

JUVENILES IN JEOPARDY:
RECLAIMING THE JUSTICE SYSTEM’S
REHABILITATIVE IDEALS

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ABSTRACT

Although still a relatively recent phenomenon, mental health courts, including some specifically focused on juvenile offenders, have seen a significant upsurge in the past decade. Despite this upsurge, few comprehensive studies have been done on their effectiveness. This Note examines various aspects of juvenile mental health courts and analyzes interviews with two mental health court professionals: one judge and one program director. The Note concludes by outlining the most effective ways to ensure the success of juvenile mental health courts in the future.

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I. INTRODUCTION

The United States is facing a health-care crisis today that is worse than ever. Although the media’s focus surrounding the health-care debate has been on people who suffer from cancer and other common physical illnesses,¹ perhaps nowhere is the health-care crisis more evident than in the mental health sector. This is in large part because, as mental health law expert Dr. Elyn Saks has pointed out, the two largest mental health institutions in the United States are the Los Angeles County Jail and Rikers Island Correctional Facility in New York City.² This phenomenon is even more apparent in the juvenile justice system, where between 50 and 75% of all offenders suffer from mental illness.³

Some skeptics claim that mental health disorders are prevalent in the juvenile justice system because the criteria used to define conduct disorders are very similar to the general characteristics of delinquent offenders.⁴ However, even if conduct disorders are disregarded, juveniles

¹ E.g., *Health News Coverage in the U.S. Media*, PEW RES. JOURNALISM PROJECT, <http://www.journalism.org/2008/11/24/health-news-coverage-in-the-u-s-media/> (last visited Mar. 16, 2014).

² Gilien Silsby, *Saks Institute Examines Criminalization of Mental Illness*, USC GOULD SCHOOL OF LAW (June 10, 2013), <http://weblaw.usc.edu/news/article.cfm?newsID=4030>.

³ See Patrick Geary, *Juvenile Mental Health Courts and Therapeutic Jurisprudence: Facing the Challenges Posed by Youth with Mental Disabilities in the Juvenile Justice System*, 5 YALE J. HEALTH POL’Y L. & ETHICS 671, 678 (2005).

⁴ JENNIE L. SHUFELT & JOSEPH J. COCOZZA, NAT’L CTR. FOR MENTAL HEALTH & JUVENILE JUSTICE, *YOUTH WITH MENTAL HEALTH DISORDERS IN THE JUVENILE JUSTICE*

with mental health disorders still account for a majority of all juvenile offenders.⁵ In fact, one study found that “66.3% of youth still met criteria for a mental health disorder other than conduct disorder.”⁶ Still, many juveniles are in the system for drug-related offenses, and substance use disorders are often categorized as mental illnesses.⁷ After eliminating both conduct disorders and substance use disorders from the analysis, 45.5% of juvenile offenders met the criteria for a mental health disorder.⁸

This Note addresses one of the purported solutions to the prevalence of mental health disorders in the juvenile justice system—specialized mental health courts—by examining its effectiveness and comparing it to other alternatives. Section II examines the history of the juvenile mental health court system, including a brief introduction of how the rehabilitative model of drug treatment courts served as a precursor for mental health courts and an overview of the emergence of mental health courts for adults and juveniles. Section III discusses a juvenile’s role in the treatment process, juvenile decision-making capacity, and issues relating to the juvenile mental health system, including the prevalence of co-occurring disorders and the role of abuse in mental health disorders and delinquency. Finally, Section IV concludes by arguing that juvenile mental health courts should be incorporated into more justice systems across the country.

II. HISTORY OF THE JUVENILE JUSTICE MENTAL HEALTH COURT SYSTEM

In order to understand how juvenile mental health courts emerged, one must understand the history of the juvenile justice system. Juvenile courts first began to operate separately from the regular criminal justice system at the beginning of the twentieth century.⁹ Juvenile courts were given wide discretion to determine the fate of juveniles under the state’s

SYSTEM: RESULTS FROM A MULTI-STATE PREVALENCE STUDY 1, 3 (2006), *available at* <http://cfc.ncmhjj.com/wp-content/uploads/2013/11/PrevalenceRBP.pdf>.

⁵ Geary, *supra* note 3, at 677 (“Although many delinquents are deemed simply socially maladjusted by the juvenile justice system, a considerable portion of these children have serious, diagnosable emotional disturbances.”).

⁶ SHUFELT ET AL., *supra* note 4.

⁷ *Id.*

⁸ *Id.*

⁹ Barry C. Feld, *The Transformation of the Juvenile Court*, 75 MINN. L. REV. 691, 691 (1991).

parens patriae power.¹⁰ The mission of these courts was to provide juveniles with individualized treatment tailored to their specific needs.¹¹ Juvenile courts took a more rehabilitative approach than traditional criminal courts, focusing on reformation rather than punishment.¹²

As a result of this paternalistic system, hearings were kept confidential and records were limited.¹³ Meanwhile, juveniles were afforded fewer due process protections than adults: they had no access to lawyers and were not entitled to a jury trial.¹⁴ Similarly, the rules of evidence were not applicable in juvenile courtrooms.¹⁵

Juvenile courts focused more on the life and circumstances of the offender than on the nature of the offense.¹⁶ The courts were assisted by social workers and they utilized psychological principles to determine what treatment options were in the best interest of the juvenile offender.¹⁷ The broad discretion given to juvenile court judges was supposed to provide the necessary flexibility to diagnose and treat juveniles who might have a variety of different needs.¹⁸

However, this discretion was often abused, and by the 1960s, the public grew dissatisfied with the perceived leniency of juvenile courts in the wake of rising juvenile crime rates.¹⁹ In 1967, perhaps in part because of this criticism, the United States Supreme Court ruled in *In re Gault*, that juveniles had the right to notice of charges, to be represented by an attorney, to confront and cross-examine witnesses, and the privilege against self-incrimination.²⁰ In *Gault*, the parents of a fifteen-year-old boy, who had been committed to an Arizona detention center as a juvenile delinquent, filed a petition for a writ of habeas corpus, alleging a violation of the minor's due process rights.²¹ The United States Supreme Court

¹⁰ *Id.* at 695. Parens patriae refers to the public policy power of the state to act on behalf of any child or individual, often against abusive or neglectful parents.

¹¹ Barry C. Feld, *The Juvenile Court Meets the Principle of Offense: Punishment, Treatment, and the Difference it Makes*, 68 B.U. L. REV. 821, 824 (1988).

¹² *Id.*

¹³ *Id.* at 825.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ See Geary, *supra* note 3, at 674.

²⁰ *In re Gault*, 387 U.S. 1 (1967).

²¹ *Id.* at 4.

reversed the Arizona Supreme Court's denial of the writ, holding that the Fourteenth Amendment and the Bill of Rights do not solely protect adults and that due process of law is "the primary and indispensable foundation of individual freedom."²²

By eliminating some of the procedural differences between juvenile courts and the adult criminal justice system, *Gault* caused the two systems to converge in many respects.²³ The juvenile justice system became more focused on the culpability of juvenile offenders.²⁴ Since *Gault*, reforms have imposed mandatory minimum sentences, made it easier for juveniles to be transferred to adult court, and reduced confidentiality provisions.²⁵ Increasingly, the juvenile justice system became less and less distinguishable from the criminal justice system.

A. DRUG TREATMENT COURTS

Despite the public backlash against the perceived leniency in the juvenile justice system, there was also an increasing belief that the traditional system was not appropriate for all offenders.²⁶ In the late 1980s, this sentiment led to the establishment of the first set of specialized drug courts in Miami, Florida, which were designed "to address the 'underlying problems of drug crimes—drug use and drug addiction.'"²⁷ However, not every drug offender is able to take advantage of this new system. Drug offenders only become eligible if community officials determine that they have a strong chance of recovery and are not a serious threat to society.²⁸ Like the early juvenile court system, drug courts put a strong emphasis on rehabilitation.²⁹ As soon as possible after their first appearance in a drug treatment court, offenders are placed in intensive drug treatment programs.³⁰ In some jurisdictions, offenders are transported directly from the court to the treatment center; in others, the treatment providers are present in the courtroom to enroll them immediately.³¹ Offenders are

²² *Id.* at 20.

²³ Geary, *supra* note 3, at 674.

²⁴ *Id.*

²⁵ *Id.* at 675.

²⁶ *Id.* at 681–82.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.* at 683.

³⁰ *Id.*

³¹ Peggy Fulton Hora, William G. Schma & John T.A. Rosenthal, *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice*

expected to own up to their substance abuse problems and to make a commitment to the recovery process.³² Treatment programs usually involve three to four phases consisting of detoxification, stabilization, aftercare, and/or educational counseling.³³ Progress is monitored through frequent, or in some cases daily, urine samples.³⁴ Empirical studies of these courts' effectiveness are encouraging.³⁵ There is evidence that drug treatment courts have precipitated a decline in recidivism rates as well as a decline in expenditures in the criminal justice system.³⁶

Soon after the first drug treatment courts were established, some jurisdictions began to incorporate the model into their juvenile justice system.³⁷ While these courts were originally structured much like their counterparts in the criminal justice system, administrators quickly began to realize that developmental differences between adolescents and adults, in areas such as judgment and impulse control, made some adjustments necessary.³⁸ In addition, fewer juveniles in the system were re-offending and it was thought that intervention would be more likely to succeed.³⁹ As a result, more emphasis was placed on getting juveniles' families and schools involved in the treatment process and getting youth involved in the community.⁴⁰

B. THE BEGINNING OF SPECIALIZED MENTAL HEALTH COURTS

One scholar defined therapeutic jurisprudence as "the use of social science to study the extent to which a legal rule or practice promotes the

System's Response to Drug Abuse and Crime in America, 74 NOTRE DAME L. REV. 439, 473–74 (1999).

³² *Id.* at 472–73.

³³ *Id.* at 475.

³⁴ *Id.*

³⁵ Geary, *supra* note 3, at 683.

³⁶ DRUG STRATEGIES, CUTTING CRIME: DRUG COURTS IN ACTION 1, 6 (1997), available at <http://www.drugstrategies.com/pdf/CuttingCrime97.pdf>; Hora et al., *supra* note 31, at 502; see Steven Belenko, *Research on Drug Courts: A Critical Review*, 1 NAT'L DRUG CT. INST. REV. 10, 37 (1998), available at <http://www.ndcrc.org/sites/default/files/ndcir.i1.pdf>.

³⁷ See SUBSTANCE ABUSE & MENTAL HEALTH SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., A BETTER PATH: DRUG TREATMENT COURTS OFFER HOPE FOR YOUTH 1 (2013) [hereinafter A BETTER PATH], available at http://www.samhsa.gov/samhsaNewsLetter/Volume_21_Number_1/Winter2013-volume-21-number-1.pdf.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

psychological and physical well-being of the people it affects.”⁴¹ Advocates of therapeutic jurisprudence looked for ways in which the law could be used as a “therapeutic agent.”⁴² One such method was establishing specialized mental health courts.⁴³ Proponents of mental health courts hoped they would help address problems such as prison overcrowding, an increasing rate of homelessness among the mentally ill, and the high rate of recidivism among mentally ill offenders.⁴⁴ Mental health courts are generally structured in one of two ways: one drops or suspends criminal charges when an offender is assigned to a treatment program and the other requires the offender to enter a guilty plea before being assigned to a treatment program.⁴⁵

The Orange County Opportunity Court Program (Opportunity Court), located in Santa Ana, California, uses the latter system.⁴⁶ Offenders must be eighteen years old or older and have entered a guilty plea or admitted a probation violation to qualify.⁴⁷ Although participation is strictly voluntary, oftentimes the only alternative is incarceration.⁴⁸ In entering the program, offenders agree to random drug tests and unannounced home visits.⁴⁹ Furthermore, offenders who fail to appear in court can be arrested and incarcerated.⁵⁰ The presiding judge makes the final determination as to who can participate in the program.⁵¹

Another requirement for entering the program is a diagnosis of an Axis I disorder.⁵² There is no standardized screening process; sometimes people are admitted based on previous diagnoses made by their doctors, and sometimes they are admitted based on evaluations by the Healthcare Agency, an organization affiliated with the Opportunity Court.⁵³ Many

⁴¹ Geary, *supra* note 3, at 679–80.

⁴² *See id.* at 680.

⁴³ *Id.* at 682.

⁴⁴ *Id.* at 683.

⁴⁵ *Id.*

⁴⁶ Interview with James Mahar, Dir., Orange Cnty. Opportunity Court Program, in Santa Ana, Cal. (May 8, 2013).

⁴⁷ *Id.*

⁴⁸ *Id.*; Handbook of the Orange County Opportunity Court Program 1 (on file with the author).

⁴⁹ Handbook, *supra* note 48, at 2.

⁵⁰ *Id.* at 3.

⁵¹ *Id.* at 2.

⁵² *Id.*

⁵³ *Id.*

offenders who are admitted have both Axis I and Axis II diagnoses.⁵⁴ Sex offenders and offenders with severe violent tendencies are not allowed to enter the program.⁵⁵

The proceedings at the Opportunity Court are different from standard criminal proceedings. Admitted offenders are required to make regular appearances throughout their participation, usually about once a week during the first part of the program and then about once a month when they are further along in the program. By the time an offender completes the program, the judge usually becomes well acquainted with him or her.⁵⁶ The program has four phases: Orientation and Treatment Plan Development, Early Recovery, Active Recovery, and Sustaining Recovery; and a minimum of eighteen months of commitment is required to complete the program.⁵⁷

The Opportunity Court's scene is much different than one that takes place in a typical criminal courthouse. The District Attorney (DA) and the Public Defender (PD) rarely speak during the proceeding. In fact, sometimes the DA does not even attend the proceedings.⁵⁸ The PD is required to attend all of the sessions, but speaks only in rare instances, such as when an offender wants to be transferred out of the program.⁵⁹ Instead, much of the exchange occurs between the offender and the judge. Oftentimes, following an exchange of pleasantries with an offender, the judge compliments the offender on his or her progress. A probation officer is always present and compliments the offender's progress as well.

In many cases, a treatment professional joins the chorus of positive reinforcement. However, treatment professionals provided to offenders often come from outside the court system because of the court's limited funding.⁶⁰ Although these outside professionals are allowed to attend the proceedings, many of them are not familiar with the legal process.⁶¹ The unfortunate result is that many offenders end up without the person who is perhaps the most informed about the progress they have been making during the proceedings. Regardless of a treatment professionals' presence, all participants are required to sign Health Insurance Portability and

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ Interview with James Mahar, *supra* note 46.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

Accountability Act (HIPAA) waivers,⁶² which allow the courts to access their medical records.⁶³

An offender's original offense is almost never mentioned during a proceeding. Instead, the discussion is focused on the offender's treatment process. In addition, the judge discusses other aspects of the offender's life, such as jobs, exercise programs, or volunteer coaching that the offender is involved with.

The judge will also encourage offenders to pursue educational opportunities. For example, in one case, after praising a young offender for the work he had been doing to receive his high school diploma, the judge recommended going to a community college afterward. In cases where less progress has been made, the judge will often say that the offender is "struggling" rather than directly refer to the his or her non-compliance, but will sometimes order the offender to do community service or go to an overnight rehabilitation program. The judge can also order an offender to write an essay to be read aloud in court or demote him or her to an earlier treatment phase.⁶⁴ For more serious violations, the judge can expel offenders from the program and/or order their incarceration.⁶⁵

Throughout the proceedings, the judge repeatedly comments on the offender's potential. There is a sense of camaraderie in the courtroom and the judge often asks for the courtroom to give a round of applause at the end of a proceeding. Group counseling is frequently mandated for offenders as part of the treatment plan.⁶⁶ Those who helped others during the treatment process are praised. A graduation, which occurs following successful completion of the program, is a particularly exciting time. At one woman's graduation, she was flanked by family and congratulated by other participants. She read an emotional speech and her probation officer recited an inspirational quote, which the officer had picked out because she thought it best represented the client. After discussing all the progress she had made, the judge reduced her felony to a misdemeanor and dismissed the misdemeanor, wishing her well in her future endeavors.

⁶² *Summary of the HIPAA Privacy Rule*, U.S. DEPARTMENT HEALTH & HUM. SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf> (last visited Mar. 16, 2014) (explaining that HIPAA protects individuals' health information by limiting the circumstances in which it may be disclosed by covered entities, such as health care providers).

⁶³ Interview with James Mahar, *supra* note 46.

⁶⁴ Handbook, *supra* note 48, at 20.

⁶⁵ *Id.*

⁶⁶ *Id.*

The Opportunity Court has been in existence since 2002 and, so far, it has seen a great deal of success.⁶⁷ In 2013, rates of re-arrest were only 28.8% and rates of re-conviction were only 26.7%.⁶⁸ Although there was no control group studied for the mental health courts, the control group of people that were eligible for, but did not participate in, the drug courts had a recidivism rate of 74%.⁶⁹ Furthermore, the Opportunity Court has been very successful in terms of cost-savings.⁷⁰ In its twelve years of existence, it has saved nearly \$7,380,000 in jail and prison bed costs.⁷¹

Mental illness is more common among juvenile offenders than it is among adult offenders.⁷² Juveniles that enter the juvenile justice system are far more likely than their peers to suffer from mental illness and learning disabilities.⁷³ While it is estimated that about 16% of adults in the criminal justice system suffer from mental illness,⁷⁴ experts put the prevalence of psychiatric disorders in the juvenile justice system between 50 and 75%.⁷⁵ Because of their mental health disorders, many juvenile offenders may be incompetent to stand trial.⁷⁶ The test for competency, established in *Dusky v. United States*, looks to whether a defendant “has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding-and whether he has a rational as well as factual understanding of the proceedings against him.”⁷⁷ It is not enough that the person is conscious of time and place and has some recollection of events.⁷⁸ In addition, the rates of juvenile admission to mental health facilities have greatly increased in the past few decades.⁷⁹ Child abuse and

⁶⁷ SUPERIOR COURT OF CAL. CNTY. OF ORANGE, COLLABORATIVE CTS. 2013 ANNUAL REPORT 1, 6 (2013), available at <http://www.occourts.org/directory/collaborative-courts/reports/2013-annual-report.pdf>.

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.* at 24.

⁷¹ *Id.*

⁷² Geary, *supra* note 3, at 677.

⁷³ *Id.* at 677 n.34.

⁷⁴ Fox Butterfield, *Prisons Brim with Mentally Ill, Study Finds*, N.Y. TIMES, July 12, 1999, <http://www.nytimes.com/1999/07/12/us/prisons-brim-with-mentally-ill-study-finds.html>.

⁷⁵ Geary, *supra* note 3.

⁷⁶ Tamera Wong, *Adolescent Minds, Adult Crimes: Assessing a Juvenile's Mental Health and Capacity to Stand Trial*, 6 U.C. DAVIS J. JUV. L. & POL'Y 163, 165 (2002).

⁷⁷ *Dusky v. United States*, 362 U.S. 402, 402 (1960).

⁷⁸ *Id.*

⁷⁹ Geary, *supra* note 3, at 679.

neglect are also on the rise.⁸⁰

The differing levels of mental illness among adults and juveniles is just one of many reasons that the convergence of the juvenile justice system and the regular criminal justice system is problematic.⁸¹ The convergence of the two systems, however, makes specialized juvenile mental health courts seem especially necessary. Mental illness is almost twice as common among juvenile offenders than it is among adult offenders, yet juveniles are subjected to similar criminal procedures and can sometimes receive even harsher sentences than adults.⁸²

C. EMERGENCE OF JUVENILE MENTAL HEALTH COURTS

Despite the prevalence of mental illness among juvenile offenders, the earliest mental health courts were created only for adults.⁸³ The first one was established in Broward County, Florida in 1997.⁸⁴ Subsequently, several more were established across the country.⁸⁵ However, juvenile courts were slow to catch on.⁸⁶

The first juvenile court was the Court for the Individualized Treatment of Adolescents (CITA), which was established in Santa Clara, California in 2001.⁸⁷ CITA offers a one-year treatment program to juveniles who suffer from disorders “that have a clear biological cause,” including attention deficit hyperactivity disorder, bipolar disorder, and severe depression.⁸⁸ These diagnoses are made during the initial screening administered to all juveniles upon arrival at the juvenile detention center.⁸⁹ Juveniles are screened using the Massachusetts Youth Screening

⁸⁰ *Id.*

⁸¹ See, e.g., Kelly Richards, *What Makes Juvenile Offenders Different from Adult Offenders?*, 409 TRENDS & ISSUES CRIME & CRIM. JUST. 1 (2011) (discussing important differences between juvenile offenders and adult offenders in Australia).

⁸² Trymaine Lee, *Juvenile Offenders Sentenced To Life Can Face Harsher Treatment Than Adults: Report*, HUFFINGTON POST (May 16, 2012), http://www.huffingtonpost.com/2012/05/15/juvenile-offenders-life-sentence-_n_1519298.html.

⁸³ JOSEPH J. COCOZZA & JENNIE L. SHUFELT, NAT’L CENTER FOR MENTAL HEALTH & JUVENILE JUSTICE, *JUVENILE MENTAL HEALTH COURTS: AN EMERGING STRATEGY* 1, 1 (2006), available at http://www.ncmhjj.com/wp-content/uploads/2013/07/2006_Juvenile-Mental-Health-Courts1.pdf.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.* at 2.

⁸⁸ Geary, *supra* note 3, at 688–89.

⁸⁹ *Id.* at 689.

Instrument (MAYSI), a tool developed in 2000 by Richard Barnum and Thomas Grisso.⁹⁰ The MAYSI measures seven different domains: Alcohol/Drug Use, Angry/Irritable, Depressed/Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance, and Traumatic Experiences.⁹¹

Admission to the juvenile mental health court does not necessarily mean that a juvenile will not be incarcerated. Although the majority of juveniles admitted are not imprisoned, they are given electronic bracelets while they undergo treatment.⁹² The treatment programs are determined by the court's mental health coordinator, and the juveniles return to the court every thirty to ninety days for judicial review until they successfully complete their programs, at which time they are released and the charges against them are dismissed.⁹³

The second juvenile mental health court to be established, the Los Angeles Juvenile Mental Health Court,⁹⁴ determines a juvenile's eligibility based on a variety of factors including the juvenile's record, the nature of the offense, the existence of a diagnosed mental disorder or developmental disability, and the ability to communicate with an attorney.⁹⁵ Unlike some other courts, the Los Angeles Juvenile Mental Health Court does not categorically exclude any type of offender from eligibility.⁹⁶

Cases often come to the mental health court after being referred by one of the delinquency courts in Los Angeles.⁹⁷ Upon referral, a juvenile offender is evaluated by two University of California, Los Angeles doctors—a clinical psychologist and a psychiatrist.⁹⁸ The case is then presented to all members of the mental health team, which includes the doctors, the judge, the DA, the PD, two probation officers, and an

⁹⁰ David E. Arredondo, Kurt Kumli, Larry Soto, Enrique Colin, Jill Ornellas, Judge Raymond J. Davilla, Jr., Judge Leonard P. Edwards & Judge Eugene M. Hyman, *Juvenile Mental Health Court: Rationale and Protocols*, JUV. & FAM. CT. J., Fall 2001, at 1, 4, available at http://www.judgehyman.com/downloads/JMHC_RATIONALE_AND_PROTOCOL.PDF.

⁹¹ THOMAS GRISSO & RICHARD BARNUM, MASSACHUSETTS YOUTH SCREENING INSTRUMENT VERSION 2: USER'S MANUAL & TECHNICAL REPORT (2006).

⁹² *Id.*

⁹³ *Id.*

⁹⁴ Geary, *supra* note 3, at 690 n.136.

⁹⁵ *Id.* at 689.

⁹⁶ Interview with the Hon. Christina Hill, Judge, Superior Court of Cal. Cnty. of L.A., in L.A., Cal. (May 15, 2013).

⁹⁷ *Id.*

⁹⁸ *Id.*

educational liaison.⁹⁹ The doctors present their diagnoses of the juvenile and the rest of the mental health team has a chance to ask questions.¹⁰⁰ The judge and the DA both have the power to veto a juvenile's admission into the program. This power is rarely used, but when it is used, it is usually only in cases of attempted murder and when there is entrenched gang involvement and the juvenile has no desire to break out of the involvement.¹⁰¹

After an offender is determined to be eligible and accepts the jurisdiction of the court, a team of mental health professionals, school administrators, and probation officers determine the individual's treatment plan.¹⁰² The probation officer and a school-court liaison oversee the treatment process, while the psychologist and the psychiatrist continue to play an active role.¹⁰³ Judges, assisted by mental health professionals, educational and service providers, and representatives from the DA's office and the PD's office, monitor an offender's progress for the duration of the program until it is successfully completed and the charges against the offender are dismissed.¹⁰⁴ As with the Orange County Community Court, HIPAA waivers need to be signed to give the mental health team access to a juvenile's health records.¹⁰⁵ The program is designed to last two years, but it can be shorter or longer depending on the juvenile's needs and level of progress.¹⁰⁶

Since the establishment of the courts in Los Angeles and Santa Clara, nine other juvenile mental health courts have been established.¹⁰⁷ While most of these mental health courts are administered by the juvenile court system, others are administered by the probation department or the family services agency.¹⁰⁸ In many cases, eligibility to participate in these courts is limited to juveniles with the most serious mental illnesses.¹⁰⁹ Most exclude juveniles who suffer only from a conduct disorder or an

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² Geary, *supra* note 3, at 690.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ Interview with the Hon. Christina Hill, *supra* note 96.

¹⁰⁶ *Id.*

¹⁰⁷ COCOZZA ET AL., *supra* note 83.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 3.

oppositional defiant disorder.¹¹⁰ Although it is too early to conduct a full-scale assessment of the effectiveness of juvenile mental health courts, early reports are encouraging.¹¹¹

However, these specialized courts are not necessarily the only adequate way to address the alarming rate of mental illness among juvenile offenders.¹¹² In fact, one scholar suggests that “[c]reating 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.”¹¹³ There are problems with attempting to implement mental health programs into the broader criminal justice system. James Mahar, Director of the Opportunity Court, notes that the criminal justice system is slow and is not equipped to immediately respond to offenders’ needs.¹¹⁴ One of the strengths of the collaborative court system is that it is able to respond quickly with a therapeutic response tailored to the offender’s needs.¹¹⁵

III. JUVENILES IN THE TREATMENT PROCESS

A. THE ROLE OF A JUVENILE

A rehabilitative approach cannot be successful unless these courts adequately address the needs of the juvenile offenders. Perhaps the most obvious way to do so is to let juveniles play an active role in the process. Indeed, evidence suggests that allowing a juvenile to play an active role in the treatment process enhances the therapeutic effect.¹¹⁶ As Richard Barnum and Thomas Grisso point out, “[a]n offender is more likely to have a positive response to treatment when he or she is able to take responsibility for the behavior that the treatment aims to change.”¹¹⁷

¹¹⁰ *Id.*

¹¹¹ E.g., *Juvenile Justice: Voices from the Trenches: Raymond Davilla*, KQED, <http://www.kqed.org/w/juvenilejustice/kqedorg/davilla.html> (last visited Mar. 16, 2014).

¹¹² Geary, *supra* note 3, at 691.

¹¹³ *Id.*

¹¹⁴ Interview with James Mahar, *supra* note 46.

¹¹⁵ *Id.*

¹¹⁶ Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L.J. 1265, 1330–31 (2000).

¹¹⁷ Richard Barnum & Thomas Grisso, *Competence to Stand Trial in Juvenile Court in Massachusetts: Issues of Therapeutic Jurisprudence*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 321, 336 (1994).

However, determining when it is appropriate for the law to allow juveniles to make their own decisions is easier said than done. Oftentimes it is hard to know when a juvenile's decisions are truly voluntary.¹¹⁸ The dual issues presented by youth and mental illness confound this problem.¹¹⁹ For example, mentally ill adults who are found to be incompetent to stand trial are often treated until their competence is restored.¹²⁰ However, when a juvenile is found to be incompetent to stand trial, incompetence is often the result of not only mental illness, but also developmental immaturity, which cannot be restored.¹²¹ Therefore, it is important to determine what functional deficits a juvenile faces, how these deficits might interfere with the juvenile's ability to take part in proceedings, and whether these deficits are likely to be restored with treatment. One study found that about one-third of eleven to thirteen-year-olds and about one-fifth of fourteen to fifteen-year-olds are as "impaired in capacities relevant to adjudicative competence as are seriously mentally ill adults who would likely be considered incompetent to stand trial."¹²² These figures demonstrate the likelihood that a large number of juvenile's competency to stand trial cannot be restored.

Currently, inquiries regarding a juvenile's competency to stand trial focus on understanding and fail to take other factors, such as decisional competency, into account.¹²³ This may be a result of not only cognitive differences between juveniles and adults, but also differences in what Thomas Grisso calls "psychosocial maturation."¹²⁴ Because juveniles often lack decisional competency, they may make choices that they would not make later in life when their brains are further developed.¹²⁵

¹¹⁸ See, e.g., COCOZZA ET AL., *supra* note 83, at 5 ("Given the mental health status of youth participants, their status as minors, and the stress and uncertainty associated with their contact with the juvenile justice system, concerns have been raised about a youth's ability to make informed, independent decisions about whether to participate and whether participation is truly voluntary.").

¹¹⁹ Wong, *supra* note 76, at 179.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² Thomas Grisso, Laurence Steinberg, Jennifer Wollard, Elizabeth Cauffman, Elizabeth Scott, Sandra Graham, Fran Lexcen, N. Dickon Reppucci & Robert Schwartz, *Juveniles' Competence to Stand Trial: A Comparison of Adolescents' and Adults' Capacities as Trial Defendants*, 27 L. & HUM. BEHAV. 333, 356 (2003), available at [http://stopyouthviolence.ucr.edu/pubs_by_topic/5 Juveniles' %20competence %20to %20stand %20trial.pdf](http://stopyouthviolence.ucr.edu/pubs_by_topic/5%20Juveniles'%20competence%20to%20stand%20trial.pdf).

¹²³ *Id.* at 357.

¹²⁴ *Id.* at 355.

¹²⁵ *Id.*

Judge Hill of the Los Angeles Juvenile Mental Health Court (LA JMHC) notes that juvenile incompetency is a particularly difficult issue because their lack of competency is often a result of immaturity rather than mental illness.¹²⁶ The LA JMHC does not automatically exclude incompetent juveniles, although dealing with incompetent juveniles was not the original mission of the court.¹²⁷ Part of the problem is that incompetent juveniles are not wards of the court and cannot be put on probation, so it is hard for them to be incorporated into the program.¹²⁸ Currently, there is no formal restoration program for juveniles.¹²⁹ However, the LA JMHC is working to establish such a program, and a panel of judges who have been tasked with writing reports about competence have been vetted.¹³⁰

Because competency determinations are expensive and lack of competency is prevalent before the age of fourteen, avoiding regular criminal trials for youth in that age group may be advisable.¹³¹ Courts have often considered competency standards to be lower in juvenile courts than in regular criminal courts because they are, in theory, less punitive.¹³²

Because mental health courts generally focus on an offender's situation rather than the circumstances of the offense, it is less important to ensure that the offender understands certain procedural aspects of the case in a mental health court. In a standard criminal trial, whether in adult or juvenile court, offenders probably cannot adequately defend themselves if they do not understand the elements of the crime for which they are charged and whether their acts meet those elements. It is also probably important for an offender to understand what evidence is admissible. However, in a trial at a mental health court, the rules of evidence are less strict, and the trial focuses on the offender's behavior and treatment rather than on the elements of the crime. Therefore, it may be most important for an offender to understand his or her own behavior rather than court procedures. Furthermore, the offender has less to lose by being unable to assist himself in trial because the outcome is designed to help rather than punish the offender.

In addition to instituting a minimum age for trying juveniles in

¹²⁶ Interview with the Hon. Christina Hill, *supra* note 96.

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ See Grisso et al., *supra* note 122, at 360.

¹³² See *id.*

criminal court, trying mentally ill juveniles who are above the minimum age in mental health courts would help the complex issues surrounding competency to stand trial. If juveniles who are not competent to stand trial due to mental illness are taken out of the criminal justice system, it would be easier to determine who is not competent to stand trial because of youth and immaturity. Futile attempts to restore competency where competency cannot be restored would be less likely.

Not all mental health courts serve offenders who are incompetent to stand trial. Mahar notes that the Opportunity Court used to serve lower-functioning offenders who had conservators representing their interests.¹³³ However, many conservators felt that the court was too punitive and fought against the court on everything it tried to do.¹³⁴ Oftentimes, Mahar felt that the conservators were enabling the offenders' bad behavior.¹³⁵ This is unfortunate, but could probably be changed if conservators are educated about the program.

B. JUVENILE DECISION-MAKING CAPACITY

The issues involved in determining a juvenile's competency to stand trial are also implicated in the determination of a juvenile's capacity to make decisions regarding his or her treatment. Traditionally, the law limited juveniles' autonomy regarding their medical treatment. Usually parents, rather than juveniles, are allowed to make medical decisions. However, when a state believes that parents are not acting in the best interests of their child, it can step in and exercise its *parens patriae* power.¹³⁶

The law's presumption that juveniles are not capable of making their own medical decisions is not based on scientific evidence.¹³⁷ In fact, an increasing number of studies indicate that adolescents possess a decision-making capacity comparable to that of adults.¹³⁸ In one study, researchers asked a group of ninth grade students to list qualities in a health care provider that would affect their decision to seek treatment.¹³⁹ The

¹³³ Interview with James Mahar, *supra* note 46.

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ See, e.g., *Novak v. Cobb County-Kennestone Hosp. Authority*, 849 F. Supp. 1559 (N.D. Ga. 1994).

¹³⁷ Hartman, *supra* note 116, at 1333.

¹³⁸ *Id.* at 1267-68.

¹³⁹ Kenneth R. Ginsburg, Gail B. Slap, Avital Cnaan, Christine M. Forke, Catherine M.

researchers found a high level of thoughtful and mature perceptions in the students' responses.¹⁴⁰ A similar study found that the "independent effect that health care providers' interpersonal style can have on adolescent patient satisfaction" is similar to that of adult patients.¹⁴¹ Another study examined the difference in medical decision-making ability among participants aged nine, fourteen, eighteen, and twenty-one.¹⁴² It found the fourteen-year-old participants' decision-making ability to be very similar to that of the eighteen-year-old and twenty-one-year-old participants.¹⁴³ These studies support Swiss psychologist Jean Piaget's theory of cognitive development: that by adolescence, most people reach the stage of formal operational thinking and have cognitive abilities similar to that of adults.¹⁴⁴

Some jurisdictions recognize that adolescents are sometimes capable of making autonomous decisions about their treatment. For example, a California court in *In re Roger S.* held that adolescents aged fourteen years or older are entitled to "procedural due process in determining whether the minor is mentally ill or disordered."¹⁴⁵ This right cannot be waived by a parent or a guardian.¹⁴⁶ Similarly, Pennsylvania allows adolescents to voluntarily commit themselves to treatment without parental consent.¹⁴⁷ By and large, however, the law has not caught up to the scientific realities of adolescent decision-making capacity.

C. TRANSLATING COGNITIVE DEVELOPMENT INTO DECISION-MAKING CAPACITY

Conducting a proper assessment of a juvenile's capacity to consent requires knowledge of cognitive development and decision-making

Balsley & Dionne M. Rouselle, *Adolescents' Perceptions of Factors Affecting Their Decisions to Seek Health Care*, 273 JAMA 1913, 1914 (1995).

¹⁴⁰ *Id.*

¹⁴¹ Lorraine H. Freed, Jonathan M. Ellen, Charles E. Irwin, Jr. & Susan G. Millstein, *Determinants of Adolescents' Satisfaction with Health Care Providers and Intentions to Keep Follow-Up Appointments*, 22 J. ADOLESCENT HEALTH 475, 478 (1998).

¹⁴² Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589, 1589 (1982).

¹⁴³ *Id.*

¹⁴⁴ Hartman, *supra* note 116, at 1285.

¹⁴⁵ *In re Roger S.*, 569 P.2d 1286, 1288 (1977).

¹⁴⁶ *Id.*

¹⁴⁷ Hartman, *supra* note 116, at 1331.

capacity.¹⁴⁸ Courts have struggled to determine what decisions juveniles are capable of making and, as a result, there are many incongruities in the law.¹⁴⁹ In some cases, a fourteen-year-old child can be tried as an adult in criminal court, but can be found unable to consent to medical treatment.¹⁵⁰ An emancipated fifteen-year-old child can consent to medical treatment,¹⁵¹ while a fifteen-year-old child under parental guardianship cannot consent to treatment regardless of his or her maturity level.¹⁵² And yet a fifteen-year-old parent can consent to their child's medical treatment or put the child up for adoption.¹⁵³ In addition, a fifteen-year-old child can make decisions related to treatment of a sexually transmitted disease, but not for all complications that may result from it.¹⁵⁴ The difficulty of determining a juvenile's decision-making capacity is further complicated when the juvenile suffers from mental illness.

In certain situations, the law has given parents little deference when their children's well-being is at stake. Early in the nineteenth century, long before the beginning of the modern juvenile justice system, authorities often placed children in orphanages if they determined that their parents were providing inadequate supervision, moral training, or financial support under the theory that children should not be punished for their parents' misfortune.¹⁵⁵ Eventually, various institutions, such as houses of refuge and orphan asylums, were established for these children, which in some ways were the underpinnings of the modern juvenile justice system.¹⁵⁶ Parents did not play an important role in the process because juvenile delinquency was thought to be the result of a lack of family discipline, and juveniles in these institutions were thought to be beyond their parents' control.¹⁵⁷

When it comes to health care, however, the Supreme Court has generally given parents considerable discretion in making decisions about

¹⁴⁸ *Id.* at 1286–87.

¹⁴⁹ *Id.* at 1287.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.* at 1267.

¹⁵⁵ Lois A. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773, 776 (1988).

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 776–77.

their children's treatment.¹⁵⁸ In holding that parents have a broad right to determine the best medical treatment for their children, the Court adhered to "Western civilization concepts of the family as a unit with broad parental authority over minor children" and found that parents have a "'high duty' to recognize symptoms of illness and to seek and follow medical advice."¹⁵⁹

Justice Brennan, in his dissenting opinion, joined by Justices Marshall and Stevens, argued that the Court was giving too much deference to parental decision-making.¹⁶⁰ He argued that the state has a special obligation to protect the rights of children, noting that "[p]arents may be free to become martyrs themselves[, but] it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."¹⁶¹ Justice Brennan also pointed out that several studies have shown that parents often make decisions to institutionalize their children based on hardships in the family or on other factors that are unrelated to their children's mental health needs.¹⁶² Furthermore, he pointed out that even when parents do have their children's best interests in mind, they are often ill informed about the treatment options available to them.¹⁶³ As a result, he argued, giving complete deference to parental authority could undermine a child's due process rights.¹⁶⁴

Despite Justice Brennan's strenuous objections, modern day jurisprudence seems to support giving significant deference to parents when it comes to their children's treatment.¹⁶⁵ The fact that courts have traditionally given parents little deference when it comes to administering juvenile justice and significant deference when it comes to mental health treatment poses an interesting challenge for juvenile mental health courts. At the LA JMHC, parents sometimes strenuously object to the possibility of their children receiving psychotropic drugs.¹⁶⁶ The court tries to educate

¹⁵⁸ *E.g.*, *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

¹⁵⁹ *Id.*

¹⁶⁰ *Id.* at 631.

¹⁶¹ *Id.* at 632 (Brennan, J., dissenting) (quoting *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944)).

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *See id.* at 603.

¹⁶⁶ Interview with the Hon. Christina Hill, *supra* note 96.

the parents on the benefits of the medication, but occasionally, when parents are adamant in their opposition, a child is not accepted into the jurisdiction of the court on the belief that he or she will not receive the full benefits of the program.¹⁶⁷

Although a state has a legitimate interest in exercising its *parens patriae* power over parental objections in certain situations, parents and other family members still have an important role to play in a juvenile's treatment process. In order to hold offenders accountable, it is important that they have people whose opinions they value expressing both their disappointment and continued faith in the offender.¹⁶⁸ This process, known as re-integrative shaming, helps to prevent reoffending and to promote the success of the treatment process.¹⁶⁹

Family involvement often affects even an adult offender's success in the program. One woman at the Opportunity Court repeatedly noted that she never could have successfully completed the program without her brother who constantly helped and encouraged her throughout the program. Another offender was unable to complete the program, in part because his mother encouraged his destructive behavior, even purchasing him a hotel room so that he had a place to abuse drugs.¹⁷⁰ For juveniles, family involvement is even more important because they tend to depend on their families in their day-to-day lives. In addition, parents are often ordered to attend court sessions with juveniles. Therefore, it is important that families remain actively engaged in the judicial process, especially when the offender is a juvenile.

D. PREVALENCE OF CO-OCCURRING DISORDERS

Another important issue when addressing mental health disorders in the juvenile justice system is the high rate of co-occurring disorders, particularly substance use disorders. One study found that almost 60% of juveniles who have mental health disorders also have substance use disorders.¹⁷¹ In fact, two mental health courts in the United States limit eligibility to juveniles who suffer from both mental illness and substance

¹⁶⁷ *Id.*

¹⁶⁸ DECLAN ROCHE, ACCOUNTABILITY IN RESTORATIVE JUSTICE 10 (Per-Olof H. Wikström ed., 2003).

¹⁶⁹ *Id.*

¹⁷⁰ Interview with James Mahar, *supra* note 46.

¹⁷¹ A BETTER PATH, *supra* note 37, at 2.

use disorders.¹⁷² It is important that youth suffering from co-occurring mental health and substance use disorders receive adequate treatment for both. One study found that drug courts can be effective in combating both disorders.¹⁷³ The study examined seventeen juvenile drug courts and found a 60% decline in scaled indicators of emotional problems and difficulties with self-control.¹⁷⁴ Mental health courts can also be effective in treating both problems if they incorporate drug treatment programs into their procedures.

Co-occurring disorders are probably even more prevalent among adult offenders. Mahar estimates that about 99% of the court's Monday through Wednesday population have co-occurring disorders.¹⁷⁵ The fact that drug abuse becomes even more prevalent among mentally ill offenders later in life demonstrates the importance of early treatment of drug disorders.

E. THE ROLE OF ABUSE IN MENTAL HEALTH DISORDERS AND DELINQUENCY

When addressing the mental health needs of youth in the juvenile justice system, it is important to consider that many delinquent juveniles have been abused. A history of abuse is particularly common among females,¹⁷⁶ who constitute a steadily increasing share of the juvenile justice system.¹⁷⁷ Oftentimes, juvenile girls with a history of abuse respond by running away, becoming truant, and engaging in high-risk sexual behavior, causing them to be labeled as delinquent.¹⁷⁸ In addition, a history of abuse can often lead to emotional problems.¹⁷⁹ One study suggests that over 75% of juvenile girls labeled as delinquent are victims

¹⁷² COCOZZA ET AL., *supra* note 83, at 3.

¹⁷³ A BETTER PATH, *supra* note 37, at 2.

¹⁷⁴ *Id.*

¹⁷⁵ Interview with James Mahar, *supra* note 46.

¹⁷⁶ LAURA PRESCOTT, GAINS CTR., IMPROVING POLICY AND PRACTICE FOR ADOLESCENT GIRLS WITH CO-OCCURRING DISORDERS IN THE JUVENILE JUSTICE SYSTEM 3 (1998), available at https://www.nttac.org/views/docs/jabg/grpcurriculum/improving_policy.pdf.

¹⁷⁷ THOMAS GRISSO & LEE A. UNDERWOOD, U.S. DEP'T OF JUSTICE, SCREENING AND ASSESSING MENTAL HEALTH AND SUBSTANCE USE DISORDERS AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM: A RESOURCE GUIDE FOR PRACTITIONERS 9 (2004), available at <https://www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf>.

¹⁷⁸ PRESCOTT, *supra* note 176.

¹⁷⁹ *E.g., id.*

of sexual abuse.¹⁸⁰ It is therefore important that mental health courts be sensitive to the needs of abuse victims. Although they have access to a client's medical records, the Opportunity Court does not seek people's "deepest darkest secrets about when they were molested."¹⁸¹ Instead, if the court wants to find out why an offender is struggling during the program, it asks the treatment professionals general questions about whether the offender is having difficulties in his or her personal life.¹⁸² That way, the court can recognize that an offender is going through a difficult time without re-traumatizing or embarrassing the offender.

IV. CONCLUSION: THE FUTURE OF JUVENILE MENTAL HEALTH COURTS

Early signs of success among the existing mental health courts offer a lot of hope for the mental health court model. Mental health courts have the potential to reduce recidivism and cut costs by reducing the number of people who are incarcerated. Specifically, juvenile mental health courts have the greatest potential to do this because providing treatment for a mentally ill juvenile early in life, when criminal behavior starts to emerge, will have a lasting impact. However, there are a few measures that must be taken to ensure that these courts reach their full potential.

First, given the fact that juvenile mental health courts focus more on offenders than their offenses, they should not categorically exclude any class of offenders. Many offenders for whom the program is most successful have committed offenses that would, in some mental health courts, exclude them from eligibility.¹⁸³ Furthermore, eligibility should be limited to offenders with Axis I disorders,¹⁸⁴ but should not have any other blanket restrictions. Other offenders might be excluded on an individual basis after an evaluation by the mental health team, as some offenders with entrenched gang involvement are at the LA JMHC. Offenders should

¹⁸⁰ *Id.* at 3–4.

¹⁸¹ Interview with James Mahar, *supra* note 46.

¹⁸² *Id.*

¹⁸³ Interview with the Hon. Christina Hill, *supra* note 96 (contrasting the Orange County Opportunity Court, in which sex offenders and offenders with severe violent tendencies are excluded, with the Los Angeles County Mental Health Court, which is often most successful for offenders who are accused of violent or sexual offenses).

¹⁸⁴ Axis I disorders are the highest level of disorders according to the American Psychiatric Association's classification system. They include mood disorders, anxiety disorders, eating disorders, psychotic disorders, dissociative disorders, and substance use disorders. *See generally* AM. PSYCHIATRIC ASS'N: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Am. Psychiatric Ass'n, 5th ed. 2013).

only be excluded sparingly, however, to ensure mental health courts' potential for success with a wide variety of offenders.

Second, it is important that courts implement a standardized screening process so that they are consistent in accepting and treating all offenders equally. The MAYSI has already been implemented successfully in Santa Clara County and could be used for other juvenile mental health courts across the country.¹⁸⁵ The MAYSI can help identify which juveniles have Axis I disorders and are most likely to be the ones who mental health courts are designed to help.¹⁸⁶

Third, courts should recognize that juveniles, particularly adolescents, often have a well-developed decision-making capacity given that numerous studies have shown that they are capable of making mature treatment decisions.¹⁸⁷ Although judges should have the final say regarding a juvenile's treatment plan, the juvenile's own voice should be heard, and he or she should be encouraged to play an active role in his or her treatment. The likelihood of success likely will be greater when a juvenile takes more responsibility for his or her treatment. If the MAYSI, or a similar test, is implemented in the screening process, it will help to determine each individual's actual capacity.

Fourth, due to the prevalence of co-occurring disorders, drug treatment must be an integral part of the treatment program. For offenders with co-occurring disorders, addressing only one disorder would be inadequate. Drug tests and medication can decrease drug use¹⁸⁸ and lead to fewer emotional problems and better self-control.¹⁸⁹

Fifth, treatment professionals who work closely with offenders during the program should be part of the court system in order to ensure that the offenders are treated equally and that they all have people who can

¹⁸⁵ See Arredondo et al., *supra* note 90, at 4, 17.

¹⁸⁶ See Todd L. Grande, Janelle M. Hallman, Lee A. Underwood, Kellie M. Warren & Mark Reh fuss, *Treating Detained Juveniles: Measuring Mental Health Traits and Gender Differences*, 4 REV. EUR. STUD. 14, 15 (2012), available at <http://www.ccsenet.org/journal/index.php/res/article/view/20996/13729>.

¹⁸⁷ Hartman, *supra* note 116.

¹⁸⁸ See MICHAEL L. DENNIS ET AL., EVALUATING THE IMPACT OF ADDING THE RECLAIMING FUTURES APPROACH TO JUVENILE TREATMENT DRUG COURTS 15 (2012), available at http://www.gaincc.org/_data/files/posting_publications/rf_jtcdc_slides_5-8-12.ppt (explaining that urine tests and medication to ease withdrawal were among the methods used at the drug courts).

¹⁸⁹ *Id.* at 18, 20 (indicating that in a study of 1934 young people, those participating in drug courts saw a decrease in the number of incidents of drug and alcohol use, as well as with their scores on a scale measuring emotional problems and difficulties with self-control).

speak to their mental health progress during the proceedings. Although this is often difficult because of the limited funding available to mental health courts, providing these professionals should be made a priority.

Sixth, courts should implement procedures for dealing with offenders with a history of abuse to ensure that they are not embarrassed or re-traumatized. Court guidelines should direct judges to ask more general questions to offenders and treatment professionals rather than questions about their abuse history.

Seventh, the importance of family involvement in the process should be recognized and families should be encouraged to play a supportive role and to provide positive reinforcement in the treatment process. The treatment process can be long and arduous, and many offenders cannot make it through the process without the support of someone close to them.

Finally, conservators should be educated about the treatment process and how the mental health courts work, so they are better able to act as decision makers and advocates for the offenders. Getting conservators more involved in mental health courts could allow the courts to accept more offenders who are deemed incompetent.

The eleven mental health courts currently in existence across the country provide a good start to battling the criminalization of juvenile mental illness. However, given the prevalence of mental illness among juvenile offenders, eleven is far from enough. The successes of existing juvenile and adult mental health courts should provide encouragement for their expansion, and future courts can, in large part, model themselves after the existing mental health courts. At the same time, future courts can learn from the shortcomings of the existing courts and continue to improve upon the rehabilitative model.