Common Characteristics of Juvenile Mental Health Courts

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Introduction

We have identified seven common characteristics of Juvenile Mental Health Courts (JMHCs) as part of a National Institute of Justice–funded study, Assessing the Effectiveness of Juvenile Mental Health Courts as a Community Justice Strategy. These common characteristics are based on a national survey (Callahan, Cocozza, Steadman, & Tillman, 2012), stakeholder interviews, participant focus groups, parent/guardian focus groups, stakeholder focus groups, observations of status hearings, and extensive interviews with current participants and their guardians. While the courts we surveyed and observed vary in size — from 8 to 50 enrollees — and specifics, these seven characteristics are applicable to any jurisdiction, regardless of size and available treatment services.

These seven common characteristics are not prescriptive. They do, however, identify a broad blueprint for communities to use when establishing a docket or court to address behavioral health issues of justice-involved youth. While technically we studied mental health courts, most JMHCs, like Adult Mental Health Courts (AMHCs), address substance use as part of their overall treatment plan in addition to mental disorders. Some of the common characteristics are similar to those for most AMHCs — specialized docket, informal interactions, team management, screening/assessment, incentives/sanctions, and graduation requirements. However, JMHCs are not simply AMHCs for kids. Each element of a JMHC must be age-appropriate, targeting fewer age years but allowing greater variation in development and maturity. An additional crucial factor is that the youth’s success hinges not only on their adherence to program requirements but their guardian’s cooperation as well. The youth is accountable, but so is the adult. Thus, one major distinction of JMHCs is that the network of accountability is much broader than in the adult system. Further, JMHCs, unlike AMHCs, have stakeholders such as families and schools to include in programs, along with the agencies and providers that adult courts must include.

Most states provide expanded Medicaid services to all children under age 18 from low-income families, and the Affordable Care Act requires screening, assessment, and treatment for behavioral health to be included in all health care plans for youth. Having a mandate is one aspect of providing services; translating the mandate into action by prioritizing and providing behavioral health services for youth is a hurdle many communities face. Regardless of whether a youth has access to an extensive formal network of behavioral health services dedicated to adolescent and family mental health and substance use disorders, we strongly encourage juvenile court judges and staff to invite the entire community that touches children’s lives to contribute to a JMHC. This will gain the support and commitment from the community and contribute to the program’s sustainability. Establishing a communitywide advisory board that includes not-for-profits, pediatricians, family physicians, pharmacists, housing providers, schools, and faith communities, along with formal treatment providers and justice professionals, allows the court to marshal many more resources that are sensitive to different pressures than the court or treatment providers.

Families with justice-involved youth are struggling — it is not only the kids who are having difficulties. Communities that want to launch or improve their JMHC need to know who their families are. A parent agreeing to enroll their child into a JMHC requires resources and commitment. Families in our evaluation study have very stressful lives, both currently and across their lifetimes. In their first interview at baseline, parents reported the following stressful events in their family: 28 percent laid off; 21 percent serious accident; 21 percent close friend or family member died; 17 percent abused drugs; 17 percent lost a job — in the past 30 days. Across their lifetimes, stress and trauma were even more pervasive: 62 percent household violence with this child in the home; 59 percent convicted of a crime; 55 percent psychiatric hospitalization; and 35 percent treated for substance abuse.
Parents who agree to program requirements told us that they are desperate, and grateful, for help. They will put their best foot forward by not revealing how they, too, are struggling. Our study reveals that the parents are often living with multiple crises. Courts need to know about the kids and families in their programs so they can structure the requirements — such as the time and location of status hearings — as well as be generous with incentives and flexible when conditions cannot be met.

7 Common Characteristics of Juvenile Mental Health Courts

1. Regularly scheduled special docket
   JMHCs are distinguished from regular juvenile courts in having a regular time and day of the week set aside for status hearings and new cases, a team meeting to discuss program suitability of potential participants, and status updates of continuing cases. Most have criteria for participation, such as diagnosis and arrest charge.

   Status hearings are a common feature of all JMHCs, and most courts reduce the frequency of the hearings with progress through the program. Their frequency and structure vary. Some JMHCs begin with monthly status hearings, and others initially have the youth attend court weekly. Some courts have the youth enter the courtroom one at a time for their hearing; other courts have all of the participants present to hear the proceedings for other participants.

2. Less formal style of interaction among court official and participants
   JMHCs resemble formal courts in that the judge/magistrate presides over the hearings and the youth and his/her advocate or family member sit at the defense table. However, the judge usually engages the youth by name in conversation about how his/her week has gone, praises the youth for adhering to conditions or achieving a milestone, and admonishes the youth for violations. The judge solicits input from the case manager or probation officer and the parent, as well as from the youth. Frequently, one incentive for youth and their families to comply with court conditions is the opportunity to be heard first so they can leave the court. This also provides the new youth or those who have violated conditions to observe the youth who are progressing through the program, serving as role models.

3. Age-appropriate screening and assessment for trauma, substance use, and mental disorder
   Early screening for trauma, substance use, and mental disorder provides information for case-specific decision making, program suitability, and flexibility in referrals, assessments for treatment, and supervision. Screening is conducted early in the intake process, either in detention or in the probation office. These screens, such as the Massachusetts Youth Screening Instrument (MAYSI-2), provide the court staff a “quick glance” into difficulties the youth may be having, including mental disorder, substance use, and suicide risk, that need immediate attention in a more in-depth follow-up. The subsequent, more extensive clinical assessments are completed prior to team meetings and decision-making, addressing the holistic clinical profile of each youth in a routine, systematic manner.

4. Team management of JMHC participant’s treatment and supervision
   Probation plays a central role in JMHC’s, and probation work is combined with case management. Probation officers in JMHCs are often very experienced officers who have a reduced caseload, such as in both of our NIJ evaluation sites. The caseload...
is misleading, however, in that probation officers in JMHCs have the youth and their family as a unit of supervision and treatment, not just the individual on probation.

The JMHC team most often comprises the judge/magistrate, probation officer, program coordinator, and at times, representatives from the district attorney and public defenders’ offices. Attorneys for JMHCs, as compared with AMHC attorneys, are less integral to the team meetings and status hearings. It varies by jurisdiction (and judge) as to whether or not attorneys attend the status hearings. Most state laws and ethics guidelines allow judges to participate in treatment court team meetings, but some judges choose not to.

A goal of the team meetings is to forge a coherent clinical picture to guide supervision and treatment services for the youth. Transition planning for youth involves leaving the court-based program, and in many cases, transitioning out of the juvenile system of care into the adult system of care.

5. System-wide accountability enforced by the juvenile court

While treatment courts in general focus on accountability, the primary focus is on the accountability of the participant to voluntarily comply with court conditions and to be held accountable for his/her behavior. With Juvenile Mental Health Courts, accountability is spread across many people and systems that touch the lives of children. Youth who participate in JMHCs “voluntarily” agree to the program requirements, but many of the decisions that affect the youth’s life and participation in the JMHC are made by adults – individuals and agencies. Consequently, adults – parents, families, schools, child welfare, adult criminal justice system, juvenile justice system, community treatment providers, numerous social service agencies, and in some cases, not-for-profit agencies – must be held accountable by the court for successful program completion.

6. Use of graduated incentives and sanctions

Treatment court research demonstrates that graduated incentives and sanctions work well in helping reshape adult participants’ behavior. One major focus of JMHCs is to encourage prosocial activities that youth should be doing anyway, such as attending school and engaging in family activities. Doing so usually leads to lessened supervision as an incentive for reaching program goals. As with most treatment interventions, incentives and sanctions are highly individualized, both in their meaning and effectiveness. Incentives and sanctions need to be tied to the overall therapeutic approach for each youth. Further, JMHCs are sensitive to the fact that youth are often at the mercy of the many adults in their lives; for example, youth likely rely on adults for transportation to status hearings and treatment appointments. Detention is used as a last resort in most JMHCs and is not viewed by most as a therapeutic intervention.

7. Defined criteria for program success

Most JMHCs have program levels or phases with defined goals, such as weeks of sobriety, days of school attendance, and negative drug tests, that provide structure for moving through the phases. The final phase is generally regarded as the preparation for program completion, with reduced status hearings and fewer probation visits. Many programs have formal graduation ceremonies, with some referring to the completion as “commencement.” Most programs do not excuse, dismiss, or expunge the youth’s record at the time of program completion. A few programs, however, expunge the youth’s entire delinquency record, including charges unrelated to the JMHC program. Because perfection is difficult to achieve, some courts consider the “maximum program benefit” as successful program completion.

The court does a great job of identifying the people who need to be involved and making sure that they are.

— Community Stakeholder

I realized there were people out there who actually wanted to help.

— Former Participant

The probation officers are great. They never seem rushed. They remember the kids’ faces and names. The probation officer is a great tool for the parents to vent to and get advice from.

— Parent
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Online Resources

SAMHSA’s GAINS Center: http://gainscenter.samhsa.gov/
National Center for Mental Health & Juvenile Justice: http://www.ncmhjj.com/
Center for the Study of Prevention of Violence: http://www.colorado.edu/cspv/blueprints/
Council of State Governments: http://www.justicecenter.csg.org/
Substance Abuse and Mental Health Services Administration: http://www.nrepp.samhsa.gov/

Research Publications


Goodale, G, Callahan, L, & Steadman, HJ. (2013). What can we say about mental health courts today? Psychiatric Services, 64, 298-300.


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