A National Survey of U.S. Juvenile Mental Health Courts

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Objective: **The authors surveyed U.S. juvenile mental health courts (JMHCs).** ***Methods:*** **Forty-one were identified in 15 states, and 34 returned surveys; one was completed on the basis of published information. Topics included the court's history, youths served, inclusion and exclusion criteria, the court process, and services provided.** ***Results:*** **Half (51%) reported that the juvenile court was responsible for the program; for 11% the probation agency had the responsibility, and 17% reported shared responsibility by these entities. Fifty-one percent reported that all youths with any mental disorder diagnosis are eligible. The most commonly reported participant diagnoses are bipolar disorder (27%), depression (23%), and attention-deficit hyperactivity disorder (16%). Seventy percent currently include participants with felony offenses, and 91% with misdemeanors; 67% exclude status offenses, and 21% exclude violent offenses. A guilty plea was required by 63%. Incentives to participate included dismissal of charges (40%), reduction in court hearings (43%), praise by the judge and probation officer (60%), reduction in curfew restrictions (23%), and gift cards or gifts (71%). Sanctions for not participating included increased supervision or hearings (60%), performing community service (54%), and placement in residential detention (60%). Most JMHCs reported use of a multidisciplinary team to coordinate community-based services to prevent protracted justice system involvement.** ***Conclusions:*** **JMHCs are being developed in the absence of systematically collected outcome data. Although they resemble adult mental health courts, they have unique features that are specific to addressing the complex needs of youths with mental disorders involved in the justice system. These include diagnostic and treatment challenges and issues related to involving families and schools. (*Psychiatric Services* 63:130–134, 2012; doi: 10.1176/appi.ps.201100113)**

It is now well documented that most youths in the juvenile justice system—65% to 70%—experience mental disorders (1–3) and that their treatment needs are serious and complex. Shufelt and Cocozza (1) found that 28% of the youths in their study required significant and immediate mental health treatment: 80% met criteria for two or more disorders, and 61% had a co-occurring substance use disorder. Such studies confirm what juvenile justice administrators, program directors, and staff already know—the nation's juvenile justice system is facing a crisis regarding the large number of youths with mental health needs in its care.

Concern over this issue is now shared by policy makers, practitioners, and the public, heightened in part by a number of recent independent reports drawing attention to the scope and consequences of this issue. For example, a Department of Justice investigation of juvenile facilities in 14 states found major inadequacies in the identification and treatment of youths with mental disorders (4). Other reports suggest that many of these youths are detained or placed in the juvenile justice system for relatively minor, nonviolent offenses and end up in the system simply because of a lack of community-based treatment options (5). A 2004 Congressional report on a study of 698 detention centers across the country documented the extensive, inappropriate use of detention centers as "warehouses" for youths with mental disorders (6). A recent study on court-imposed treatment for youths involved in the justice system found that recidivism was reduced when clinical and service needs were assessed and met (7). Janku and Yan (8) showed that factors not necessarily associated with diagnoses of mental disorders, such as behavior problems, often lead to service recommendations from courts.

Neither the importance of this issue nor the need to respond to this crisis is debated. The questions facing the juvenile justice system are now focused on how best to respond to the large numbers of youths with mental health problems. Over the past few years, the field has witnessed the introduction across the country of

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strategies for use at various decision points and focused on multiple subpopulations (9).

One of these approaches reflects a more general trend in the United States to use specialty courts to address the needs of specific subpopulations of adult and, more recently, juvenile offenders. The most widely known and utilized type of specialty criminal court is drug court (10). More recently, a new type of specialty court—the mental health court—has emerged (11). Like drug courts, mental health courts focus on engaging and maintaining individuals in community-based treatment through a separate docket as an alternative to deeper involvement in the traditional justice system, coupled with a team approach and regular judicial supervision. However, unlike drug courts, mental health courts are specifically designed to address the needs of individuals with mental illnesses and have been used in the adult criminal justice system for some time. More than 250 mental health courts are now in existence across the country. Evidence points to the effectiveness of adult mental health courts in diverting individuals from the justice system and into treatment, reducing subsequent arrests and jail days (12).

Recently, this strategy has expanded to the juvenile justice system in an effort to better address the mental health needs of juvenile offenders. The only survey to date of juvenile mental health courts (JMHCs) identified features common to most of the surveyed courts: a separate docket, some form of community supervision to monitor compliance with court orders, judicial review to monitor a youth's progress, and use of a multidisciplinary team that oversees JMHC cases and makes recommendations to the judge (1). Adult mental health courts share these features. Because of the proliferation of JMHCs, it is unclear how many there are in the United States. It is also unclear whether, like adult mental health courts (13), there will be a second generation of JMHCs and whether the newer courts will resemble earlier courts, and what this suggests for policy, practice, and research. Further, some suggest that JMHCs are simply a return to the intention of the first juvenile court—nonadversarial, rehabilitation-oriented, family- and community-based treatment focused on the "best interests of the child." To what extent this suggestion is consistent with emerging JMHCs is uncertain.

This article reports findings from a national survey of JMHCs conducted in 2009–2010 by Policy Research Associates and its National Center for Mental Health and Juvenile Justice.

Methods

The survey was approved by a federally sanctioned institutional review board. Respondents were JMHC officials, such as program directors, and they were given the option of declining to participate. They were informed that by returning the survey they were consenting to participate in the study.

Juvenile mental health courts were identified by using a combination of methods, including recontacting courts that participated in the 2006 survey, posting a survey on the GAINS Center Web site, sending it to relevant Listservs, and inviting participation via news media. The survey was mailed in December 2009 to the 41 identified JMHCs in operation. We followed up with e-mail and phone contacts to ensure return of the surveys. We received 35 completed surveys, including 34 completed by respondents and one that we completed on the basis of publicly available information. One court was too new to provide any data, four did not respond to multiple inquiries, and one declined to participate. Survey topics included history of the court, youths served by the court, inclusion and exclusion criteria, the court process, and services provided. The questions were exploratory and open ended, which limits specificity in presenting our results.

Results

Although it is commonly reported that the Santa Clara Court for the Individualized Treatment of Adolescents (CITA), which began operation in 2001, was the first JMHC, our survey data indicate that the first JMHC was started in 1998 in York County, Pennsylvania, followed by a JMHC in Mahoning County, Ohio, that began in 2000. From 2000 through 2010, an additional 38 courts were established and continue to operate and two JMHCs were started and later discontinued.

The most common reason reported by respondents for initiation of the JMHC in their jurisdiction was a growing awareness of the mental health problems of the youths in their courts (N=33, 94% of survey respondents) and the lack of mental health services available to youths involved in the justice system (N=16, 46%). Table 1 presents data on the organizational features of the courts in the survey. In terms of having responsibility for the JMHC program, the juvenile

Table 1

Characteristics of 35 juvenile mental health courts (JMHCs)

Characteristic	N	%
Responsibility for JMHC		
Juvenile court	18	51
Probation	4	11
Juvenile court and probation	6	17
Other combined team	7	20
Points of access to JMHC		
Preadjudication only	12	34
Postadjudication only	9	26
Both pre- and postadjudication	14	40
Organizations involved with JMHC		
Juvenile court	33	94
Probation	32	91
Local mental health agency	30	86
Local substance abuse treatment agency	19	54
Detention facility	14	40
State juvenile justice agency	11	31
Law enforcement	8	23
State mental health agency	4	11
Funding source		
State government	24	69
Local government	23	66
Medicaid	13	37
Federal government	9	26
Private insurance	7	20
Grants	5	14
Program fees	2	6
Other	8	23
Multidisciplinary team members		
Probation	30	86
Juvenile court	29	83
Local mental health agency	27	77
Educators, schools	18	51
Local substance abuse treatment agency	14	40
Private providers	14	40
Family service agency	12	34
Advocacy organization	9	26

Table 2

Characteristics of participants in 35 juvenile mental health court programs

Characteristic	N	%
Age range of current participants		
6–17	3	9
11–16	3	9
11–17	7	20
13–16	2	6
13–17	12	34
15–16	1	3
15–17	7	20
Race of current participants		
African American		
<25%	20	57
25%–50%	11	31
>50%	4	11
Hispanic		
<25%	23	66
25%–50%	6	17
>50%	6	17
Sex of current participants		
<50% males	6	17
≥66% males	18	51
Participants' current offenses		
Felonies	23	70
Misdemeanors	30	91
Status offenses	11	33
Violent offenses	26	79
Most common diagnosis among program participants		
Bipolar disorder	28	27
Depressive disorder	23	23
Attention-deficit hyperactivity disorder	16	16

court and the probation agency were cited the most often (51% and 11%, respectively), with some JMHCs (17%) reporting shared responsibility by these two entities. The agencies involved in JMHCs reflect the treatment orientation of the programs, as well as the importance of involving schools and families. When a youth (or adult) agrees to participate in a specialty court, it is typically with agreement from both the defense and the prosecuting attorneys. Therefore, the individual has previously pleaded guilty in lieu of detention or the case is handled as an acquittal in consideration of dismissal. In our sample, a guilty plea was required by 20 JMHCs (63%) before youths could participate in the program.

Table 2 presents data on the characteristics of participants. When asked about the ages of youths currently in their court, the most commonly provided range was 13–17 (34% of the courts); three courts reported accepting youths aged ten and under. Courts were also asked to report the race of their current caseload. A small portion of courts reported that their caseload comprised over 50% African American (11%) or Hispanic (17%) youths. More than half of the courts (51%) reported that males accounted for at least two-thirds of participants. At the time of the survey, 30 JMHCs reported that their current cases included youths with a misdemeanor charge, 23 had current cases with felony charges, and 11 had current cases with status offenses. Twenty-six JMHCs reported that their current cases included youths with violent offenses. However, the survey data also indicated that some JMHCs specifically excluded youths with certain offenses: most sex offenses, ten JMHCs (30%); gang-related charges, two JMHCs (6%); and drug-trafficking offenses, two JMHCs (6%).

About half of the JMHCs (N=18, 51%) reported that all youths with a diagnosis of a mental disorder are eligible for their program. When asked to rank the most common disorder of youths who enter the program, bipolar disorder was cited most often (27% of JMHCs), with smaller proportions of JMHCs citing depressive disorder (23%) and attention-deficit hyperactivity disorder (16%) as most common. The survey did not ask how youths received their diagnosis and who provided it.

One reason that youths and their families become involved in a JMHC is to gain access to treatment and services. Respondents were asked to provide a list of services available through the JMHC program. They were not asked for data on how many youths required or accessed these services. The most commonly listed services for youths were individual outpatient treatment (N=25, 71%), family therapy (N=19, 54%), and case management (N=15, 43%). Among the incentives to participate in a JMHC is dismissal of charges upon completion of the program, and 12 JMHCs (40%) reported that charges are dismissed for participants. The other 18 courts that responded to this question reported either that charges are not dismissed or that dismissal occurs on a case-by-case basis.

Respondents reported other incentives for participating in JMHC programs, including a reduction in court hearings (N=15, 43%), praise by the judge and probation officer (N=21, 60%), reduction in curfew restrictions (N=8, 23%), and gift cards or gifts (N=25, 71%). Respondents also reported sanctions for not participating in JMHC programs, including increased supervision or hearings (N=21, 60%), performing community service (N=19, 54%), other additional tasks such as writing essays for the court (N=18, 51%), electronic monitoring (N=8, 23%), and placement in residential detention center (N=21, 60%).

Most courts reported setting a minimum period of program participation (N=20, 59%), and six to nine months was the most commonly reported period (N=11, 55%). Fewer courts set a maximum period (N=6, 18%), and the average length of time in the program was a year (N=30). Most courts reported that the youth is supervised by a probation officer (N=31, 89%), and most reported that a parent or guardian is required for participation (N=31, 91%). Reported JMHC caseloads ranged from six to 60, with most falling between 20 and 30 youths in the program at any time.

We further examined our results by region, and we compared programs in Ohio and California because they each have by far the largest number of JMHCs—nine and eight, respectively—compared with the state with the next largest number, Texas, with four JMHCs. Whether the programs were compared by structure, funding sources, or eligibility criteria, the differences were consistent with the grouped outcomes with no notable regional or state patterns emerging. Therefore, although pooling the data for all states had the potential for overstating common features while overlooking differences, we did not find that to be the case. The differences were simply idiosyncratic to the jurisdiction.

Discussion

JMHCs have developed in response to an increased recognition of the rise in diagnosed mental disorders among

youths involved with the justice system and either the lack of community treatment available to youths and their families or the failure to connect families to services. As in adult mental health courts, the juvenile court judge can use the power of the gavel to both compel agencies to treat youths and require the youths and their families to comply with court conditions.

It may appear that JMHCs are being quickly established, but only 15 states have such courts, and more than half of the courts are in Ohio (N=9) and California (N=8). Thus JMHCs are not yet a national phenomenon. In both California and Ohio, a judge has championed JMHCs with energy and visibility. The major hurdle to developing and sustaining effective JMHCs is the same one faced by the behavioral health system—funding. New York State's Task Force on Transforming Juvenile Justice concluded that the annual cost of keeping a youth in detention exceeds $210,000 (14). Ohio's RECLAIM Ohio law (Reasonable and Equitable Community and Local Alternatives to the Incarceration of Minors) provides financial rewards to counties that develop diversion programs for youths that result in reduced state custody expenditures and improved outcomes for youths, such as reduced recidivism (15). JMHCs are a form of diversion for youths involved in the justice system and are an opportunity to provide evidence-based services to youths and their families, prevent further involvement in the justice system, and in turn improve communities.

JMHCs share some features with adult mental health courts, such as use of a multidisciplinary team, use of incentives and sanctions to gain compliance, acceptance of participants with serious and less serious offenses, connection to treatment, and the goal of preventing extensive involvement in the justice system. The JMHCs that we studied share many such elements in their structure and target group.

The possible benefits to youths, families, and communities of establishing a JMHC have been previously described by Cocozza and Shufelt (16) and include use of leverage to gain compliance from the youths and their families and to compel communities to provide services, implementation of a multidisciplinary team to address the complex needs of youths, addition of another diversion option for judges, provision of intensive supervision for youths with mental health problems and substance use disorders who are involved in the justice system, and increased awareness of the issue, highlighting the need for early intervention and services.

On the other hand, three major concerns have been raised about JMHCs: "net widening," voluntariness, and their ultimate necessity. Concerns about JMHCs widening the net and involving greater numbers of youths in the justice system may be partly alleviated by the finding that most courts do not accept participants with status offenses but instead accept only those with misdemeanor and felony charges. Although the diagnostic process is imperfect for adults and most certainly for youths, survey data indicate that JMHCs attempt to exclude participants with disorders that arise specifically from behavioral problems and focus instead on youths with depression and bipolar disorder. In an ideal world, youths with mental health problems are identified and receive effective community services before they become involved in the justice system. However, in many communities, it is the court contact that sounds the alarm. JMHCs provide an opportunity to link youths and their families to a wide range of services, including individual counseling, family therapy, educational supports, and substance abuse treatment. Even though families are linked to services, any contact with the justice system carries with it collateral impact through social stigma and the negative experience of being involved in a court. Arrest, court hearings, and detention are disruptive to a youth's life. As with the evolution of adult mental health courts, which have preceded JMHCs by about ten years, it is possible that these diversion programs will be narrowed to include only youths who are charged with more serious offenses, diverting less serious offenders earlier in the process.

An additional concern about JMHCs, as well as all adult treatment courts, is the degree to which participation is truly voluntary and to what extent participants know the potential consequences of program "failure." Some critics of treatment courts argue that decisions made in a court setting are necessarily coercive, given the choice between detention and treatment and release (17,18). It is further argued that many treatment court participants are not fully informed of the consequences of their decision to enter a guilty plea, a requirement of most treatment courts, including JMHCs (18). Finally, given the purported rehabilitation orientation of JMHCs, some have argued that they are simply unnecessary and that rehabilitation and service provision are roles that all juvenile courts are intended to fill. However, because juvenile courts have drifted away from a rehabilitation philosophy to focus more on punishment (19,20), a gap has developed for youths with a wide array of behavioral health and justice problems. As noted above, this gap in services and the revolving door of juvenile courts for some youths provided an impetus for the development of JMHCs.

The importance of dismissal of charges by JMHCs cannot be overemphasized. Having a conviction or adjudication record can follow a youth and complicate his or her life in unanticipated ways, such as by limiting access to federal student loans, employment, and military service. A guilty plea may result in a felony conviction, which can also restrict access to public housing and other public entitlement programs. Our survey found that fewer than half of JMHCs dismiss charges upon completion of the program. Therefore, a guilty plea associated with these programs has far-reaching collateral consequences, particularly if the underlying charge is a felony or drug charge.

To date JMHCs have not been empirically examined, and we can only speculate about possible benefits and problems. Currently, a study funded by the National Institute of Justice is under way to assess many of the issues discussed above, including whether youths in JMHCs have bet-

ter or worse outcomes than similar youths in the same jurisdictions who proceed through the typical juvenile court process. These data will provide an evidence-based foundation for continued evaluation of whether the anticipated benefits outweigh the perceived costs of JMHCs as a diversion program for youths involved in the justice system.

Conclusions

JMHCs are new treatment courts that are emerging in the absence of systematically collected outcome data from existing programs. As with many early studies of adult treatment courts, the few extant in-house JMHC program evaluations have measured outcomes of graduates, not of those who quit or were terminated from the program. Although JMHCs resemble adult mental health courts to some extent, they have unique features that are specific to addressing the complex needs of youths with mental disorders who become involved in the justice system. These include diagnostic and treatment challenges and issues related to involving families and schools in treatment. Judicial leadership and funding are critical factors in the initiation and sustainability of JMHCs and of appropriate treatment services in the community.

It is unknown whether JMHCs are a form of net widening, as feared by critics, or a form of diversion from the justice system that connects youths to appropriate community services, as claimed by their champions. As these new treatment courts continue to develop, it is critical to systematically collect and analyze data to determine whether JMHCs meet the promise of early intervention to prevent further involvement in the justice system.

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