

## **Expanding Juvenile Mental Health Courts in the Children's System of Care**

As many as three million children, or 20% of California's youth, will experience a mental health disorder in any given year. Children and youth involved in the juvenile justice and child welfare systems have been shown to have an even greater prevalence of mental health disorders, which often go untreated. Research shows a correlation between untreated mental illness, substance abuse and juvenile delinquency. Research also shows that there are specific treatment models that not only restore young people to good health, but also prevent future harmful or criminal behavior (Fight Crime, 2005).

The President's New Freedom Commission Report (2003) points out the youth with serious mental illnesses should be kept out of the juvenile justice system. It argues that the potential for recovery of the offender with a mental illness is frequently derailed by inadequate care and the superimposed stigma of a criminal record. The Commission recommends widely adopting juvenile justice diversion programs to avoid unnecessary incarceration of nonviolent juvenile offenders with mental illnesses.

Similarly, juvenile justice diversion programs are consistent with the mission and values espoused by the California Mental Health Master Plan (2003). The Master Plan states that the goals for children and their families are that they are safe, live at home, are productive at school or at work, have supportive relationships with others, have meaningful connections to their communities, and abide by the law.

### **I. Purpose**

The California Mental Health Planning Council is interested in ensuring that children and youth in the juvenile justice system and those at-risk of entering the juvenile justice system have adequate access to mental health services. There is an increasing reliance on the juvenile justice system to care for children and youth with mental illness. The California Mental Health Planning Council advocates for the expansion of Juvenile Mental Health Courts (JMHC) as an alternative to incarceration.

Drug Courts and Adult Mental Health Courts already have a proven track record for reducing recidivism, providing offenders with affordable treatment, and boosting the number of patients who stay in their treatment programs, as well as cutting costs for taxpayers (Kuehn, 2007). In a February 2005 report, the Government Accountability Office concluded that adult drug court programs substantially reduce crime by lowering re-arrest and conviction rates among drug court graduates well after program completion, providing overall greater cost/benefits for drug court participants and graduates than comparison group members (GAO-05-219). Like drug courts, mental health courts focus on treatment to restore health and reduce criminal activity. They focus on providing mentally ill offenders with better access to treatment, consistent supervision, and support to reconnect with their families.

A report from the Urban Institute points out that, in many respects, the trend of establishing specialized youth courts, including mental health courts, results from the same motivations that led to the establishment of the first juvenile courts, including concerns about lengthy delays in processing cases, the lack of individualized and appropriate treatment and sanctioning, and the lack of sustained and consistent monitoring of the progress youth make while under court supervision. Advocates for juvenile mental health courts argue that the juvenile justice system offers a unique opportunity to intervene in the lives of children with mental disabilities before additional negative outcomes materialize (Bazelon, 2004).

## **II. Description**

The National Center for Youth Law, reports that JMHCs help to identify the mental health needs of detained youth, provide more human and effective treatment, and improved safety regarding self-harm. They also identify the mental health resources that are needed and result in an improved match between the child and community resources. They provide more disposition alternatives for judges and an expedited court process. Furthermore, they improve family education on mental illness and facilitate increased family involvement. Finally, JMHCs result in more effective coordination of longitudinal care and decreased recidivism (National Center for Youth Law, 2007).

JMHCs aim to improve youth mental health and reduce recidivism through a specialized juvenile court process that identifies juvenile offenders with mental health problems and provides them with treatment and case management. The program is voluntary and requires consent by the youth, parent, and assigned counsel. The objective of the JMHC is to protect public safety while also preventing youth with mental illness from being thrust into a juvenile justice system that is not equipped to rehabilitate them. A multi-disciplinary team of staff from County Probation, the County Department of Mental Health, the District Attorney's Office, and the Public Defender's Office decides which youth to refer to the JMHC. Participating youth undergo a comprehensive mental health assessment, receive mental health treatment from community providers, gain access to other health and educational resources as needed, have frequent face-to-face meetings with Deputy Probation Officers, and make repeated court appearances. This process allows juveniles to be commended on their progress, allows challenges or problems to be addressed as they arise, and provides an opportunity for therapists/community mental health treatment agencies to provide input. Family participation is also an integral part of this process. The assigned district attorney, public defender, probation officials, mental health care workers, and civil advocates all participate in multi-disciplinary team meetings to screen cases and review progress of the participants. Together, they develop a case management plan that focuses on obtaining and coordinating services necessary for the participant to remain at home, in school, and out of the juvenile detention system.

## **III. Evidence of Need**

There is a growing awareness of mental health disorders among youth in the general population. The Surgeon General's Report on Mental Health (2002) found that:

- Approximately 20% of children and adolescents in the general youth population are experiencing a mental disorder
- Approximately 10% experience mental illness severe enough to cause impairment at home, in school, and in the community
- Less than half will receive the treatment that they need

This report sheds light on the fact that mental disorders among youth in the general population are significantly higher than what was previously believed (United States Department of Health and Human Services, 2002). There is also an increasing sense of awareness and crisis surrounding the care and treatment of youth with mental disorders in the juvenile justice system. The mental health needs of this population have been notoriously neglected. Attention is now being paid in a way that has largely been absent. Both the juvenile justice and mental health systems are expressing a growing concern regarding the criminalization of mental illness. There is an increase in attention by the media, advocacy organizations (National Alliance on Mental Illness, National Mental Health Association, Federation of Families), and funding organizations (private foundations like MacArthur and Casey, as well as federal agencies such as SAMHSA and the Office of Juvenile Justice and Delinquency Prevention). Investigations conducted by the Department of Justice into the conditions of confinement of youth in juvenile detention and correctional facilities across the country have consistently highlighted the lack of appropriate screening, assessment, and treatment available to youth; the inappropriate use of medication; and the inappropriate responses to suicide threats. Lack of parent involvement is also a major issue (Department of Justice, 2003).

Research indicates that incarceration does not rehabilitate juvenile offenders and that more and more youth who end up in juvenile halls or state prisons are non-violent offenders. California data is detailed below. California leads the nation in juvenile arrests and incarceration rates. In 1997, California's juvenile custody rate was one and a half times higher than the national average.

In the year 2001, California had:

- 63,889 Juvenile Felony Arrests
- 139,669 Juvenile Misdemeanor Arrests
- 121,433 Youth admitted or booked in juvenile halls
- 6,985 Youth incarcerated in California Youth Authority (CYA), now known as the Division of Juvenile Justice (DJJ), facilities on an average day
- 4,474 Youth on parole from DJJ on an average day

These figures include a growing number of girls and a disproportionate number of minorities (Center on Juvenile and Criminal Justice, 2002). According to data compiled from the 12 most populous counties in California in 2000 comprising 75% of the state's population:

- Black youth were 9% of the population, 43% of arrests, and 35% of the DJJ population

- Hispanic Youth were 43% of the youth population, 19% of total youth arrests, and 45% of the DJJ population
  - White Youth were 35% of the total youth population, 25% of total youth arrests, and 15% of DJJ commitments
  - Other Youth of Color were 13% of the Youth population, 13% of total youth arrests, and 5% of DJJ commitments
- (Center on Juvenile and Criminal Justice, 2002)

The National Council on Crime and Delinquency (September 2003) conducted a survey of mental health delivery to youth in the California juvenile justice system which is provided in Table 1.

Table 1: Status of Youth in Juvenile Justice System per Month

	Small County	Medium County	Large County
Detention in Juvenile Halls	13	66	379
Detention in Camps/Ranch	2	17	330
Out of Home Placement	13	40	480
Field Supervision	152	507	4088

Source: National Council on Crime and Delinquency (September 2003)

Related to the numbers in Table 1, County representatives reported that, on average, 42% of youth in detention, 59% of youth in placement, and 33% of youth under field supervision have a mental health issue serious enough to require treatment or services. Approximately 77% of youth in detention, 76% of youth in placement, and 66% of youth under field supervision are considered to have substance abuse problems. On average, 23% of youth in detention, 32% of youth in placement, and 18% of youth under field supervision are prescribed psychotropic medication. On average, counties reported that 29% of youth in detention, 44% of youth in placement, and 18% of youth under field supervision have an actual diagnosis of a major mental health illness. On average, 24% of youth in detention, 28% of youth in placement and 16% of youth under field supervision have some other indication of severe mental illness (Hartney, McKinney, Eidlitz, Craine, 2003).

Nearly two-thirds of boys and nearly three-quarters of girls in juvenile detention facilities have at least one psychiatric disorder, far exceeding the 15 percent among the general population (Council of State Governments, 2005). Many factors contribute to this sense of crisis. There is an increasing number of youth with mental disorders entering the juvenile justice system. Many of these youth are incarcerated for minor, non-violent offenses. Increasingly, the juvenile justice system is becoming the system of "last resort" for many youth. A 1999 survey by the National Alliance for the Mentally Ill (NAMI) found that 20% of families surveyed reported having to give up custody of children to the state in exchange for adequate mental health services (NAMI, 1999). A study conducted by the U.S. General Accounting Office estimated that in fiscal year 2001-02 parents placed over 12,700 children into the child welfare or juvenile justice systems so that these children could receive mental health services (GAO-03-397).

#### **IV. Existing JMHC Models**

In California, six counties have developed juvenile mental health courts. Santa Clara, Ventura, Los Angeles, Alameda, Fresno, and Monterey.

##### Santa Clara County

The Santa Clara County juvenile mental health court, known as the Court for the Individualized Treatment of Adolescents (CITA), opened in February 2001 in San Jose. CITA “operates on the principle that neither institution [mental health or juvenile justice] has the exclusive solution to the complex problems presented by mentally ill children who commit delinquent acts, a principle that is confirmed by the abysmal track record of both in dealing with the issue independently.” (Bazelon, 2004) CITA’s target population is “juveniles with a serious mental illness (SMI) that has contributed to their criminal activity, and likely, to their involvement with the juvenile justice system.” For purposes of the project, “SMI” includes “brain conditions with a genetic component, including major depression, bipolar disorder, schizophrenia, severe anxiety disorders, or severe ADHD, developmental disabilities such as pervasive developmental disorders, mental retardation, ...autism and brain syndromes, including severe head injury.” (Bazelon, 2004) To be eligible for participation in CITA, a youth must have been under 14 years of age at the time of the offense. CITA excludes youth who have committed certain violent felonies.

The court uses a multi-disciplinary team approach to assess, monitor, and make recommendations to the court regarding a youth participant’s case. The team consists of representatives from mental health, probation, a prosecutor, and defense attorney. Referral resources for CITA include juvenile hall, probation, district attorney, and the public defender. Upon acceptance to CITA, all youth receive a clinical assessment, which includes psychological, behavioral, educational, social and family assessments. In some instances, standardized assessment instruments, such as the Diagnostic Interview Schedule for children (DISC), are used. These assessments are overseen by a mental health coordinator, who is also responsible for conducting the initial assessment to determine program eligibility. Once accepted to CITA, the coordinator monitors and coordinates treatment planning and reports to the multidisciplinary team. Community supervision through face-to-face visits with the youth and visits with the family is the responsibility of the probation officer, who then reports this information to the court. A number of mental health services are available through CITA, including therapy, emergency services, medication, and wraparound services. As the youth progresses through CITA, transition planning is conducted to help facilitate a successful transition to the community (National Center for Mental Health and Juvenile Justice, 2005). The length of the program varies to meet the needs of each youth.

Personnel involved with the Santa Clara court note that the program benefits include decreased recidivism, fewer unnecessary detentions, and expedited processing of the court’s caseload, all of which are likely to result in substantial savings (Fight Crime, 2005). The prognosis for participating youth in Juvenile Mental Health Courts is

extremely good, and there is evidence that access to these specialized courts has lowered the recidivism rate to as low as 7 percent (compared to the 25 percent recidivism rate for the general juvenile population) in Santa Clara County (Judge Raymond Davilla, 2002) CITA has a set population cap of 75 minors at any one time. 171 have successfully completed the one year program out of a total of 255 participants.

The Council on Mentally Ill Offenders (COMIO) awarded CITA a Best Practices Award in March 2008 (CDCR, 2008).

### Los Angeles County

The Los Angeles County Juvenile Mental Health Court is a full-time court that serves youth in Los Angeles County. Although there are no formal exclusion criteria with respect to current charges, the team and judge use discretion when dealing with very serious felonies. The court uses a team approach to make decisions regarding new cases and to monitor the progress of youth. This team consists of the judge, district attorney, public defender, an alternate public defender, Department of Mental Health psychologist, school liaison, probation officers, and a psychiatric social worker. The primary source of referrals for the court is post-adjudication from the Los Angeles delinquency/juvenile courts. Youth are screened by a consulting psychiatrist from the UCLA for mental health issues. The JMHC maintains an active caseload of approximately 70 youth. However, the court has had as many as 90 youth on its caseload. Youth are involved with the court a minimum of two years.

The psychiatrist functions largely as a case manager, forming connections with providers and overseeing treatment and progress. Participating youth receive case management services and referrals to community-based mental health services, including medication and therapy. Many of these youth are temporarily detained in juvenile hall, which has a care unit for youth with mental illness. Most youth reside in group homes or with their family during their participation in the court. Participants are monitored through a formal delinquency court review every six months as well as through judicial review in the JMHC. The frequency of these reviews is customized to meet the specific needs of each youth and may be as frequent as every week as appropriate. If reduced frequency of appearances is deemed to be an incentive to a youth, such action will be used by the court to encourage positive change. Upon completion of the program, petitions are routinely dismissed (National Center for Mental Health and Juvenile Justice, 2005).

### Ventura County

The Ventura County JMHC called Adelante! provides mental health services to youth with serious mental health issues through the collaboration of a multidisciplinary team of professionals, which include a judge, district attorney, public defender, probation officers, psychiatrist, therapist, and a school liaison. Adelante! accepts youth with a serious mental illness as long as there is sufficient family support to manage the youth at home. Although the court does not formally exclude youth based on their current charges, it does exercise discretion with respect to youth who commit serious felonies and/or sex

offenses. The majority of Adelante!'s referrals come from the juvenile court post-adjudication but prior to disposition. Youth are screened and assessed by the court's clinician. Participation is typically a condition of probation. However, the court also receives referrals from probation and behavioral health and occasionally serves as an aftercare program for youth post-commitment.

Adelante! provides mental health services directly to participating youth. Since its founding, Adelante! has served approximately 22 youth and anticipates increasing its capacity in the near future. Progress and compliance are monitored by the probation department and through bi-weekly judicial review. In cases of non-compliance, youth may be required to complete community service or to be temporarily admitted to a detention facility. The court also utilizes electronic monitoring when necessary and youth can be returned to juvenile court by the probation department (National Center for Mental Health and Juvenile Justice, 2005).

### Alameda County

The Alameda County Juvenile Collaborative Court diverts youth with mental health issues from the juvenile justice system. The court does this by providing families with medical treatment services, educational and vocational opportunities, and other community supports. In 2007, 13 juveniles aged 15 to 17 were enrolled in the program and only one had a subsequent offense. All but one of the 13 is now living at home (National Center for Mental Health and Juvenile Justice, 2005).

### Fresno County

The Fresno County Behavioral Health Court (BHC) combines mental health screenings and assessments with intensive treatment and services provided through one of two evidence-based models, either Family Functional Therapy (FFT) or Assertive Community Treatment (ACT). Youth are assessed by using the MAYSI-2 model during the juvenile hall booking process. Those identified as possibly having mental health conditions are referred to the newly developed Behavioral Health Court (BHC). The purpose of the court is to provide evidence-based interventions for youth with identified mental health problems and ensure coordinated case management of youth receiving mental health services while involved in the justice system. An interdisciplinary BHC team comprised of probation, clinical staff, a Juvenile Justice Services Coordinator, a public defender, deputy district attorney, and an educational liaison determines the youths' eligibility and suitability for the program.

Youth admitted to the program receive a comprehensive psychiatric evaluation and intensive case management and probation supervision while in the community. The BHC team works with each youth and his/her family to develop an individualized treatment plan for FFT or ACT services, which may include in-home individual and family therapy; medication management; crisis counseling; and assistance with housing, employment, education, transportation; and incentives. As deemed necessary, the Judge orders periodic

reviews to monitor the youths' progress. In each case, the BHC team determines successful completion of, or termination from, the program.

The BHC was evaluated by the Stanford Criminal Justice Center (SCJC). The SCJC conducted extensive interviews and focus group meetings, evaluated program processes according to subjective and objective criteria, and analyzed data in order to evaluate program outcomes (National Center for Mental Health and Juvenile Justice, 2005). The SCJC completed their evaluation of the BHC in December of 2008. The evaluation states that early data indicate some preliminary findings. Not only are females more likely than males to be accepted into the program, but also, once they enter they are more likely to complete the program successfully. Hispanics were the racial group least likely to be accepted into the program overall, and also the least likely to complete the program successfully. The BHC is still very new, and has collected little data about its participants and processes (Stanford Criminal Justice Center, Stanford Law School. December 2008).

### Monterey County

The Monterey County program for assisting juvenile offenders with mental health problems is called Collaborative Action Linking Adolescents (CALA). CALA now incorporates a Juvenile Mental Health Court that was formed in 2008. CALA's purpose is to identify, early on, youth with mental health problems, and provide the appropriate and effective services to address their needs, using a collaborative model that includes all agencies in the criminal justice system and service providers. This team offers CALA youth and their families support on a 24/7 basis and works with the county's System of Care to ensure the appropriate coordination of services.

## **VIII. Funding**

A solid piece of research on Adult Mental Health Courts showed that these courts are a cost-effective form of treatment. The RAND Corporation conducted a fiscal impact study of the Allegheny County Mental Health Court in Pennsylvania. The study identified the treatment, criminal justice, and cash assistance costs for the Mental Health Court participants, compared those costs with the costs of routine adjudication and processing, and calculated the fiscal impact of the Mental Health Court program. The findings suggest that the Mental Health Court program may help decrease total taxpayer costs over time due to a dramatic decrease in jail costs compared to treatment costs. In addition, to the extent that Mental Health Court participation is associated with reductions in criminal recidivism and utilization of the most expensive sorts of mental health treatment (i.e., hospitalization), the study suggests that the Mental Health Court program may actually result in net savings to government (Ridgley, Susan M., et.al, 2007)

In California, researchers have completed two studies that demonstrate significant cost-benefit savings due to drug courts. Both studies demonstrate a minimum savings of \$18 million per year through California drug courts. The studies concluded that California's investment of \$14 million, in combination with other funds, created a total cost avoidance

of \$43.3 million over a two year period (Judicial Council of California, & the California Department of Alcohol and Drug Programs, 2002) Based on the promising early data from JMHC's, it is reasonable to assume that such savings will result from these programs as well.

Each of the JMHCs in California has used different approaches for funding their programs. CITA in Santa Clara County is primarily funded through reallocation of existing resources. In Los Angeles, Congressman Adam Schiff and Assembly member Tony Cardenas worked to secure a state grant to start LA JMHC in the fall of 2001. This grant is used to cover staff salaries (with the exception of the alternate public defender). Services are provided through a variety of sources, including the Regional Center and other community-based organizations. In Ventura County, Adelante!, is funded through a three year grant from SAMHSA beginning March 2004. When possible, the court also accesses Medi-Cal funds to pay for services. Fresno County used funds from a Mentally Ill Offender Crime Reduction Grant for its program. Although counties have not used Mental Health Service Act (MHSA) funds for JMHCs, they would be available to fund the mental health treatment costs associated with JMHCs (National Center for Youth Law, 2007).

## **IX. Recommendations**

When considering the quality and quantity of treatment and recidivism, little longitudinal data exists on the effectiveness of juvenile mental health court interventions, as little outside analysis or research has been done. At this stage, further research is needed to establish evidence-based practices. With the success of adult mental health courts, and drug courts in reducing recidivism, the application of mental health court principles to populations in the juvenile court is a logical step.

- A. County mental health departments should advocate for and provide the mental health services for Juvenile Mental Health Courts.
- B. Counties should explore a variety of funding sources, including the MHSA, SAMHSA Block Grant, Medi-Cal, and reallocation of existing resources to implement JMHCs.

## **X. Resources**

Counties interested in starting JMHCs are directed to the following resources for technical assistance.

- A Guide to Mental Health Court Design and Implementation: provides detailed guidance on issues such as determining whether to establish a mental health court, selecting the target population, ensuring confidentiality of mental health information, and sustaining the court. Examples from existing mental health courts illustrate key points.  
[www.consensusproject.org/mhcourts/Guide-MHC-Design.pdf](http://www.consensusproject.org/mhcourts/Guide-MHC-Design.pdf)

- Navigating the Mental Health Maze: A Guide of Court Practitioners: offers a basic overview of mental illness, including symptoms, diagnosis, and treatment, and discusses the coordination of community-based treatment systems and court-based services.  
[www.consensusproject.org/mhcourts/Navigating-MHCMaze.Pdf](http://www.consensusproject.org/mhcourts/Navigating-MHCMaze.Pdf)
- A Guide to Collecting Mental Health Court Outcomes Data : provides practical strategies to both well-established and newly operating courts for deciding which data to collect; obtaining, evaluating, and comparing the data; and overcoming common challenges.  
[www.consensusproject.org/mhcourts/MHC-Outcome-Data.pdf](http://www.consensusproject.org/mhcourts/MHC-Outcome-Data.pdf)
- MHCP Web site: maintained by the Consensus Project in its capacity as technical assistance provider for BJA's Mental Health Courts Program (MHCP), the MHCP Web site provides information about conferences, funding, and technical assistance opportunities; links to research publications and court resources; and facilitates interaction with peers across the country through bulletin boards and "Ask the Expert" sessions.  
[www.consensusproject.org/mhcourts](http://www.consensusproject.org/mhcourts)

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