic jurisprudence ideals nonetheless promise innovation and improvement in the legal system’s response to mental health concerns.\textsuperscript{55}

The therapeutic jurisprudence movement is a product of a growing impetus for change in the U.S. justice system’s approach to the complex problems presented by “defendants whose substance abuse or mental disabilities appear to be related inextricably to repeated criminal [or delinquent] behavior.”\textsuperscript{56} Therapeutic jurisprudence recognizes that the courts are not manned by mental health professionals but hopes to encourage the courts to be sensitive to mental health issues: “It is unrealistic to suggest that lawmakers should be social scientists. Rather, law-makers, particularly judges, should be asked to take account of social science.”\textsuperscript{57}

The therapeutic jurisprudence movement continues to mature, and its principles have already influenced the development of specialized “treatment courts” and the juvenile justice system’s goals, as discussed below. In fact, therapeutic jurisprudence represents a theoretical basis for the entire “treatment court” movement and once served as the cornerstone of the juvenile justice


\textsuperscript{54} Among these other legal considerations, scholars have singled out the protection of defendant’s rights, the protection of societal interests, and the enhancement of daily procedural interests in the legal system. David Finkelman & Thomas Grisso, \textit{Therapeutic Jurisprudence: From Idea to Application}, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 243, 249 (1994); Wexler, \textit{supra} note 53, at 259-60.

\textsuperscript{55} Finkelman & Grisso, \textit{supra} note 54, at 248 (“By applying psychological research and theory to mental health law in particular, therapeutic jurisprudence promises to reinvigorate the area and, if successful, to produce better mental health law, and better treatment for those who find themselves involved in the mental health law system.”).

\textsuperscript{56} Teresa W. Carns et al., \textit{Therapeutic Justice in Alaska’s Courts}, 19 ALASKA L. REV. 1, 2 (2002).

\textsuperscript{57} NURCOMBE & PARTLETT, \textit{supra} note 7, at 9.
system. The formation of specialty “problem-solving” or “treatment” courts to better address specific categorical concerns and common needs of certain types of offenders is perhaps the best example of the application of therapeutic jurisprudence concepts in the justice system. These courts have emerged in both the criminal and juvenile justice systems and demonstrate an institutional capacity to address the substance abuse and mental health needs of offenders.

A. “Problem-Solving” Courts in the Criminal Justice System

Specialized therapeutic courts handle a wide array of issues, ranging from family problems and domestic violence to substance abuse and mental health concerns. These “holistic” courts draw together the efforts of legal and mental health professionals to fashion treatment plans and supervision models. Judges use innovative procedures to facilitate creative solutions to the issues presented by each individual offender. These judges are given the freedom to set aside the paternalistic leanings associated with their traditional role in the criminal justice system and demonstrate heightened respect for the dignity and autonomy of offenders. They may employ persuasive techniques to encourage defendants to complete treatment plans in the hopes of increasing compliance with programs tailored to ensure that individuals will avoid the justice system in the future.

While some have criticized the coercive and paternalistic potential inherent in specialized therapeutic courts, advocates of these courts tout as benefits the reduced recidivism rates and the greater likelihood that defendants will return to their communities as productive individuals. The Conference of Chief Justices, the Conference of State Court Administrators, and the American Bar Association have all expressed support for the maintenance and formation of specialized

58. See Gene Griffin & Michael J. Jenuwine, Using Therapeutic Jurisprudence To Bridge the Juvenile Justice and Mental Health Systems, 71 U. CIN. L. REV. 65, 67 (2002) (“Juvenile courts, by their very nature, were designed to be more therapeutic than the adult criminal justice system.”).
60. Winick, supra note 59, at 1068-97.
62. Winick, supra note 59, at 1066-78.
63. Id. at 1079-89.
64. Carns et al., supra note 56, at 54.
therapeutic courts.\footnote{Id. at 9-10.} Despite frequent concerns about the resources required to establish and maintain therapeutic courts,\footnote{Id. at 10-11.} the size, number, and diversity of these courts continues to grow.\footnote{See Susan Finlay, The Changing Face of Justice: Alternative Approaches to Problem Solving, 29 FORDHAM URB. L.J. 1981, 1982 (2002). Finlay recounts a number of recently fashioned “problem-solving courts,” including juvenile mental health courts, homeless courts, unified family courts, juvenile dependency drug courts, teen or youth courts, child support courts, and DUI courts. Id. at 1984-86.} While the oldest and most prominent specialized therapeutic treatment courts were developed primarily to handle the problems of substance abuse, a much younger mental health court movement has now emerged and expanded in step with the growing understanding of therapeutic jurisprudence and the mental health needs of offenders.

The first drug treatment court began operation the summer of 1989 in Miami, Florida.\footnote{Hora et al., supra note 51, at 454.} In only fifteen years time, drug treatment courts have proliferated and now “apply the concepts of therapeutic jurisprudence . . . in hundreds of courtrooms across America.”\footnote{Id. at 448.} These drug treatment courts do more than simply expedite the judicial process in courts with crowded dockets; they seek to address the “underlying problems of drug crimes—drug use and addiction.”\footnote{Id. at 463.} By treating substance abuse not as a criminal failing but as a physiological condition requiring therapeutic intervention, drug treatment courts shift their orientation away from the retributive aims of the general criminal justice system.\footnote{Id. at 468.}

For drug offenders to be eligible for drug treatment courts, community officials must determine that these defendants have a substantial chance at recovery and pose a minimal threat to public safety.\footnote{Id. at 507.} For these offenders, drug treatment courts use a system that is cooperative, rather than adversarial, and focus on promoting recovery through coordinated response.\footnote{Id. at 469 (citing DRUG COURTS PROGRAM OFFICE, U.S. DEP’T OF JUSTICE, DEFINING DRUG COURTS: THE KEY COMPONENTS 6 (1997)).} Using a therapeutic lens, drug treatment courts look at offenders as clients and at potential relapses or other obstacles to recovery as an expected part of the treatment process.\footnote{Id.} Judges
and teams of court personnel follow clients through the full life cycle of their cases and may become intimately familiar with each defendant's particular circumstances and needs.75

With the cooperation of local law enforcement and community drug rehabilitation services, drug treatment courts substitute supervised treatment plans for incarceration and probation. The need for immediate services is paramount, and defendants are placed into programs as soon as possible after their first drug court appearance.76 Drug treatment courts aim to provide offenders with an opportunity to overcome addiction and thereby eliminate a significant cause of the behavior that led to their entrance into the criminal justice system.77 While many drug courts are too new to make empirical analysis meaningful,78 statistics and accounts assessing older drug treatment courts seem to indicate positive results. These older courts have largely demonstrated their effectiveness by reducing recidivism rates, increasing treatment program retention, and conserving criminal justice system resources.79

Mental health courts have followed on the heels of the drug treatment court movement’s success.80 Pushed by an assortment of social and systemic factors—deinstitutionalization, the extraordinary prevalence of mental illness among the growing homeless population, prison overcrowding, and the high rates of recidivism in mentally-ill offenders81—these specialized courts were established to address a portion of the adults with mental health needs entering the criminal justice system.82 Today there are roughly thirty mental health courts in existence

75. Id. at 472.
76. Id. at 473. There is an important dichotomy in the timing of drug treatment court adjudication processes: Preadjudicative drug court models defer prosecution and divert more readily, while postadjudicative courts defer only sentencing or entry of judgment. Id. at 513. The preadjudicative model would appear to be more consonant with therapeutic goals, as it does not require the entry of a guilty plea to obtain treatment. Id.
77. Id. at 463.
78. Carns et al., supra note 56, at 8-9.
79. DRUG STRATEGIES, CUTTING CRIME: DRUG COURTS IN ACTION 6 (1997); Hora et al., supra note 51, at 502; see also STEVEN BELENKO, RESEARCH ON DRUG COURTS: A CRITICAL REVIEW 7 (2001).
80. Kessler, supra note 61, at 63.
81. See, e.g., Carns et al., supra note 56, at 21; LeRoy L. Kondo, Advocacy for the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders, 28 AM. J. CRIM. L. 255, 272 (2001) (noting that mentally ill offenders reported high rates of homelessness, unemployment, substance abuse, and either physical or sexual abuse).
and more are being planned. Each of these courts maintains a separate docket and employs judges, prosecutors, and defense attorneys trained and familiar with the special needs of mentally disabled defendants. There are two basic mental health court models: those in which courts drop or suspend criminal charges when a person is assigned to a treatment program ("meaningful diversion") and those that require a guilty plea before assignment. Individuals must qualify for participation in mental health courts, and while criteria are expanding in many systems, eligibility is frequently limited to those charged with less serious crimes and diagnosed with a current or previous mental health problem.

Continuing participation in mental health courts is often strictly voluntary. Once a case enters the mental health court system, judges, counsel, other court personnel (frequently including a case manager or coordinator), and designated outside agencies begin to develop treatment strategies. Clients return to the courtroom for non-adversarial court proceedings and regular meetings to assess their progress and monitor their program compliance. While courts may choose to become operational—the Broward County Mental Health Court in Broward County, Florida—recognized the importance of developing a new strategy... to isolate and focus upon individuals arrested for misdemeanor offenses who are mentally ill or mentally retarded in view of the unique nature of mental illness and mental retardation, and the need for appropriate treatment in an environment conducive to wellness and not punishment, as well as the continuing necessity to insure the protection of the public.

Id. (quoting Admin. Order No VI-97-1-1A, In re Creation of a Mental Health Court Subdivision Within the County Criminal Division (Fla. Cir. Ct. June 6, 1997)).


84. Id. at 150.

85. Bernstein & Seltzer, supra note 83, at 153 ("A guilty plea adds a conviction to the individual's record, making it harder to get or keep the housing and employment that are so crucial to effective mental health treatment, community tenure and management of a long-term psychiatric disability."); Nat'l Mental Health Ass'n, Mental Health Courts, Nov. 17, 2001, at http://www.nmha.org/position/mentalhealthcourts.cfm (revised Nov. 13 2004) ("NMHA does not support mental health courts unless a particular court provides a meaningful alternative to criminal sanctions... .").

86. See, e.g., Petrla et al., supra note 82, at 18. Roughly half of mental health courts limit jurisdiction to defendants with misdemeanor charges, although many courts are beginning to accept people charged with more serious and violent offenses. Bernstein & Seltzer, supra note 83, at 154-55.

87. See, e.g., Bernstein & Seltzer, supra note 83, at 150; Carns et al., supra note 56, at 27; Petrla et al., supra note 82, at 19.

88. See, e.g., Carns et al., supra note 56, at 27; Petrla et al., supra note 82, at 20.

89. See, e.g., Carns et al., supra note 56, at 27; Kondo, supra note 81, at 291-92; Petrla et al.,
Juvenile Mental Health Courts and Therapeutic Jurisprudence

to impose sanctions for non-compliance, most mental health courts instead respond by modifying treatment plans and ensuring that participants’ needs are being met. 90

Looking to the future of the mental health court movement, the National Mental Health Association (NMHA) suggests that “mental health courts [can] play a role in convening criminal justice, mental health, substance abuse and other relevant social service agencies to facilitate diversion from the criminal justice system.” 91 NMHA advises that mental health courts not “risk further criminalizing people with mental illness, [or] fragmenting the mental health and criminal justice system,” and notes that courts cannot and should not run the mental health system. 92 Advocates believe that acceptable mental health court models should neither coerce nor compel treatment, 93 but rather work to “effectively determine individual needs and advocate for good individual treatment.” 94 This individualized treatment should focus on recovery and choice, and include “mental and physical health care, case management, housing, supportive education, substance abuse treatment, and psychosocial services in the least restrictive environment possible.” 95 Finally, in order for mental health courts to benefit the offender and community alike, court systems must avoid simply straining already insufficient local resources; they must promise to bring additional treatment resources into the communities where they operate. 96

Even if advocates’ hopes for mental health courts are not fully realized, the role of these specialized treatment courts in the criminal justice system is likely to expand. In 2000, Congress authorized the Attorney General to make grants available for up to one hundred mental health courts in the America’s Law Enforcement and Mental Health Project Act. 97 The Act synthesizes information

---

90. See, e.g., Carns et al., supra note 56, at 27-29; Petrila et al., supra note 82, at 20. Mental health advocates have suggested that “[i]f the goal is to lessen the incarceration of people with mental illnesses, then using incarceration as punishment is a perversion of the whole idea of mental health courts.” Bernstein & Seltzer, supra note 83, at 158.

91. Nat’l Mental Health Ass’n, supra note 85; see also Bernstein & Seltzer, supra note 83, at 149 (recommending that “a mental health court . . . coordinate not only with police, sheriff, and prosecution but also with state and local service systems”).

92. Nat’l Mental Health Ass’n, supra note 85.

93. See Nat’l Mental Health Ass’n, supra note 85 (“Mental health courts should act as conveners of criminal justice and treatment resources, not as wielders of criminal justice sanctions to coerce mental health treatment.”); see also Bernstein & Seltzer, supra note 83, at 14.

94. Nat’l Mental Health Ass’n, supra note 85.

95. Id.

96. Id.


685
and recommendations from mental health and criminal justice professionals and endorses mental health court models offering continuing judicial supervision of qualified, non-violent offenders with mental disabilities.\textsuperscript{98} The Act also calls for the creation of coordinated programs to train court and law enforcement personnel to recognize offenders with mental health needs, to provide voluntary mental health treatment as a “meaningful diversion” from criminal sanctions, to centralize case management processes by coordinating mental health treatment plans with the provision of social services, and to provide continuity in psychiatric care following release.\textsuperscript{99} Although mental health courts are by no means a panacea for the individual problems and systemic failures that have brought people with mental illnesses in contact with the criminal justice system, they might at least offer partial solutions by reducing the incarceration and recidivism rates of mentally ill offenders and facilitating their reintegration into their communities.\textsuperscript{100}

\textbf{B. “Problem-Solving” Courts in the Juvenile Justice System}

“Problem-solving” courts in the juvenile justice system implement “special strategies to address the particular risk factors that influence the growth and development of children today.”\textsuperscript{101} While the subject matter of these courts may vary, they share the goal of improving therapeutic outcomes for youthful offenders.\textsuperscript{102} Specialized juvenile courts are designed to intervene aggressively and immediately in the lives of troubled youth. Through early intervention and comprehensive treatment plans, “problem-solving” courts empower judges to consider the needs of individual offenders and creatively tailor dispositions.\textsuperscript{103}

Existing juvenile specialty court models tend to converge on very similar therapeutic elements to a greater degree than the diverse specialized treatment

\begin{thebibliography}{100}
\bibitem{98} Id.
\bibitem{99} Id; see also Kondo, \textit{supra} note 81, at 289 (“Judges and governmental task forces who wish to establish a [Mental Health Treatment Court] in their state may find it advisable to consider some of the following suggestions: begin with less complex misdemeanor cases with gradual transition to more complex felony cases; establish organized procedures for law enforcement and jail staff to recognize potential candidates for the [Mental Health Treatment Court]; devise probationary and conditional release plans and criteria for release of offenders from institutional commitment; and implement an organized system for follow-up to ensure that mentally ill offenders are regularly reassessed and monitored.”).
\bibitem{100} Bernstein & Seltzer, \textit{supra} note 83, at 148.
\bibitem{101} Gilbert et al., \textit{supra} note 5, at 1202.
\bibitem{102} Id.
\bibitem{103} Id. at 1203.
\end{thebibliography}
courts in the adult criminal justice system. "Problem-solving" juvenile courts universally strive to use both consequences and incentives in treatment and recovery plans\(^{104}\) and focus on "the role and functioning of the youth's family in terms of rehabilitating the youth."\(^{105}\) These common goals can best be clarified through an examination of juvenile "problem-solving" courts in existence today, with a focus on the more established juvenile drug courts and the nascent juvenile mental health court movement.

Tailoring the drug court treatment model to juveniles has proven far more difficult than had been originally anticipated.\(^{106}\) Juvenile drug courts have faced unique challenges, ranging from offenders' lack of maturity and differing developmental stages to negative peer influences and family environments that often foster substance abuse problems.\(^{107}\) As these and other issues have arisen, courts' attempts to meet the needs of juvenile drug offenders have relied in large part on their own institutional flexibility. To begin, juvenile drug courts have implemented earlier and more comprehensive mental health screening assessments to identify youth and family substance abuse needs than their mainstream juvenile court counterparts. Once needs have been assessed, fashioning an individualized youth drug court treatment plan involves a much greater range of individuals and institutions than the adult substance abuse treatment model. Juvenile drug courts increasingly rely on coordination among court actors, the family, the treatment community, the school system, and various other juvenile-focused community agencies.\(^{108}\) Through this coordination, juvenile drug courts strive to provide each child with a solid psychological, social, and educational foundation, including "an opportunity to be clean and sober; constructive support to aid them in resisting further criminal activity; support to perform well in school and develop positive relationships in the community; and skills that will aid them in leading productive, substance-free, and crime-free lives."\(^{109}\)

104. See id. at 1210-11 ("The use of consequences and incentives is an important component of... specialty courts. Consequences must be structured to promote each juvenile's ability to take responsibility for his or her actions. Positive rewards and incentives for compliance with program conditions are as important as negative sanctions for program compliance... It is important to develop an appropriate array of both consequences and incentives and to communicate those to the family and youth early on in the process.").

105. Id. at 1203.


107. Id.

108. Id.

109. Id.
One of the first juvenile courts to open its doors was the Escambia County Juvenile Drug Court of Pensacola, Florida. The Escambia Court employs a typical multi-tiered approach to tackling the issues of juvenile substance abuse throughout youths’ required twelve-month commitment to treatment. Juvenile offenders are screened within twenty-four hours of intake and referred to the juvenile drug treatment court between forty-eight hours (detainees) to three weeks (non-detainees) later. As in adult drug treatment courts, courtroom procedures are designed to facilitate and reinforce substance abuse treatment programs and seek to provide an “‘early intervention [that] serves as a meaningful alternative to incarceration.’” However, the juvenile drug court goes a step beyond the adult courts in at least one respect—its focus includes the “family and social facets of juvenile addiction and drug abuse.” The court’s program accordingly places an additional, rehabilitative emphasis on the offender’s “‘vocational, educational, and spiritual needs’” in the community. The court assigns “family intervention specialists” to assist in meeting both the youth’s and his family’s “‘psychiatric, psychological, social, economic, and medical’” needs.

Over the past three years, the focus of therapeutic “problem-solving” courts in the juvenile justice system has increasingly expanded beyond substance abuse concerns to include broader juvenile mental health concerns. This shift has led to the introduction of juvenile mental health courts. This movement, like its adult counterpart, stems from a recognition that mental disabilities often cause, or contribute to, delinquent behavior. The juvenile justice system—an institution designed to treat and rehabilitate youth—offers a unique opportunity to intervene in the lives of children with mental disabilities before any negative behavioral or psychological patterns take hold. Though the procedures employed by courts may vary, all appear to focus on the importance of developing individualized treatment programs for offenders and returning to the rehabilitative ideal.

To date, the progress of the juvenile mental health court movement has been limited: The only two juvenile mental health courts in operation are in California’s Santa Clara and Los Angeles counties. In Santa Clara, the Court

110. Hora et al., supra note 51, at 500.
111. Id. at 502 (quoting ESCAMBIA COUNTY, JUVENILE DRUG COURT PROGRAM 2 (1996)).
112. Id. at 500-01.
113. Id. at 500 (quoting ESCAMBIA COUNTY, supra note 111, at 1).
114. Id. at 501 (quoting ESCAMBIA COUNTY, supra note 111, at 3).
117. See Michelle Guido & Yomi S. Wronge, Juvenile Court Targets Mental Illness, SAN JOSE
for the Individualized Treatment of Adolescents (CITA) offers one-year treatment programs to certain non-violent youth diagnosed with organic disorders “that have a clear biological cause,” such as attention deficit hyperactivity disorder, bipolar disorder, or severe depression. To identify candidates for CITA, all minors undergo initial screening for these and other mental disabilities upon arrival at the juvenile detention center. Eligible youth receive further comprehensive assessments and—with the consensus of a multi-disciplinary team consisting of the district attorney, defense counsel, probation officer, and mental health coordinator—may ultimately be offered participation in the program.

For youth who choose to accept CITA jurisdiction, the court’s mental health coordinator develops individualized treatment plans, drawing from a full range of mental health services. Though more serious offenders may still be incarcerated, the majority are placed on an electronic monitoring system and released to receive individualized treatment and rehabilitation services “designed to keep youth in their homes, schools and communities while providing comprehensive mental health services.” While on probation, youth return to CITA for judicial review every thirty to ninety days. To remain in the program, they must, at a minimum, demonstrate their willingness to participate in psychological counseling, comply with any prescribed medication regimens, and exhibit a “generally positive attitude.” If all conditions are met and the treatment program is successfully completed, juveniles are then “released from the court’s jurisdiction and the pending charges are dismissed.”

The Los Angeles Juvenile Mental Health Court operates on a similar model for youth whom the district attorney’s office and other county agencies believe can benefit from the court’s intervention. Youth eligibility for the court is

---

118. Karen de Sa, Court Addresses Causes of Juvenile Delinquency, SAN JOSE MERCURY NEWS, Nov. 23, 2002, at 1A.
120. Arredondo et al., supra note 115, at 11.
121. Id. at 11-13.
122. Id. at 15.
123. Guido & Wronge, supra note 117.
125. Id. at 17.
126. Cichon, supra note 116, at 60.
127. CAL. HEALTHCARE FOUND., supra note 117; Greg Krikorian, Mental Health Court Offers
Based on several criteria, including the presence of a diagnosed mental disorder or developmental disability, the ability to communicate with an attorney, the seriousness of the offense at issue, and the degree of violence in the youth's delinquent record.128 Once eligible youth have accepted the court's jurisdiction,129 the court employs a team of mental health professionals, school administrators, and probation officers to determine appropriate individual service plans.130 Judges order the implementation of these service plans to provide for "home, family, therapeutic, educational, and adult transition services."131 Following disposition, judges continue to monitor each youth's progress in the assigned treatment program with assistance from an interdisciplinary team of mental health professionals, education and service providers, and representatives from the public defender and district attorney's office.132 Probation officers and a school-court liaison oversee juveniles' educational and treatment progress, with probation officers making frequent visits to ensure that juveniles meet the conditions of the disposition.133 In addition, clinical psychologists conduct site visits and participate in regular treatment meetings as long as treatment continues, while psychiatric social workers hold service providers accountable for providing agreed-upon assistance.134 Upon successful completion of the treatment program, delinquent charges are dismissed.135

While it is still too early for any comprehensive analysis of this approach to have been completed,136 some data have indicated that the juvenile drug court concept may effectively facilitate recovery and lower participants' likelihood of

128. CAL. HEALTHCARE FOUND., supra note 117. If necessary the court may also opt to order a comprehensive psychological evaluation to aid in eligibility determinations. Agata DiGiovanni, The Los Angeles County Juvenile Mental Health Court: An Innovative Approach to Crime, Violence, and Delinquency Among Our Youth, 23 J. JUV. L. 1, 6 (2003).


133. DiGiovanni, supra note 128, at 7.

134. Id.

135. Id. at 6.

136. Given the Santa Clara and Los Angeles courts' openings in February and October 2001, respectively, there has simply not been time to comprehensively evaluate their success.
JUVENILE MENTAL HEALTH COURTS AND THERAPEUTIC JURISPRUDENCE

There is unfortunately even less extensive longitudinal data on the effectiveness of juvenile mental health court interventions. Nevertheless, the preliminary data from CITA do seem to offer some hope for this model's viability. For example, Santa Clara Juvenile Court Judge Davilla reports that internal assessments show a relatively substantial reduction in recidivism for those who participate in the specialized CITA program.138

IV. A RETURN TO THE REHABILITATIVE IDEAL: USING THE JUVENILE MENTAL HEALTH COURT MODEL TO REDISCOVER THE THERAPEUTIC GOALS OF THE JUVENILE JUSTICE SYSTEM

While the juvenile mental health court movement may be laudable in its aspirations, the promise of juvenile mental health courts is incredibly limited when placed against the background of an overwhelmingly large population of children and adolescents in need of mental health services.139 This is not a flaw in the model espoused by juvenile mental health court advocates; it is simply a reflection of the reality that anywhere from a large minority to a sweeping majority of minors who come before the juvenile justice system exhibit mental disabilities.140 Creating a network of juvenile mental health courts large enough to serve such a large proportion of the juvenile offender population seems unwise and entirely unnecessary in light of the existing juvenile justice system's potential to do the same.

The support for therapeutic jurisprudence ideals and programs embodied in the juvenile mental health court movement—even in the face of punitive reforms—may signal a renewed opportunity for the juvenile justice system to return to its fundamental emphasis on treatment and rehabilitation for all offenders.141 Juvenile mental health courts have reintroduced the important goals

137. See Hora et al., supra note 51, at 502; see also Kessler, supra note 61, at 63.
138. KQED, supra note 119 ("[W]e have lowered the recidivism rate... to 7 percent [compared to the 25 percent recidivism rate for the general juvenile population].").
139. Romo, supra note 132.
140. NAT'L MENTAL HEALTH ASS'N, supra note 37; Warboys & Wilber, supra note 11, at 506 (citing N.A. Brandenburg et al., The Epidemiology of Childhood Psychiatric Disorders: Recent Prevalence Findings and Methodological Issues, 29 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 76 (1990)); see also Baerger et al., supra note 37, at 21 (finding that more than one-third of adolescents arrested and adjudicated within the juvenile justice system exhibit symptoms of major affective disorders); supra Part I.
141. Gilbert et al., supra note 5, at 1197-1201. Gilbert posits that "[a] more heightened and intensified emphasis on therapy and rehabilitation, accompanied by appropriate accountability and due process safeguards, does not represent a dramatic philosophical shift from past and current juvenile justice considerations and objectives." Id. at 1200-01.
of “accountability, treatment, healing, and a long-range successful outcome for the child and family,” which may well be a “necessary step for meaningful reform.”\(^{142}\) The commentary that juvenile mental health courts have inspired from the press, public, and the courts’ own actors—noting, for example, the courts’ ability to look at “‘why a kid got involved in the system and how we can prevent it from happening again,’”\(^{143}\) and “‘the real, underlying issues ... with these kids.’”\(^{144}\)—is remarkably reminiscent of the traditional juvenile justice system’s goals. CITA has been touted as “a national model for its efforts to address delinquency’s causes,”\(^{145}\) while the court’s judge has firmly suggested “‘if we can get young people on track early on, get their parents on track early on . . . we can make an impact.’”\(^{146}\)

The juvenile mental health court model has successfully readjusted its primary focus away from punishment and culpability and back toward the concepts of individualized treatment and rehabilitation. This focus on mental health in the juvenile justice system is not new; there was “considerable psychiatric involvement in the original juvenile courts” and a long-recognized linkage between psychiatry and juvenile delinquency.\(^{147}\) Despite the current juvenile justice system’s failure to effectively address offenders’ mental health needs, there is continuing support for a “positive orientation toward fundamental issues related to mental health.”\(^{148}\) Whatever punitive reforms have come to pass, juvenile court actors still essentially “believe offenders can be reformed, mental health services have value, and the youth’s mental status is significant for making case dispositions.”\(^{149}\) If the juvenile court were to build on these beliefs, it might find a renewed ability to meet the mental health needs of those before it.

Nevertheless, the juvenile justice system’s emphasis on mental health concerns continues to wane as dispositions focus less and less on desirable

\(^{142}\) Cichon, _supra_ note 116, at 61. Indeed, the title of the first juvenile mental health court alone—the “Court for the Individualized Treatment of Adolescents”—strongly suggests a return to the diagnostic, case-by-case approach of the early juvenile court.

\(^{143}\) Krikorian, _supra_ note 127 (quoting Nancy Ramseyer, Deputy Public Defender, Los Angeles County).

\(^{144}\) Guido & Wronge, _supra_ note 117 (quoting Judi Marshall, Deputy Probation Officer, Santa Clara County).

\(^{145}\) de Sa, _supra_ note 118.

\(^{146}\) KQED, _supra_ note 119 (quoting Judge Raymond Davilla, Santa Clara County Juvenile Court).


\(^{149}\) _Id._
treatment outcomes. But if this system were to draw upon the ideas and practical operations of the juvenile mental health courts, perhaps it could find its way back to an individualized, case-by-case approach to administering justice. The juvenile mental health court model can encourage juvenile courts to function as child-centered, family-focused, community-based, and culturally competent institutions.\textsuperscript{150} Advocates have pushed for the development of specialized juvenile mental health courts in the hope that these courts would effectively identify, triage, and treat mentally-disabled youth with a comprehensive array of integrated and coordinated services.\textsuperscript{151} However, it is well within the power and purview of the larger juvenile court to address the concerns of these juvenile mental health court advocates without isolating mental health considerations in a specialty court.\textsuperscript{152} To do so, juvenile courts must begin to establish linkages with therapeutic treatment and social service providers at the organizational level. These courts should strive to institute more therapeutic procedures, roles, court rules, information systems, and sentencing options.\textsuperscript{153} At a more general level, those guiding the system must adopt policies that foster therapeutic outcomes and awareness of mental health needs. Advocates should also attempt to convince state legislatures to enact and revise laws reflecting the principles of therapeutic jurisprudence.\textsuperscript{154}

V. POISED FOR REFORM: RECOMMENDATIONS FOR ADDRESSING THE MENTAL HEALTH ISSUES OF YOUTH IN THE JUVENILE JUSTICE SYSTEM

Even decades of punitive juvenile justice reform have not wholly eroded the rehabilitative ideal; virtually all juvenile courts retain some portion of their original mandate "to provide any and all necessary services to rehabilitate and treat youths."\textsuperscript{155} Acknowledging and meeting the mental health needs of youth in the juvenile justice system may not only enable states to address an important

\textsuperscript{150} Arredondo et al., supra note 115, at 14.
\textsuperscript{151} Id.
\textsuperscript{152} See Bernstein & Seltzer, supra note 83, at 149.
\textsuperscript{153} Id. at 147.
\textsuperscript{154} Gilbert et al., supra note 5, at 1201. For example, many therapeutic justice advocates favor a softening of the adversarial system to better obtain more just resolution of cases and the best available treatment options. Kondo, supra note 81, at 262.
\textsuperscript{155} See Mears et al., supra note 44; see also Theodore Fallon, Jr. & Dawn Dawson, Juvenile Justice: Yesterday and Today, in AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY, supra note 61, at 14-15 (noting that "[a]lthough it may seem otherwise, even after a century of modifications, and broad variations from state to state, most juvenile justice laws and governmental structures specify that the juvenile justice system continues to act in the best interest of the youth.").

693
factor contributing to antisocial behavior, but may also lead the juvenile court back to its original aim to serve the “best interests of youths.” However, despite the increasing attention that children’s mental health needs have received in recent years, there remains only minimal recognition of the importance of these needs. While today’s juvenile courts may not be the ideal means for handling youth with mental health needs, states must realize that they are a necessary one: “[I]t is crucial that we deal not only with the specific behavior or circumstances that bring [juveniles] to our attention, but also with their underlying, often long-term mental health and substance abuse problems.”

The juvenile justice system remains uniquely equipped to address the backgrounds and characteristics of young offenders and to provide opportunities for rehabilitation through individualized assessments and treatment plans. Though the juvenile court has grown increasingly similar to its retributive criminal counterpart, this shift has not completely detached the juvenile justice system from its focus on rehabilitation; both justice systems aim to achieve “[the] proscription of deviant behavior, social protection through supervision and incapacitation, and reform and rehabilitation of delinquents.” To this end, the American Psychiatric Association believes both that the importance of the involvement of mental health professionals in the juvenile justice system remains constant in the face of punitive reforms and that resources should be reallocated to adequately address the mental health needs of those young offenders amenable to treatment.

The sad reality is that the current juvenile justice system is simply not equipped to meet the mental health needs of large numbers of juveniles who

157. Mears et al., supra note 44.
158. Id.; Teplin et al., supra note 41, at 1139; Michelle Wierson et al., Epidemiology and Treatment of Mental Health Problems in Juvenile Delinquents, 14 ADVANCES BEHAV. RES. & THERAPY 93 (1992).
160. Wong, supra note 33, at 165.
162. Am. Psychiatric Ass’n, supra note 147, at 1584.
either have psychiatric disorders or are at risk of developing them. Juvenile courts' access to services available in schools, welfare agencies, and community organizations may make them exceptionally capable of tailoring integrated treatment plans to the mental health needs of children who come before them. Juvenile justice officials must recognize the proper care of youth with diagnosable or emerging mental health problems as “among their greatest challenges.” While research to date has produced only limited evidence of how best to contend with obstacles to meeting the mental health needs of juvenile offenders, recommendations for mental health care reform in juvenile justice abound. The recommendations address a wide range of issues, including the problems of screening and assessment, education and training, coordination across systems, treatment, and delivering mental health care during incarceration.

A piecemeal approach to meeting juvenile mental health needs—as has been adopted in far too many juvenile court jurisdictions—is inadequate. Screening programs are fruitless if results do not come to the attention of juvenile court personnel, just as the court’s awareness of detected mental health needs is of little use should there be no services available to meet those needs. An effective system for addressing juvenile mental health needs must incorporate strategies for dealing with these needs from the time they are identified through the completion of post-dispositional treatment.

Youth must be adequately screened before they can be matched with appropriate mental health services. Court staff

164. Handle with Care, supra note 30; Teplin et al., supra note 41, at 1139.
165. See Nat’l Mental Health Ass’n, supra note 36.
166. See Nat’l Council of Juvenile & Family Court Judges, supra note 3, at 3.
168. Mears et al., supra note 44.
170. Quite possibly, no integrated juvenile justice system has ever existed; instead there have been “an assortment of aggregate entities of varying quality that do not generally communicate with each other in meaningful ways.” Charles Billikas, The Ideal Juvenile Rehabilitation Program: An Integrated System, 21 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 411, 418 (1995).
171. Griffin and Jenuwine argue that “in an ideal setting, a mentally ill youth who was arrested could move from an assessment center, to a detention center with treatment planning, to a mental health court, to a court order for community-based services . . . . allow[ing] the juvenile courts to embrace the tenets of therapeutic jurisprudence.” Griffin & Jenuwine, supra note 58, at 86. The philosophy behind such a system is very straightforward—as the Maryland Juvenile Justice Coalition summarizes, an effective treatment model must “identify the services and supports that a child and his/her family needs and provide them as long as they are needed.” Md. JUVENILE JUSTICE COALITION, PRINCIPLES OF A MODEL JUVENILE JUSTICE SYSTEM 10 (2002), http://www.acy.org/web_data/Model%20Juvenile%20Justice%20System%202002.pdf.
must be trained to work with these youth and to arrange for these services while juveniles remain under the jurisdiction of the court. Interagency coordination must bridge the gaps between the juvenile justice, mental health, and educational systems to enable juveniles to obtain the necessary treatment in all areas of their lives.

**A. Screening and Assessment**

In order to meet youths’ mental health needs, their mental health status must be evaluated at both the initial point of contact with the juvenile justice system and at every subsequent stage in the adjudication process. 172 Indeed, each “referral to the juvenile justice system presents an opportunity to identify a child in need of mental health treatment.” 173 This evaluation may come in two forms—screening and assessment. Screening is the relatively brief process used to identify youth at an increased risk for mental disorders or in need of immediate attention and more complete review. 174 Assessment offers this review and further examines a youth’s psychological needs and problems. 175

Most juvenile courts do not adequately screen youth in contact with the juvenile justice system and also lack clear guidelines for identifying mental

---

172. See Bilchik, supra note 159; Soler, supra note 169, at 322; Warboys & Wilber, supra note 11, at 507 (“At each stage of the juvenile court process, there are opportunities for... mental health professional[s] to play an extremely important role.”). Nurcombe and Partlett provide a listing of typical times mental health professionals might become involved in the process and what issues courts might ask them to explore:

*Prior to the disposition hearing.* Amenability to treatment? Appropriate disposition? Recommended treatment?

*Prior to a transfer hearing.* Amenability to treatment? Dangerousness? Competence to waive due process rights? Competence to stand trial? Mental health at the time of offense?

*Prior to adjudication.* Competence to stand trial? Competence to waive due process rights? Mental state at the time of the offense? Recommended psychiatric treatment? Appropriate disposition?

*Prior to diversion.* Amenability to treatment? Appropriate diversion? Recommended treatment?

Nurcombe & Partlett, supra note 7, at 306.


175. Id.
health problems in youth. In many jurisdictions, juveniles simply do not receive mental health screening or assessment at all. In those systems that do offer mental health evaluations, the instruments used often present numerous reliability, validity, and administrative problems. The development of systematic intake procedures to determine and evaluate mental health needs is, however, essential to meeting those needs in the juvenile justice system. Every minor in contact with the system should be screened and—if necessary—evaluated for the presence of mental health disorders.

The screening and assessment process involves more than the simple administration of a psychometric testing instrument. To gain a full picture of a juvenile’s mental health needs, medical histories for both the youth and her family must be obtained and evaluated. Yet in the current system, intake personnel are rarely provided all relevant “reports, records, or background information pertinent to the child’s behavior,” leaving the juvenile court with

176. Soler, supra note 169, at 322
177. Fallon & Dawson, supra note 155, at 16 (finding that many juveniles are not screened for mental health problems either pre- or post-adjudication); Drew H. Barzman et al., Attention-Deficit Disorder Diagnosis and Treatment, 25 J. LEGAL MED. 23, 25 (2004); Soler, supra note 169, at 323 (noting that many systems do not offer mental health assessments at arrest, admission, disposition, or placement).
178. See Cocozza & Skowyra, supra note 39, at 9; Soler, supra note 169, at 323. Social scientists caution against the use of instruments that have not been adequately researched or tested on adolescents. Grisso & Underwood, supra note 174, at 5. Many recommend using only instruments tailored to minimal reading levels that are “amenable to administration with youth of diverse ethnic, cultural, and linguistic backgrounds.” Id. These and other considerations suggest that great care should be taken in selecting the most appropriate screening and assessment instruments for youth. Id. One promising example of a standardized screen may be the recently developed Massachusetts Youth Screening Instrument—a shorter, easily administered, well-normed inventory. Cocozza & Skowyra, supra note 39, at 9.
179. Redding, supra note 31 (noting that “mental illness and substance abuse are significant risk factors for delinquency”); see also Barzman supra note 177, at 26 (“[A] systematic method of identification of mental illness is the cornerstone to developing an appropriate approach to youths who may need further evaluation and treatment.”).
180. Cocozza & Skowyra, supra note 39, at 9; see also Barzman, supra note 177, at 25 (“One recommended approach is to screen youths upon their entry into the juvenile justice system to evaluate for unknown mental health issues.”). More specifically, Curtis Heaston recommends a three-tiered assessment approach, with the first level of assessment for juveniles first entering the justice system, the second level in the courtrooms for juveniles whose cases are filed, and the third level for juveniles held in the detention center. Curtis Heaston et al., Mental Health Assessment of Minors in the Juvenile Justice System, 11 WASH. U. J.L. & POL’Y 141, 149 (2003).
little help in its efforts to make a well-informed decision. In addition to correcting this initial informational shortfall, court personnel should make reassessments and administer necessary interventions, psychopharmacological or otherwise, where appropriate. Early screening and continuing mental health evaluation are essential to facilitate the expedient and appropriate placement of youth with mental disorders in the juvenile justice system into safe, appropriately suited treatment environments.

B. Educating and Training Juvenile Justice Personnel

From judges and defense attorneys to prosecutors and probation officers, most juvenile court personnel have received little to no formal education or training in handling youth with mental disorders. The large majority of them have limited background knowledge of child and adolescent development generally, let alone the subset of issues related to childhood mental disability. As a result, many actors in the juvenile justice system may be unable to understand the results of mental health assessments, the mental needs of individual youth, or the promise of appropriate treatment options. Juvenile justice personnel must have access to more opportunities for education and training to respond effectively to the mental health needs of juvenile offenders.

C. Coordinating Across Systems

Both the problems created by fragmented mental health services and the need for increased coordination have long been recognized. Although many youth present coexisting mental disabilities, individual state entities often offer only limited services to individuals qualifying for treatment in multiple systems.
Juvenile Mental Health Courts and Therapeutic Jurisprudence

Such youth clearly need the services of more than a single public system. Care coordination involves accessing and assembling medical, psychiatric, social, educational, and other support services essential to meeting these youth's mental health needs. The Child and Adolescent Service System Program (CASSP)—an organization that links mentally-disabled children and adolescents with needed services—has consistently advocated for a continuum of care that provides youth with an array of child-centered, family-focused, community-based, multi-system, and culturally competent services. These recommendations have at last begun to make inroads into the juvenile justice system and cross-system collaboration is quickly emerging as indispensable to the effective provision of mental health treatment solutions for children and adolescents.

All agencies involved in the treatment and care of youths with mental disorders—including the criminal and juvenile justice systems, mental health systems, schools, family and social service organizations, law enforcement agencies, medical institutions, and substance service systems—must collaborate to develop and implement effective treatment strategies. Comprehensive integrated services are more likely to attend to the underlying causes of delinquency and recidivism, thereby offering youths an opportunity for a smoother transition out of the juvenile justice system into productive adult lives. An approach that brings each and every agency responsible for administering juvenile mental health treatment together for planning, cross-training, and service delivery is ideal.

D. Delivering Mental Health Care to Incarcerated Juvenile Offenders

Between 1923 and 1974, the rates of admission to juvenile correctional facilities increased nine-fold. Congress' recognition that many of these placements were inappropriate prompted it to pass the Juvenile Justice and

190. MD. JUVENILE JUSTICE COALITION, supra note 171, at 10.
191. Gilbert et al., supra note 5, at 1180.
194. HANDLE WITH CARE, supra note 30; Cocozza & Skowyra, supra note 39, at 7-8.
195. Warboys & Wilber, supra note 11, at 518.
196. Cocozza & Skowyra, supra note 39, at 11.
197. Weithorn, supra note 1, at 803.

699
Delinquency Prevention Act (JJDPA) of 1974. Although the JJDPA’s supporters had hoped to remove all but the most serious juvenile offenders from correctional facilities, the Act ultimately demanded the removal of only non-offenders (dependent and neglected youth) and status offenders (youth whose actions were considered delinquent only as a result of their status as minors). Though rates of institutionalization quickly plummeted, the Act still left many children with mental and emotional disorders vulnerable to incarceration in the difficult and often severely overcrowded environments of detention centers and youth prisons.

Punitive reforms in juvenile justice, including state transfer laws and shrinking juvenile court jurisdiction, have begun to unravel the juvenile justice policy created under the JJDPA. The escalating numbers of juveniles tried in adult criminal courts and incarcerated in adult jails and prisons has become a particularly alarming trend. The youth incarcerated in prisons more than tripled in the 1990s, despite evidence that juveniles incarcerated in adult institutions are “5 times more likely to be sexually assaulted, twice as likely to be beaten by staff, and 50% more likely to be attacked with a weapon than youth in juvenile facilities.” These conditions may be especially damaging for youths with mental disorders, who are almost eight times more likely to commit suicide in adult jails than in juvenile institutions. The data strongly suggest that incarcerating juveniles, in particular those with mental health needs, in adult prisons is inappropriate and that states should work to develop separate juvenile facilities for transferred offenders that are better able to meet the special needs of incarcerated youth.

Even in juvenile correctional facilities, however, mental health services are inadequate. Most juvenile facilities provide only crisis intervention and occasional group counseling; the vast majority do not administer one-on-one

199. Weithorn, supra note 1, at 803.
200. Id.
201. Nat’l Mental Health Ass’n, supra note 36.
203. Id.
205. Soler, supra note 169, at 326.
207. Soler, supra note 169, at 327.
therapy nor offer services in collaboration with providers outside the system.\textsuperscript{208} All professionals—from social workers and nurses to correctional officers and facility administrators—must advocate for the adequate staffing of mental health professionals to address the mental health needs of incarcerated youth.\textsuperscript{209}

The National Mental Health Association recommends certain guidelines for reforming treatment during confinement, including round-the-clock mental health services and special treatment for children with histories of family abuse, violence, substance abuse, and educational difficulties.\textsuperscript{210} Treatment should be individualized and provided in the least restrictive environment possible, and children should be transferred to appropriate medical or mental health facilities when conditions so warrant.\textsuperscript{211} Effective treatment plans cannot terminate upon release and discharge plans should facilitate the integration of incarcerated children back into their families and communities.\textsuperscript{212} Unfortunately, most facilities have failed to develop even weak links with community-based health programs and aftercare services to meet the specific needs of youth released from custody.\textsuperscript{213} These links must be forged. If incarceration is unavoidable, juvenile offenders with mental disabilities should be placed in correctional or mental health institutions able to meet their needs and returned to their families and communities as swiftly as possible.

\textbf{E. Effective Community-Based Treatment Options}

The juvenile court, throughout much of its existence, has placed a premium on allowing children to grow up in community settings.\textsuperscript{214} As noted above, the juvenile justice and mental health systems must work together to develop programs and implement services that meet the mental health needs of youth, preferably in their home environments.\textsuperscript{215} The National Mental Health

\begin{footnotesize}
\addcontentsline{toc}{footnote}{Notes}

\footnote{208. \textit{Id.} at 323.}
\footnote{209. Nat'l Mental Health Ass'n, \textit{supra} note 36. In addition, the American Medical Association strongly supports both model legislation that addresses the mental health care needs of detained and incarcerated youth and further steps necessary to implement such legislation on state and federal levels. Louis J. Kraus, \textit{Standards for Juvenile Detention and Confinement Facilities}, in AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, \textit{supra} note 61, at 27.}
\footnote{210. Nat'l Mental Health Ass'n, \textit{supra} note 36.}
\footnote{211. \textit{Id}.}
\footnote{212. \textit{Id}.}
\footnote{213. Soler, \textit{supra} note 169, at 323.}
\footnote{214. Zimring, \textit{supra} note 6, at 2481.}
\footnote{215. Nat'l Mental Health Ass'n, \textit{supra} note 36; see also BILCHIK, \textit{supra} note 159; Soler, \textit{supra} note 169, at 324 (noting the importance of interagency collaboration in improving treatment services).}

701
Association recommends that these services be "treatment-oriented, appropriate for the child’s age, gender, and culture, individualized, and family focused." 216 Most jurisdictions, however, fail to provide adequate non-institutional public mental health services for children and families. 217 Rekindling the rehabilitative underpinnings of the juvenile justice system may intensify the public’s interest in providing mentally disabled youth with the services to which they are entitled. 218

Non-residential, community-based services would offer these jurisdictions cost-effective opportunities to intervene when a juvenile’s aggressive or delinquent behavior first arises. 219 These services are designed to keep youth active in their home, school, and community environments “while providing a comprehensive set of services that respond to their mental health needs and related problems.” 220 They maintain the integrity of the juvenile’s family unit, 221 are less restrictive and invasive for emotionally and mentally disordered youth, and offer more effective treatment prospects than either institutional or residential placements. 222 Across the board, “[t]here is a growing, if not already established, consensus that community-based care is more effective than hospitalization in treating all but the most severe mental disorders,” with a growing body of research documenting the “superiority” of community-based treatment over institutionalization. 223

While returning mentally disabled juvenile offenders to safe and stable homes is critical to effective treatment plans, youth in the juvenile justice system are often from highly dysfunctional family settings or have suffered from parental neglect or abuse. 224 Successful community-based services do not merely return delinquent youths to their often confused or anxious families; they strive to treat the families of delinquent offenders in addition to the juveniles

---

216. Nat’l Mental Health Ass’n, supra note 41.
217. See Weithorn, supra note 1, at 829.
218. Anderson, supra note 9, at 78. ("It is still possible to imagine ways juvenile delinquents might be sanctioned and supervised effectively as juveniles, not adults, without removing them from the community. The drift away from historical juvenile justice remains premature.").
220. Cocozza & Skowyra, supra note 39, at 10.
221. Sutnick, supra note 219, at 145-46.
222. Weithorn, supra note 1, at 788-94.
223. Cichon, supra note 189, at 538.
JUVENILE MENTAL HEALTH COURTS AND THERAPEUTIC JURISPRUDENCE

themselves. 225 Supportive family involvement is crucial, and mental health treatment plans must provide the families of juveniles with psychiatric disorders with the requisite knowledge and tools necessary to effectively manage the mental health needs of their children. 226 Focusing on families, as opposed to juvenile delinquents in isolation, can lead to "a fundamental change in the lifestyle of the youths and families that will, at minimum, substantially reduce the likelihood of their further involvement with the justice system, increase public safety, and significantly enhance the likelihood that the youths and their families will function as productive community members." 227

Finding effective treatment models for youth and families involved in the juvenile justice system and meeting their emotional, mental health, and behavioral needs can be quite difficult. 228 However, the traditional "one-size-fits-all" model often used in juvenile justice and mental health systems does not appropriately address these needs. 229 Non-residential community-based programs avoid depriving juveniles of the liberty necessary for productive development, are less expensive than institutionalization, and are more effective in treating all but a small minority of youth facing mental disabilities. 230 Several available treatments—wraparound services, 231 multi-systemic therapy, 232 and functional family therapy 233—offer juveniles and their families comprehensive and coordinated services from a variety of service systems. 234 These same treatments

226. Sutnick, supra note 219, at 145 ("[P]rograms that work with families as whole units generally achieve more long-term success than does [sic] hospitalization because they teach the families strategies for dealing with their children's needs.").
227. Gilbert et al., supra note 5, at 1187 (noting that "[t]he laws nationwide are becoming more and more reflective of the theory that intervention strategies of treatment must be provided to not only the juvenile at risk but also the juvenile's family").
229. Id.
230. Cichon, supra note 189, at 530.
231. Mears et al., supra note 44 ("Wraparound service programs focus on providing treatment that is tailored to the needs of each youth. . . . [T]he Wraparound philosophy is specifically oriented toward placing youths in 'small group homes with individualized care, flexible programming, and a 'never give up' philosophy.'" (citation omitted)).
232. See Cocozza & Skowyra, supra note 39, at 10 ("[Multisystemic Therapy] is a family- and community-based treatment model that provides services in the home and community settings and addresses a range of family, peer, school, and community factors.").
233. See HANDLE WITH CARE, supra note 30, at 43 ("Functional Family Therapy . . . is an 'outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behavior and related syndromes.'").
234. Soler, supra note 169, at 323.
promise the juvenile justice system more successful therapeutic outcomes and dramatic drops in recidivism rates—according to some, decreases in recidivism rates range from twenty-five percent for “structured, meaningful, and sensitive treatment” to eighty percent for programs deemed to be the “most successful.”

VI. IMPLEMENTING AN EFFECTIVE SYSTEM TO MEET JUVENILE MENTAL HEALTH NEEDS IN THE MODERN JUVENILE COURTS

Without adequate mental health treatment programs in place for juvenile offenders and their families, “there will be serious long term and financial consequences.” Unfortunately, both the juvenile justice and mental health systems are chronically under-funded. In a constrained budgetary environment, funding shortages severely limit the mental health services localities can offer juvenile offenders. Juvenile offenders are given relatively low priority within this population of children and adolescents with mental health needs, and their often forced reliance on costly emergency services and limited case management causes further strain on the limited funds made available to meet their needs. The lack of early and effective mental health intervention jeopardizes youthful offenders’ ability to remain at home in family care, spawning a “downward spiral” of deteriorating functioning that often results in expensive short and long-term institutional placements. Not only is delayed mental health intervention more expensive and less effective than early intervention, it leads to other social costs as well, including “school failures, teen pregnancies, juvenile delinquency, welfare, community disintegration, violence and imprisonment.”

Although prospects for many youthful offenders with mental health needs are bleaker than ever, there is still strong hope that the juvenile courts’ ability to serve these offenders could be “revitalized” through additional and reorganized funding. State and local governments seem particularly well-suited to fuel this

235. HANDLE WITH CARE, supra note 30, at 42.
236. Nayowith, supra note 4, at 367.
238. Nayowith, supra note 4, at 366.
240. Id.
241. Nayowith, supra note 4, at 367. The costs of this “downward spiral” are high. For example, while residential treatment facilities in New York State operate at a cost of roughly $400 per day and community-based day services reach a lower daily cost of only $150 to $300, one day of acute inpatient care in a municipal hospital costs nearly $1000. Id.
242. Id. at 383.
revitalization and are encouraged to follow in the footsteps of the model programs described below. The promising results from mental health courts' increased emphasis on treatment, including reduced recidivism and economic savings, may create strong incentives for these governments to increase funding allocations to meet the mental health needs of juvenile offenders.\(^{244}\) Well-funded initiatives geared toward early identification of youthful offenders with mental disabilities would not only provide for more successful and humane treatment; they would also enable the juvenile justice system to reproduce economic and social benefits created by adult mental health courts, including decreased recidivism, a reduction in unnecessary detentions, and a better use of expensive detention beds.\(^{245}\) Although there is still little federal and state funding available for outpatient and at-home services, the community-based mental health services on which these models are based have repeatedly been shown to be both therapeutically effective and more economically efficient than institutional or residential treatment.\(^{246}\) Many new and innovative program models are now “designed with appropriate treatment and cost-effectiveness in mind.”\(^{247}\) Dollars allocated today to meet the mental health needs of youth with mental disabilities “will be repaid many times over through lower public costs” by way of “reduction[s] in expensive long term health care, diminished need for welfare benefits, and less costly judicial processes,” as well as corresponding increases in “educational achievement, employment opportunities, improved development of communities and the enhancement of family life.”\(^{248}\) Moreover, as the mental health resource needs for offenders with serious mental disabilities are more precisely identified, the system will be better able to match available resources with existing mental health treatment needs and future resource development priorities, in the end producing “more effective longitudinal coordination of care and rehabilitation services.”\(^{249}\)

Overall, juvenile justice funding must be made adequate to support a “comprehensive continuum of child and family treatment and support services in communities,” and flexible enough to allow for “the most appropriate placements of children and the most efficient use of available dollars.”\(^{250}\) The bureaucratic distribution of current funding streams reinforces interagency competition rather than encouraging integrated cooperation.\(^{251}\) “Flexible-funding,” however, could

\(^{244}\) Kondo, supra note 81, at 310-11.
\(^{245}\) Arredondo et al., supra note 115, at 3.
\(^{246}\) See Cichon, supra note 189, at 543.
\(^{247}\) Nayowith, supra note 4, at 387.
\(^{248}\) Id. at 383.
\(^{249}\) Arredondo et al., supra note 115, at 4.
\(^{250}\) Nayowith, supra note 4, at 370.
\(^{251}\) Billikas, supra note 170, at 418.
attach money to an individual youth and his or her mental health treatment needs, encouraging “multisystem treatment for complex, troubled youths.” This funding may be redirected from institutions to community-based services offering case management and “adequately fund[ed] services that prevent out-of-home placement.” The bulk of resources currently spent on ineffective and costly “institutions and residential placements can be used instead to pay for non-residential intensive supervision, the wraparound intervention strategy, and family therapeutic programs that have proven results.”

Political pressure must also be placed on state legislators to increase funding for integrated juvenile justice and mental health initiatives. Advocates have successfully exercised such pressure in many jurisdictions, and states across the country have begun to fund juvenile delinquency control and prevention efforts, largely as block grants to counties or other municipalities. Block grants provide communities with the necessary resources and flexibility for “local control in program development, implementation and design.” Typically, incentives are included to reduce delinquency and curb the use of residential placements by treating offenders effectively in the community. Such grant programs have been viewed as overwhelmingly successful and are a step toward meeting the mental health needs of youthful offenders. A few of the more exemplary legislative initiatives—the Reasoned and Equitable Community and Local Alternatives to the Incarceration of Minors (RECLAIM) program in Ohio, the Virginia Juvenile Community Crime Control Act (VJCCCA), and the Schiff-Cardenas Crime Prevention Act of 2000—are discussed below.

252. Id. To implement such a funding system, existing funding sources must be reassessed and reorganized to direct streams toward juvenile offenders and the localities and community mental health providers that serve them. See Redding, supra note 31.
253. MD. JUVENILE JUSTICE COALITION, supra note 171, at 12.
254. Id. at 18.
255. Langemo, supra note 50, at 162.
256. See MD. JUVENILE JUSTICE COALITION, supra note 171, at 6.
257. Id.
258. Id.
261. See DiGiovanni, supra note 128, at 4-5.
RECLAIM Ohio offers Ohio counties the opportunity “to develop or purchase a range of community-based options to meet the needs of each juvenile offender or youth at risk of offending.”\(^262\) Piloted in 1994 and implemented statewide in 1995, RECLAIM apportions juvenile court funding “for the local treatment of youthful offenders and at-risk youth,” with allocations “based on a four-year average of felony adjudications, with deductions for [the Department of Youth Services] and community corrections facility bed day usage in the prior year.”\(^263\) Paired with the Youth Services Grant initiative, monies received are “used for a vast array of treatment, intervention, diversion and prevention programs” including community-based treatment, intensive probation, and residential treatment.\(^264\) RECLAIM is designed both to improve the state Division of Youth Services’ treatment and rehabilitation efforts and to increase localities’ autonomy by giving juvenile court judges expanded sentencing options and community-based disposition alternatives.\(^265\)

Overall, RECLAIM has been a successful program—institutional populations have decreased since its enactment, while localities have achieved a greater ability to meet the treatment needs of the juvenile offender population.\(^266\) Moreover, the program encouraged collaboration among a fragmented network of juvenile courts, the Division of Youth Services, and various other state agencies. In all, funds retrained pursuant to RECLAIM surpassed $25 million in 1999\(^267\) and the program’s achievements promise to ensure similar levels of funding in years to come.

B. The VJCCCA

In 1994, the Virginia state legislature responded to an acknowledged lack of comprehensive mental health services by enacting the VJCCCA.\(^268\) The Act offers localities an opportunity to establish continuums of care and “an array of

\[^{262}\] Ohio Dep’t of Youth Servs., \textit{supra} note 259.
\[^{263}\] \textit{Id}.
\[^{264}\] \textit{Id}.
\[^{266}\] \textit{Id}.
\[^{267}\] Ohio Dep’t of Youth Servs., \textit{supra} note 262.
pre- and post-dispositional services\textsuperscript{269} for juvenile offenders designed by agency teams of local personnel\textsuperscript{270} by “develop[ing], implement[ing], operat[ing] and evaluat[ing] programs and services responsive to their specific juvenile offender needs and juvenile crime trends.”\textsuperscript{271} In 2000, the VJCCCA provided nearly $30 million in block grants to localities across Virginia to “support locally-designed community-based programs for court-involved youth.”\textsuperscript{272} Funding allocations are based on a number of factors, including the number and nature of arrests and the average daily cost of serving a child, and—although the program is voluntary—all 134 cities and counties currently participate.\textsuperscript{273} The VJCCCA offers judges additional alternative sentencing options, additional funding for new and existing programs, and increased operational flexibility.\textsuperscript{274}

\textbf{C. The Schiff-Cardenas Crime Prevention Act}

A similar block grant funding initiative emerged in California just six years after the VJCCCA project. Legislators hoping to reduce juvenile crime and delinquency enacted the Schiff-Cardenas Crime Prevention Act in 2000.\textsuperscript{275} The Act allocated $121.3 million to localities to implement juvenile justice plans.\textsuperscript{276} To be eligible for funding, such plans must include assessments of existing community resources that “specifically target at-risk juvenile offenders, and their families;” identify and prioritize communities “fac[ing] a significant public safety risk from juvenile crime;” and provide for “a continuum of responses to juvenile crime and delinquency” demonstrating “a collaborative and integrated approach for implementing a system of swift, certain, and graduated responses for at-risk youth and juvenile offenders.”\textsuperscript{277} Participating localities must file annual reports detailing certain designated “outcome measures,” including the rate of juvenile arrests; the rates of successful completion of probation, restitution, and court-ordered community service; the arrest, incarceration, and

\begin{itemize}
\item \textsuperscript{270} VA. COMM’N ON YOUTH, supra note 268, at 7.
\item \textsuperscript{271} Virginia Juvenile Community Crime Control Act, VA. CODE ANN. § 16.1-309.2 (Michie 2004).
\item \textsuperscript{273} See Virginia Juvenile Community Crime Control Act, VA. CODE ANN. § 16.1-309.2.
\item \textsuperscript{274} See id. § 16.1-309.2.
\item \textsuperscript{275} CAL. GOV’T CODE § 30061 (West 2004); DiGiovanni, supra note 128, at 4.
\item \textsuperscript{276} DiGiovanni, supra note 128, at 4.
\item \textsuperscript{277} CAL. GOV’T CODE § 30061(b)(4)(A)(i)-(iii).
\end{itemize}
probation violation rates of program participants; and the annual per capita costs of the program.\textsuperscript{278} To date, the juvenile justice plans would appear to have successfully offered California localities increased funding for innovative programs to meet juvenile mental health needs, including the nation’s first and only juvenile mental health courts.\textsuperscript{279}

\textbf{D. Suggested Future Initiatives}

Given the present and future successes of RECLAIM Ohio, the VJCCCA, and the Schiff-Cardenas Crime Prevention Act, other jurisdictions should follow suit by enacting similar community block grant programs. As one report suggested to the Commonwealth of Maryland, “reform is possible in the immediate future” with only “relatively modest increases in state funds.”\textsuperscript{280} To begin, states may be able to simply reallocate funds spent on institutions to much smaller programs and community-based intervention strategies.\textsuperscript{281} Eliminating reliance on institutions promises to offer long-term savings as recidivism falls and fewer youth are ordered into expensive institutional or residential placements.\textsuperscript{282} Finally, states need not rely solely on their own treasuries to find resources to meet young offender’s mental health needs in the juvenile justice system; many may increase their access to federal funds by relying on certain federally funded services like case management or by taking advantage of federal funds available for community-based services that help curb the high costs of institutional and residential care.\textsuperscript{283} With so many avenues available to increase funding for mental health treatment and services in the juvenile justice system, jurisdictions across the country should demonstrate their understanding of the importance of juvenile mental health needs by increasing the funding available to address these needs.

\textbf{CONCLUSION}

Mental health advocates who abhor the current systemic breakdown and increasingly punitive nature of juvenile courts have called on the juvenile justice system to follow the lead of criminal justice reforms and forge separate,
specialized courts to deal exclusively with mentally-ill youth. Ultimately, however, this solution is sorely incomplete. While the small number of youth served by juvenile mental health courts might finally receive adequate consideration of their respective mental health treatment needs, these courts all but abandon the much larger contingent of children who either have less serious needs or have committed more serious offenses. In the end, I believe that the therapeutic justice principles and systemic treatment model reforms of the juvenile mental health court movement would be better applied in an intact, mainstream juvenile justice system. With state block grant programs in place, the promises of improved mental health treatment within this system are great. By not segregating children with defined or diagnosed mental disorders, but instead calling for a true and committed return to the juvenile court’s individualized treatment model and greater rehabilitative ideal, many more young offenders will finally be able to obtain the mental health services they need—indeed deserve—from the juvenile justice system.
SYMPOSIUM

Pharmaceutical Innovation and Cost: An American Dilemma

713 Introduction
Mark Siegler, M.D., Alix Weisfeld, and Richard A. Epstein, LL.B.

717 The Problem of New Uses
Rebecca S. Eisenberg, J.D.

741 Regulatory Paternalism in the Market for Drugs: Lessons from Vioxx and Celebrex
Richard A. Epstein, LL.B.

771 The Patient’s Role in Choice of Medications: Direct-to-Consumer Advertising and Patient Decision Aids
Marshall H. Chin, M.D., M.P.H.

785 The Effects and Role of Direct-to-Physician Marketing in the Pharmaceutical Industry: An Integrative Review
Puneet Manchanda, M.Phil., Ph.D. and Elisabeth Honka

711