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USING THERAPEUTIC JURISPRUDENCE TO BRIDGE THE JUVENILE JUSTICE AND MENTAL HEALTH SYSTEMS

*Gene Griffin and Michael J. Jenuwine**

In describing the fate of two boys found delinquent of a murder they had committed when ten and eleven years old, the headline of a Chicago newspaper declared “One convicted in boy’s death free, Second lives without hope.”¹ That article went on to describe how the boys had dropped five-year-old Eric Morse to his death from a high rise building because he would not steal candy for them; how the case “became a national symbol of the rising tide in violent juvenile crime”; and how the judge, “in what has amounted to a bold experiment . . . decided to send the youths to prison but ordered state officials to provide them with intensive treatment.”² The abhorrent nature of this crime initially drew national attention, including a statement by then President Clinton, who publicly expressed his consternation about such a tragedy.³ This case is an unspeakable tragedy for the victim and his family. It also represents the need for the American justice system to acknowledge and address the psychological factors that contribute to juvenile delinquency.

The judge’s order that these two minors receive mental health treatment as part of their sentence demonstrates that the mental health and juvenile justice systems must work together to address the psychological components of rehabilitating delinquent youth. That the newspaper considered this order to be “a bold experiment” suggests how far apart these two systems can be.⁴ This article reviews the concept of therapeutic jurisprudence and how mental health principles can be integrated into the juvenile justice system. Next, it discusses reasons the mental health and juvenile justice systems have not worked well together. Finally, the article presents current theories of juvenile justice and community mental health that would allow these systems to work

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1. Gary Marx, *One Convicted in Boy’s Death Free, Second Lives Without Hope*, CHI. TRIB., Jan. 24, 2001 at § 1, p. 1.

2. *Id.*; Interviews with surviving family members involved in this case can be found in L. EALAN JONES & LLOYD NEWMAN, *OUR AMERICA: LIFE AND DEATH ON THE SOUTH SIDE OF CHICAGO* (1997).

3. Sound Portraits radio documentary transcript at <http://www.soundportraits.org/on-air/remorse/transcript.php3> (on file with the author).

4. Marx, *supra* note 1.

more closely, as well as programmatic attempts to integrate mental health care with juvenile justice.

I. THERAPEUTIC JURISPRUDENCE AND THE JUVENILE JUSTICE SYSTEM

The case for promoting awareness of the psychological issues impacting youth in the juvenile justice system may be best understood through studying the role of law as a therapeutic agent, a concept known as therapeutic jurisprudence (TJ).⁵ TJ is defined as "the use of social science to study the extent to which a legal rule or practice promotes the psychological or physical wellbeing of the people it affects."⁶ Viewing the legal system from this perspective, legal rules, procedures, and actors are seen as "social forces that, whether intended or not, often produce therapeutic or antitherapeutic consequences."⁷ TJ explores ways that knowledge from the mental health field can be used on a societal level to shape laws. A primary tenet of TJ suggests that individual legal professionals examine and adjust the roles they play so that they serve clients in a manner that is "therapeutically beneficial."⁸ The issue is not whether therapeutic or psychological treatment should be introduced into a legal system; it is already there. TJ offers a model for bringing therapeutic and psychological treatment forward to where it can be directly discussed.⁹

5. David B. Wexler, *Therapeutic Jurisprudence in a Comparative Law Context*, 15 BEHAV. SCI. & L. 233, 233 (1997).

6. David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 PSCHOL., PUB. POL'Y, & L. 220, 224 (1995) (quoting Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSCHOL., PUB. POL'Y, & L. 193, 196 (1993)).

7. Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCHOL., PUB. POL'Y, & L. 184, 185 (1997).

8. DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT 17 (1990).

9. This argument is analogous to the mental health field and its use of Behaviorism. The theory of reinforcement affecting behavior can be applied to all therapeutic interactions. The behaviorists would argue that a therapist was not suddenly deciding to introduce behaviorism into a session, but that principles of behaviorism were always at work. The therapist, by responding or not responding in certain ways, was always shaping the client's behavior. Behaviorism simply offered a way for therapists to recognize the principles and exercise more control over the effects. Similarly, TJ offers a way in which the legal actors can become aware of the therapeutic consequences which their actions are already having and, by recognizing these effects, exercise more direct control over the therapeutic or anti-therapeutic outcomes. See THEORIES OF BEHAVIOR THERAPY: EXPLORING BEHAVIOR CHANGE (William O'Donohue & Leonard Krasner eds., 1995).

A. *Juvenile Justice as Therapeutic*

Juvenile courts, by their very nature, were designed to be more therapeutic than the adult criminal justice system. Illinois was the first state to codify a juvenile court statute, thereby creating the first official juvenile court in 1899.¹⁰ At that time, American society recognized that juveniles differed from adults in their development and their needs. Juvenile courts were intended to promote rehabilitation and emphasized the best interests of the minor through the parental role of the government. Judge Julian Mack commented on this aspect of the juvenile court in a 1909 article commemorating the tenth anniversary of the juvenile court:

The Judge on a bench, looking down upon a boy standing at the bar, can never evoke a proper sympathetic spirit. Seated at a desk, with the child at his side, where he can on occasion put his arm around his shoulder and draw the lad to him, the judge, while losing none of his judicial dignity, will gain immensely in the effectiveness of his work.¹¹

The humanitarian ideals of the original juvenile court eroded over time. In the 1960s, the rhetoric of rehabilitation in the juvenile courts was challenged. The United States Supreme Court acknowledged this erosion in two landmark decisions, *In re Gault* and *Kent v. United States*.¹² Mr. Justice Fortas's oft quoted statement in *Kent* underscores how the rehabilitation of the delinquent minor was not guaranteed by juvenile court proceedings: "There is evidence . . . that the child receives the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children."¹³ With *In re Gault*, the juvenile court moved in the direction of more adversarial procedures resembling the adult criminal justice system by affording delinquent minors many of the protections previously only available to adults.¹⁴ By providing these rights to delinquent youths, the juvenile court lost some of the flexibility built into the traditional model, and began to more closely resemble the adversarial adult criminal court system. Recent trends allowing the transfer of younger juveniles to the adult criminal courts, together with blended sentencing provisions that allow judges to sentence minors to a juvenile sentence followed by time in an adult facility, indicate that the

10. Act of April 21, 1899, ILL. LAWS, §21 (1899).

11. Julian Mack, *The Juvenile Court*, 23 HARV. L. REV. 104, 120 (1909).

12. *Kent v. U.S.*, 383 U.S. 541 (1966); *In re Gault*, 387 U.S. 1 (1967).

13. *Kent*, 383 U.S. at 556.

14. *In re Gault*, 387 U.S. at 1.

juvenile justice system has moved even closer to its adult counterpart.¹⁵ Distinctions remain, however, allowing juvenile court judges to maintain unique discretion in sentencing most delinquents, thereby permitting creative sentencing to enhance potential therapeutic benefits.

1. An Example of Therapeutic Sentencing

In the Eric Morse case discussed previously, a juvenile court judge was faced with sentencing two boys, then twelve and thirteen years old, found delinquent of first degree murder. At the dispositional hearing, the boys were adjudged wards of the state and the court convened a statutorily required interagency review committee (IRC) to determine appropriate placements for these youths. In making its recommendation to the court, the IRC balanced two overlapping concerns: (1) the need for highly secure facilities to protect the public from additional violence by these minors, and (2) the minors' need for treatment. After evaluating alternatives, the committee concluded that due to the risk of violence posed by these youths, no appropriately secure treatment facility existed for these boys. An ideal solution would be a facility that could simultaneously offer both a secure setting and treatment. Because no treatment facility was available, the IRC concluded that incarceration in the Department of Corrections was the only option. Rather than sentencing the youths to traditional confinement in juvenile corrections, the judge ordered a hybrid solution. The boys were remanded to the custody of the Department of Corrections, but were required to receive treatment as a condition of that commitment. The sentence was one that neither the prosecution nor the defense requested. The unorthodox nature of the judge's order was challenged by attorneys for one of the boys.¹⁶ The Appellate Court of Illinois upheld the decision to sentence both minors to receive treatment while confined in the Department of Corrections based in part on evidence of the boys' aggressive and violent behavior, history of running away, and the nature of the offense.¹⁷

15. For a discussion of Blended Sentencing, see Chauncey E. Brummer, *Extended Juvenile Jurisdiction: The Best of Both Worlds?*, 54 ARK. L. REV. 777 (2002).

16. *In re J.R. and T.J.*, 302 Ill. App. 3d 87 (1998).

17. *See id.*

B. Juvenile Justice as Anti-therapeutic

Juvenile courts do not always attempt to be therapeutic. While state laws emphasize the goal of rehabilitating delinquents in civil proceedings, recent court decisions acknowledge that juvenile court dispositions often more closely resemble criminal sanctions.¹⁸ Holding juveniles in detention or sending them to corrections is usually based more on the need for security than treatment. At times, preserving a minor's legal rights may occur at the expense of his or her well being. The court and legal system can act in ways that are anti-therapeutic even when attempting to help the juveniles.

1. An Example of Non-Therapeutic Application of Legal Rights

State of the art crisis intervention, such as Critical Incident Stress Debriefing, emphasizes early intervention after a traumatic incident.¹⁹ Assessing victims quickly and getting them to talk about the incident may help prevent later post-traumatic symptoms. That the immediate provision of crisis services at least attenuates the severity of emotional reactions is not a new belief.²⁰ Current practice trains teams of psychiatric crisis workers to respond immediately to mass casualty disasters in order to circumvent long term emotional distress.²¹ Arguably, the two young murderers discussed above were involved in a traumatic incident, causing them to face their own form of crisis.²² They killed a boy, were quickly arrested, and were placed in the detention center where they remained for over a year as the movement toward trial and sentencing slowly progressed. They were not permitted to return home and did not receive therapy during the detention stay. Defense attorneys challenged the charges and, presumably, counseled their clients to exercise their Fifth Amendment right to remain silent.

18. See, e.g., Maricopa County Juvenile Action No. J-92130, 139 Ariz. 170, 173 (Ariz. App. 1984): "[I]t is simply too late in the day to conclude that dispositions for delinquent children, which include incarceration, fines and restitution, are not to be considered criminal sanctions"

19. See, e.g., David Wollman, *Critical Incident Stress Debriefing and Crisis Groups: A Review of the Literature*, 17 GROUP 70 (1993).

20. See, e.g., W.E. Morley, *Treatment of the Patient in Crisis*, 3 WESTERN MEDICINE 77 (1965).

21. MARLENEA.YOUNG, COMMUNITY CRISIS RESPONSE TEAM TRAINING MANUAL (2d ed. 1998).

22. To understand the trauma experienced by the young murderers in the case example, it is helpful to refer Caplan, who first defined "crisis" as a specific psychiatric term requiring four aspects: (1) an individual is faced with a novel and stressful event, (2) usual coping strategies are applied to deal with the event, (3) when these fail other coping responses are tried, and (4) if none succeed, the individual decompensates, potentially resulting in long-term psychological damage. GERALD CAPLAN, *PRINCIPLES OF PREVENTIVE PSYCHIATRY* (1964).

There are important legal reasons for discouraging defendants from discussing their actions with others outside of their legal team. From a strictly legal perspective, it is also necessary for a defendant to request and be permitted to pursue a full trial process. Exercise of these crucial legal rights, however, likely inhibited the ability of these young boys to mentally process the trauma they were experiencing. Psychological theory suggests that when a child is upset but does not talk about it, the child is more likely to “act-out” behaviorally.²³ Both minors in the murder case did misbehave while in detention, and some of their actions might be attributed to their inability to process the trauma they were experiencing.²⁴ The appellate court noted that between the two youths, there were sixty rule violations during their year in detention, including incidents of fighting, verbal outbursts toward staff, banging on doors, throwing food, using profanity, and in one case, urinating on another resident.²⁵ Detention center staff documented these acts and the state’s attorney used them against the boys in sentencing. Their behavior in detention was presented as evidence of why they were too dangerous to send directly to residential treatment. One can speculate that, had the boys entered a plea agreement rather than undergo a lengthy trial, they would have spent less time in detention. Or, had they been in treatment during their year in detention, they might have acted-out less. In either case, they might have had the opportunity to begin speaking with therapists about their ordeal sooner, allowing them to process their trauma verbally rather than through outbursts of disruptive behavior. Were this the case, evidence of improved behavior while in treatment might have helped them at the time of sentencing. Instead, by exercising their legal rights to remain silent and to have a trial, the defendants did not receive appropriate clinical interventions. From a TJ perspective, the boys’ stay in detention was “anti-therapeutic,” though still in their legal best interest.

23. While the original term “acting-out” was coined by Sigmund Freud in reference to a patient’s response to transference, the term has more commonly come to refer to behavior marked by low impulse control, easily triggered emotional outbursts, and outwardly expressive behavior. See, e.g., LAWRENCE EDWIN ABT & STUART L. WEISSMAN, *ACTING OUT: THEORETICAL AND CLINICAL ASPECTS* (1965).

24. See BRUNO BETTELHEIM, *Trauma and Reintegration*, in *SURVIVING AND OTHER ESSAYS* (1979).

25. *In re J.R.* 704 N.E. 2d 809 (Ill. App. Ct. 1998) (unpublished in part Nos. 1-96-0782 & 96-0979, 1998 Ill. App. LEXIS 837, at 63-68. (Ill. App. Dec. 4, 1998)).

II. THE JUVENILE JUSTICE AND MENTAL HEALTH SYSTEMS—WHY THEY DON'T WORK TOGETHER

A. *The Gap Between the Systems*

Recent federally funded research has begun to quantify the number of mentally ill children in the juvenile justice system. In 1995, Linda Teplin began a longitudinal study of minors in one urban juvenile detention facility. She found that over two-thirds of the males and three-fourths of the females had one or more alcohol, drug, or mental disorders.²⁶ Further, she found that over half of the juveniles with a mental illness had a co-occurring alcohol or substance abuse disorder and that fifteen percent of the juveniles had a major mental illness.²⁷ According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP), “recent federal initiatives are beginning to reveal the scope of the problem and the inadequacy of mental health care in juvenile correctional facilities.”²⁸ Given these rates of mental illness, OJJDP estimates that more than 670,000 youths in the juvenile justice system each year would meet diagnostic criteria for one or more disorders.

Traditionally, the mental health and juvenile justice systems have not worked closely together. In recent research, Lyons and colleagues interviewed juvenile court staff in several jurisdictions to compare the ways in which various juvenile court employees respond to mental health needs of detained youths.²⁹ Results showed that the staff most frequently relied on school evaluations (75%) or social histories (70.8%) to evaluate a juvenile’s mental health. Less frequently, they relied on psychological (58.3%), psychiatric (50%), or therapist (41.7%) reports.³⁰ These numbers show astonishingly little reliance on professional mental health reports. Even more shocking is data on juvenile court staff decisions to refer a minor for a mental health assessment. Half of the respondents in Lyons’s study said that they would make a mental health referral if they observed “abnormal behavior,” while only one-third would make a referral based on the recommendation of the court, and less than one-fourth would refer a juvenile for mental health services

26. Linda A. Teplin et al., *Psychiatric Disorders in Youth in Juvenile Detention*, 59 ARCHIVES GEN. PSYCHIATRY 1133, 1135 (2002).

27. *Id.*

28. This report may be accessed online from the OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION website. See MENTAL HEALTH ISSUES AND JUVENILE JUSTICE, April 19, 2001, at <http://ojjdp.ncrjs.org/about/01juvjust/010419.html> (visited Nov. 1, 2001).

29. Personal conversations with Dr. John S. Lyons (Spring 2000).

30. *Id.*

based on suicide attempts or self-mutilation.³¹ A mere 12.5% would refer a depressed or withdrawn minor for a mental health assessment.³² From the perspective of a mental health professional, all of these instances, particularly those involving suicide attempts and self-mutilation, should result in a mental health referral. Lyons's findings evidence a major gap between how professionals in the mental health and juvenile justice systems differ in their interpretations of youth behavior when making critical decisions.

1. Example of Self-Destructive Behavior in Detention

While touring a detention center in Illinois in 1999, the first author of this paper asked a staff member what he would do if a juvenile who was alone in his cell started banging his head and trying to hurt himself. The staff member explained that he would get a team together, unlock the juvenile's door, enter his cell, place his mattress on the floor, shackle the minor's hands and feet behind his back, and lay him on the mattress. A staff member would stay with the minor until he stopped banging his head. Staff would then remove the shackles, return the mattress to the frame, tend to any wounds, and return the minor to his locked cell. No mention was made of a mental health referral.

Lack of interaction between the mental health and juvenile justice system is a two-way problem. The Surgeon General of the United States refers to the prevalence of mentally ill juveniles in the justice system in several of his recent reports. In his report on Children's Mental Health, the Surgeon General states, "too often, children who are not identified as having mental health problems and who do not receive services end up in jail. Children and families are suffering."³³ He also acknowledges the difficulty of getting mental health services for a child; "the system for delivering mental health services to children and their families is complex, sometimes to the point of inscrutability—a patchwork of providers, interventions and payers."³⁴ In addition to the difficulties faced by all children and families, mentally ill minors in the juvenile justice system are often refused services by mental health providers.

31. *Id.*

32. *Id.*

33. This report may be accessed online from the Surgeon General's website. See REPORT OF THE SURGEON GENERAL'S CONFERENCE ON CHILDREN'S MENTAL HEALTH: A NATIONAL ACTIVE AGENDA, at <http://www.surgeongeneral.gov/cmh/childreport.html> (visited Nov. 1, 2001).

34. This report may be accessed online from the Surgeon General's Web site. See MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, 1999, at <http://www.surgeongeneral.gov/library/mentalhealth/home.html> (visited Nov. 1, 2001).

2. An Example of Mental Health Refusing to Treat a Juvenile Delinquent

The first author was in a juvenile courtroom when a judge asked for assistance in referring a youth for psychiatric medication. The minor was on probation, had just returned home from residential placement, and was doing well but was running out of the medication he had previously been prescribed. The author contacted the local mental health center. When the supervisor of the mental health center heard that the referral was from juvenile court, she refused to accept the intake because her agency “only worked with children who were mentally ill and not with delinquents.”³⁵ The belief that juvenile delinquents and mentally ill youths are mutually exclusive groups must be challenged in order to begin to bridge the gap between mental health and juvenile justice.

B. An Increasing Problem

Not only is there a gap between the mental health and juvenile justice systems, but the gap is one that has the potential to widen. For multiple reasons, including managed care, budget cuts, and recent “get tough” policies in juvenile justice, the number of mentally ill minors coming into the juvenile justice system is at risk of increasing.³⁶ Many of these children do not receive adequate mental health care either before, during, or after their involvement with juvenile justice.

Secondary concerns include the issues of school violence (only some of which involves mentally ill minors) and the disproportionate impact of more punitive juvenile justice laws upon minorities.³⁷ Because the juvenile justice system already has a disproportionate number of minorities in the system and mental health care is inadequate, minorities

35. A discussion of the “mad” versus “bad” distinction, outlining differences between those offenders whose unlawful behavior can be attributed to mental abnormalities versus those whose illegal acts are the result of moral corruption can be found in Andrew D. Campbell, *Kansas v. Hendricks: Absent a Clear Meaning of Punishment, States are Permitted to Violate Double Jeopardy Clause*, 30 LOY. U. CHI. L.J. 87, 92 (1998); See also Carol S. Steiker, *Punishment and Procedure: Punishment Theory and the Criminal-Civil Procedural Divide*, 85 GEO. L.J. 775, 794 (1997).

36. Linda Teplin has suggested that the rise of managed care and Medicaid reductions have resulted in fewer mentally ill youth receiving appropriate mental health services, and as a consequence enter into the juvenile justice system. See Teplin et al., *supra* note 26.

37. See BRYAN VOSSEKUIL ET AL., SAFE SCHOOL INITIATIVE: AN INTERIM REPORT ON THE PREVENTION OF TARGETED VIOLENCE IN SCHOOLS (U.S. Secret Service 2000), at <http://treas.gov/ussf/ntac.shtml>.

often suffer more from the inadequacy of the system. The question remains, though, why the gap exists at all.³⁸

C. *Contrasting the Systems*

Given that there are mentally ill minors in the juvenile justice system and youths with juvenile court charges in the mental health system, it would seem natural for these systems to work together. Yet, several differences keep them apart, some obvious and some more subtle.

1. Funding

Traditionally, both the juvenile justice and children's mental health systems are underfunded. Both systems tend to be treated as secondary to their adult counterparts. That is, the adult criminal justice system and the adult mental health system deal with many more cases than their juvenile divisions and often more serious cases. Until the recent spate of school shootings, new funding was often difficult to obtain. Which system becomes responsible for funding the treatment of a mentally ill delinquent often depends on whether the minor is in custody. If a minor is in detention or corrections, that system must pay for the care of the minor. If an unfunded mentally ill minor is in the community, the mental health system carries the obligation of funding treatment with the juvenile justice system often having the option of funding community programs. A financial incentive may exist to get a minor out of either system rather than retaining the minor and carrying the burden of linking the youth with an additional system. Joint projects to address the needs of these minors are unlikely to be developed because both systems are overtaxed and have few resources.

2. Boundaries

Another barrier to the systems working together is political and jurisdictional boundaries. In states such as Illinois, the courts are organized on a county basis, while the office of mental health is a state organization. Both contract with private providers for some services. Decision makers at the various levels face distinct issues and may have inconsistent priorities with no single higher authority to resolve these differences.

38. Michael Finley & Marc Schindler, *Primitive Juvenile Justice Policies and the Impact on Minority Youth*, 63-DEC. FED. PROBATION 11 (December 1999).

3. Language

An additional obvious difference is the languages used in each system. Both have their technical terms and acronyms which can be confusing to those not in the field. Lawyers may be confused as to why a "borderline" I.Q. is nothing like a "borderline" personality disorder, or why "rule out" means that the diagnosis is still in consideration. Mental health professionals may be equally confused by a case being stricken with leave (SOL) or any number of Latin phrases that may be used in their client's case.

4. The Essential Component of a Case

A more subtle difference is what forms the essential component of a case in the two systems. In juvenile justice, a youth's behavior leads to a criminal charge and this underlying charge is essential to a case. Without a criminal charge, there is no case. Only if there is a conviction on a charge does the court have the ability to sentence a defendant. The trial process is aimed at resolving the criminal charge. By contrast, in mental health a client's symptoms lead to a diagnosis. This diagnosis is the essential component of a case. The diagnosis shapes the treatment plan. Insurance and managed care benefits are referenced to the diagnosis. Only if the client has a diagnosable mental illness can the system plan and provide treatment aimed at controlling the symptoms of that diagnosis. Both the conviction and the diagnosis remain on a person's record even after the case is closed.

Sometimes, the charge and the diagnosis can both be relevant to the same event, as is the case of an act that results in an insanity defense. At other times, the two components do not overlap. Not all symptoms are behaviors that lead to a criminal charge. A person cannot be prosecuted for hallucinating or for feeling depressed. Not all criminal behaviors are symptoms that lead to a diagnosis. Charging a person with theft or possession of a stolen motor vehicle does not give much clinical information. Even when a behavior is a basis for both a criminal charge and a diagnosis, as with some drug use or violence, both systems will assess this behavior differently. They will also address the actor differently. They will have different goals, and they will have to make different kinds of decisions about the case. The criminal charge and the diagnosis will both remain essential elements but they may drive the case in different directions.

5. Dichotomous vs. Continuous Decisionmaking.

Another more subtle difference between the juvenile justice and mental health systems involves their styles of thinking. Courts need to make dichotomous decisions about defendants. Someone charged with a crime must be found either guilty or not guilty. He will be fit for trial or unfit. He will be held in detention or released. Cases have clear beginnings and ends with multiple decision points along the way.

In contrast, mental health providers work along a continuum, describing a person's functioning along certain dimensions. A client is not found either completely mentally ill or completely mentally healthy. The Diagnostic and Statistical Manual, 4th Edition, diagnoses people along five different axes.³⁹ One of the axes assesses functioning on a scale of 1 – 100 (rather than a dichotomous, binary 0 – 1). Medications can have a therapeutic range. Therapists often work with clients who make some progress and have some setbacks over time.

a. An Example of Decisionmaking in Mental Health Court

The interaction of the court and mental health systems can be cause for conflict. An example to set the stage for thinking about the juvenile court is in the mental health courts. At involuntary commitment hearings, the court typically needs to decide if the defendant has a mental illness (yes/no) and, because of that mental illness, if the defendant is dangerous to himself or others (yes/no). The law requires a mental health expert to testify at these hearings. Given the continuous nature of thinking in the mental health system, the expert may give less definitive testimony than the court would like. The experts can usually give a diagnosis, but may also acknowledge other possibilities. Looking at the same symptoms, one expert could talk about the defendant having a diagnosis of schizoaffective disorder while another describes him as having bipolar disorder, and a third says he has depression with psychotic features. There is enough overlap between categories that these differences would not necessarily be contradictory. Even more likely to frustrate the court, the experts will probably not want to testify to absolute dangerousness (yes/no), but will probably prefer to talk about risk factors. The more the experts qualify their testimony, the less useful it is to the courts.

39. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 4th ed. 1994) [hereinafter DSM-IV]. The DSM-IV is a collaboratively compiled manual that categorizes psychiatric disorders into a common nomenclature based on specific combinations of symptoms.

Similarly, in the juvenile courts, when there are traditional forensic issues that require expert testimony from a mental health professional, the court still needs to make dichotomous decisions. Again in this setting, the mental health and judicial styles of decisionmaking can come into conflict.

b. An Example of Decisionmaking in Juvenile Court

At the sentencing hearing of the two young offenders charged with the murder of Eric Morse, the state asked that the minors be sentenced to the Department of Corrections. The defense asked that the minors be sentenced to a residential treatment center. The attorneys were arguing for opposite sides of a dichotomous decision. One side argued the need for public safety, the other side argued the minors' need for therapy. The lead author was a member of the IRC that made a sentencing recommendation to the court. When asked whether the boys should go to corrections or to residential placement, he stated that this question could not be answered with a simple choice between two dichotomous alternatives. Instead, he argued for a continuum of care wherein the boys would begin in a secure (correctional) setting with treatment. When and if they responded to this level of care, they would be moved to less secure, more therapeutic settings. Rather than a single final order by the judge, this type of sentence would require on-going review. In sentencing these two juveniles, the judge considered the boys' mental health needs, adopting a continuum of care by ordering the boys to be placed in the Department of Corrections *and* to receive mandatory treatment. This became the "bold experiment."⁴⁰ This example shows that, in some instances, mental health and juvenile justice systems are required to work together, and that combining services from the juvenile justice and mental health systems is possible in order to reach a mutual solution. The question remains whether, despite their differences, the two systems can do so successfully.

40. Marx, *supra* note 1. In the Eric Morse case, Judge Kelly continued to oversee the case and one boy moved from corrections to residential to the community. The other boy picked up more charges in corrections and was tried as an adult. He now faces more years in adult prison. Thus, the headline at the beginning of the article, "One Convicted in Boy's Death Free, Second Lives Without Hope."

III. THE JUVENILE JUSTICE AND MENTAL HEALTH SYSTEMS—HOW THEY CAN WORK TOGETHER

This article has focused on how the juvenile justice system could benefit from the mental health system, but how these systems have not worked together. Returning to the concept of therapeutic jurisprudence, both the mental health and legal systems have theoretical bases that would allow the two systems to work together.

A. Common Theories

1. Balanced and Restorative Justice

One model of working with juveniles that has been a national initiative through the OJJDP is the Balanced and Restorative Justice (BARJ) Model.⁴¹ This model has three components: accountability, community safety, and competency development.⁴² The purpose of restorative justice is “to restore victims, restore offenders, and restore communities in a way that all stakeholders can agree is just.”⁴³ The goal of competency development seems most synonymous with mental health system principles. Competency development is that part of restorative justice that emphasizes using and enhancing the strengths of the juvenile, his family, and his community. It includes mental health services, where indicated, and emphasizes community based care.

2. Child and Adolescent Service System Program

In 1984, Congress established the Child and Adolescent Service System Program (CASSP), which is administered by the National Institute of Mental Health in an effort to promote “best practice

41. The Office of Juvenile Justice and Delinquency Prevention sets out the principles of balanced and restorative justice as follows:

Crime is injury. Crime hurts individual victims, communities, and juvenile offenders and creates an obligation to make things right. All parties should be part of the response to the crime, including the victim if he or she wishes, the community, and the juvenile offender. The victim's perspective is crucial to deciding how to repair the harm caused by the crime. Accountability for the juvenile offender means accepting responsibility and acting to repair the harm done. The community is responsible for the well-being of all its members, including both the victim and the offender.

OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, DEP'T. OF JUSTICE, 1998 GUIDE FOR IMPLEMENTING THE BALANCED AND RESTORATIVE JUSTICE MODEL 5.

42. *Id.*

43. John Braithwaite, *A Future Where Punishment is Marginalized: Realistic or Utopian?* 46 UCLA L. REV. 1727, 1743 (1999).

guidelines” when addressing the mental health needs of youths with serious mental illnesses.⁴⁴ Among the principles of this program are an emphasis on “a network of support services in the community, intensive nonresidential services, a strong partnership between parents and professionals, and response to the needs of a culturally diverse population.”⁴⁵ This model requires that services be family-centered, provide individualized treatment planning, and provide access to a full continuum of services including mental health services. CASSP emphasizes that these services be delivered in the least restrictive setting, through community-based and culturally-sensitive programs.

CASSP principles recognize that children with serious mental disorders may require numerous services and recommend that treatment, “bring together—in an interagency, coordinated fashion—services for children that wrap around the child and focus on the family to support the child’s strengths.”⁴⁶ While the original CASSP model described a wide variety of services that may be necessary to “wrap” around children and families, the model did not address the provision of legal services, nor the integration of these services with the juvenile justice system. Yet, the BARJ concept of competency development fits nicely with the CASSP model in that they both focus on the needs and strengths of the youth and his family in community based care.

Moving beyond the theoretical level, a number of new mental health programs for juvenile offenders are consistent with BARJ and CASSP principles. Each of these programs is currently being studied. Despite all the difficulties with the two systems working together, these programs are being implemented successfully.

B. The Juvenile Justice Process

An understanding of the juvenile justice process contributes to a more meaningful comparison of some of the different programs being developed to work with mentally ill youths in the juvenile justice system. For these purposes, the juvenile justice process has five relevant steps.

44. See Jane Knitzer, *Policy Perspectives on the Problem*, in CHRONIC MENTAL ILLNESS IN CHILDREN AND ADOLESCENTS 64 (John G. Looney ed., 1988); Charles Day & Michael C. Roberts, *Activities of the Child and Adolescent Service System Program for Improving Mental Health Services for Children and Families*, 20 J. OF CLINICAL CHILD PSYCHOL. 340 (1991).

45. Jeanne T. Hernandez et al., *Development of an Innovative Child and Youth Mental Health Training and Services Delivery Project*, 43 HOSP. & CMTY. PSYCHIATRY 375, 375 (1992) (citing A.J. Duchnowski & R.M. Friedman, *Children’s Mental Health: Challenges for the Nineties*, 17 J. MENTAL HEALTH ADMIN. 3-12 (1990)).

46. James Preis, *Advocacy for the Mental Health Needs of Children in California*, 31 LOY. L.A. L. REV. 937, 938-939 (1998).

Table 1: Juvenile Justice Process

1. Police Arrest Juvenile
2. Juvenile Placed in Detention Center
3. Juvenile Court Case Begins
4. Trial / Conviction
5. Sentencing

This process outlines the basic procedure for those minors who are arrested, tried, and sentenced. Not all of these steps are mandatory. For example, not all juveniles who are arrested have cases filed in court, nor are they all placed in detention. Not all juveniles whose cases are filed in court are convicted. Depending on what stage of the process is being examined, different numbers of juveniles are in the system, and different numbers of mentally ill clients are anticipated.

Table 2: Number of Juveniles in Justice Process

Juvenile Justice Process	Illinois – 1998
1. Police Arrest Juvenile	111,000
2. Juvenile Placed in Detention Center	18,451
3. Juvenile Court Case Begins	26,295
4. Trial / Conviction	13,137
5. Sentencing	4,251 to Alcohol, Drug or Mental Health Program

Table 2 simply lists the number of cases from Illinois in 1998 that existed at each step.⁴⁷ Any mental health agency designing a mental health intervention at one of these steps needs to consider the scope of the task in terms of the legal issues involved as well as the number of juveniles at that stage of the process.

47. Data from Illinois Department of Human Services, Division of Community Health and Prevention, Bureau of Youth Services and Delinquency Prevention and from the 1998 Annual Report on the Status of Juvenile Detention in Illinois, adopted by the Illinois Juvenile Justice Commission, June 15, 2000.

C. Mental Health Interventions in the Juvenile Justice System

Consistent with BARJ and CASSP, multiple community-based models are currently being implemented to work with mentally ill juveniles in the justice system. These programs can initially be categorized by the point in the juvenile justice process where they intervene. This also gives a perspective on the number of juveniles each program attempts to reach.

Table 3: Community Based Mental Health Programs in the Juvenile Justice Process

Juvenile Justice Process	Community Based Mental Health Program
1. Police Arrest	1. Community Assessment Centers
2. Juvenile Placed in Detention Center	2. Mental Health Juvenile Justice Initiative
3. Juvenile Court Case Begins	3. Mental Health Courts
4. Trial/Conviction	4. Fitness to Stand Trial/Insanity
5. Sentencing	5. Wraparound Milwaukee Multi Systemic Therapy

Each of these programs attempts to provide services for mentally ill juveniles, but does so at a different point in the process and with different services. Three of the programs have been cited by the Office of Juvenile Justice and Delinquency Prevention and by the Surgeon General as model programs in working with juvenile offenders. The Fitness/Insanity program listed is not a new service, but is a traditional service and is included for purposes of comparison.

1. Community Assessment Centers

Community Assessment Centers (CAC) exist in many jurisdictions throughout the United States and are twenty-four hour centralized points of intake and assessment for juveniles. These centers provide a drop-off point for local law enforcement officials to bring juveniles taken into their custody. CACs allow for immediate assessment and can result

in other referrals. Multiple agencies, including juvenile justice and community service agencies, coordinate the assessment. In that way, a minor need not be asked the same questions multiple times over a series of interviews. This method is used not only in juvenile justice but also in child protection in the screening of children who may have been abused or neglected.

Each agency provides funding and staff around the clock, which makes this one of the more expensive interventions reviewed. CACs do thorough mental illness assessments and usually do not have mental illness prescreening requirements because they are a starting point in the assessment process. The primary services provided are assessment and referral with some follow-up and tracking services possible.

2. Mental Health Juvenile Justice Initiative

The Mental Health Juvenile Justice Initiative (MHJJ) is an Illinois Department of Human Services, Office of Mental Health program that identifies juveniles in detention centers with severe mental illness. A local community mental health agency provides the court with a liaison whose full time job is to link minors who have had contact with detention to community based mental health services. The liaison conducts a preliminary assessment of minors exhibiting symptoms or behaviors that might suggest mental illness. For those who are found to have a severe mental illness, the liaison creates a treatment plan that indicates what services the juvenile needs (including not only mental health, but also substance abuse, special education, and public health), locates where these services are available in the community, and identifies how to pay for these services. The plan is then given to the court. The liaison does not interfere with the criminal case, but informs the court that it has a minor in detention who has a major mental illness with specific needs that can be treated in the community. If the minor is released to the community, the liaison assists the family with linkage to needed services for a period of six months.

MHJJ is funded through a single agency, the state Office of Mental Health (OMH). It funds liaisons in every county that has a detention center and provides flex money to be used when other funding sources are unavailable. The main service of MHJJ is identification and linkage. Since it uses the existing community services system, the program is less expensive than most of the other programs reviewed here. The program targets the most severely mentally ill children who are already being held in detention. Thus, it focuses on minors who are in the most trouble and are the most disturbed.

This particular program is the newest program of all those presented and is not yet endorsed on a federal level. It began as a pilot program at seven detention centers in Illinois in the year 2000. In the first full year of the program, the liaisons conducted over 500 evaluations and identified over 200 minors with severe mental illness. Early indications show that those mentally ill minors who do get treatment in the community function better, attend school more regularly, and have lower recidivism rates than other detainees. The program had enough early success that the state legislature funded expansion of the MHJJ program to all detention centers in the state of Illinois in 2002.

3. Mental Health Courts

In areas with Mental Health Courts (MHC), certain misdemeanor cases are diverted to a specific courtroom where the staff has expertise with mentally ill defendants. The court works with social service agencies to provide mental health referrals for the defendant, and the court then monitors compliance. Selection criteria can specify the severity of mental illness and the type of offense that will be handled by the MHC. If the defendant cooperates with the treatment plan, the criminal charges can be dropped. The primary service of the court is monitoring treatment compliance.

Multiple agencies provide staff for the MHC courtrooms, including some clinical staff. However, unlike the CACs, the courtroom need not be staffed twenty-four hours per day, seven days a week. Thus, MHCs are less expensive. Until recently, these courts were implemented only for adult criminal courts rather than juvenile courts. However, in 2001, a juvenile court in Santa Clara County, California began its own version of a mental health court.⁴⁸

4. Fitness to Stand Trial and Insanity

Mental health treatment related to fitness to stand trial or insanity is not new. Applying these concepts to juvenile justice cases, however, is becoming more frequent.⁴⁹ While the laws usually do not distinguish between adults and minors, the treatment provided may differ.⁵⁰ In

48. See AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY TASK FORCE ON JUVENILE JUSTICE REFORM, Oct., 2001 RECOMMENDATIONS FOR JUVENILE JUSTICE REFORM.

49. See Thomas Grisso, *Dealing with Juveniles' Competence to Stand Trial: What We Need to Know*, 18 QUINNIAC L. REV. 371 (1999).

50. JUVENILE COMPETENCY COMMISSION, 2001 FINAL REPORT OF THE JUVENILE COMPETENCY COMMISSION (submitted to Richard Devine, State's Attorney of Cook County, Illinois, August 2001).

particular, some juvenile programs are making an effort to be consistent with CASSP principles.

a. An Example of Treating Unfit Minors on an Outpatient Basis

Two minors, along with several other youths, vandalized a school. These two brothers were arrested, found unfit to stand trial, and ordered to outpatient treatment through the Illinois Office of Mental Health (OMH). OMH initially treated these cases like an adult who had been found unfit to stand trial, and informed the boys' mother that they needed to attend fitness restoration treatment at an outpatient clinic in a suburban medical center that had a forensic program. It was a good treatment program used successfully by many adults. The mother had six children, however, and was raising them by herself, relying on public aid. She had to take all the children on several buses to reach the medical center. The family did not make most of the appointments. After reviewing the case with the court and its child and adolescent network, the OMH Forensic Bureau revised the program. OMH organized a staffing with the family, the local mental health agency, the school, and the public defender. Using CASSP wraparound principles, the team drew up a plan where the local mental health agency sent a staff member to the family home once a week. They coordinated care with the school, assisted the mother with literacy training, and addressed housing issues. The plan was successful enough that OMH switched to this model for its unfit juveniles ordered to outpatient care.

5. Wraparound Milwaukee

Wraparound Milwaukee in Milwaukee, Wisconsin is a publicly funded Care Management Organization (CMO), similar to a managed care organization.⁵¹ This organization oversees mental health, substance abuse, and social service care for convicted juveniles referred to it from the juvenile justice or child protection systems. Based on a wraparound model, the program pays for community care, residential care, inpatient hospitalization, and has mobile community crisis teams.

Wraparound Milwaukee is an expensive program because it pays for all levels of mental health services and does not refuse to treat any

51. See Bruce Kamradt, *Wraparound Milwaukee: Aiding Youth with Mental Health Needs*, 7 JUV. JUS. J. (2000), available at http://www.ncjrs.org/html/ojjdp/jijnl_2000_4/wrap.html.

juvenile referred by the courts.⁵² This program serves a managed care function and is funded by multiple agencies.

6. MultiSystemic Therapy

MultiSystemic Therapy (MST) is an actual treatment model rather than a service delivery program. It is an intensive home-based cognitive-behavioral therapy.⁵³ The program's emphasis is on juveniles with behavior disorders. MST is an appropriate treatment for juveniles with minor mental illness, but traditionally excludes minors with severe mental illness. In this model, a clinician carries a limited number of cases with intensive supervision from the national MST site. The clinician works with a family for several months and assists them in developing a self-sustaining network in the community.

MST can be funded by a single agency that hires a clinical team and contracts with the MST site in South Carolina for training and supervision of clinicians. This model is an alternative to residential treatment and to using multiple providers. Given that many of the minors served by MST would otherwise be in residential care, courts can arguably recoup their costs and, therefore, MST is very cost efficient.

D. Comparison of Programs

Each of the programs just reviewed emphasizes community based mental health care for youths in the juvenile justice system. These programs vary as to the point in the juvenile justice system at which they intervene, how they are funded, their costs, their target populations, and the services they offer.

52. The Fiscal Year 2000 budget for Wraparound Milwaukee was \$29 million. Information presented at the 15th Annual Statewide Forensic Conference: Community Programs. October 17, 2000. Chicago, IL.

53. See Scott Henggeler, *Multisystemic Therapy: An Overview of Clinical Procedures, Outcomes, and Policy Implications*, 4 CHILD PSYCHOL. & PSYCHIATRY REV. 2 (1999).

Table 4: Comparison of Mental Health Programs

	CAC	MHJJ	MHC	WM	MST
Point of Intervention	Police Arrest	Detention Center	Juvenile Court Case	Sentencing	Sentencing
Funding Agencies	Multi-Agency	Single Agency	Multi-Agency	Multi-Agency	Single Agency
Costs	\$\$\$	\$	\$\$	\$\$\$\$	\$\$
Target Population	All Mental Illness	Severe Mental Illness	Misdemeanor All Mental Illness	All Mental Illness	Behavior Disorders Mild Mental Illness
Services	Assessment	Linkage	Legal Oversight	Managed Care	Home-Based Therapy

As is evidenced by these descriptions, there are a number of creative options consistent with the principles of both CASSP and BARJ for providing community based mental health care to youths in the juvenile justice system. Each of these services has both costs and limitations. At a national level, few jurisdictions employ these services, and nowhere are these programs provided concurrently. Interestingly, these services are not mutually exclusive. That is, in an ideal setting, a mentally ill youth who was arrested could move from an assessment center, to a detention center with treatment planning, to a mental health court, to a court order for community-based services. Such a plan would begin to approximate a more comprehensive approach to treating mentally ill juveniles in the juvenile justice system, and allow the juvenile courts to embrace the tenets of therapeutic jurisprudence.

Had this ideal system existed at the time of Eric Morse's murder, a more therapeutic outcome might have been possible. The police, at the time of arresting the ten and eleven year old boys, could have taken them to an assessment center where treatment needs might have been identified. Given the security issues, the two boys would still be held in detention, but when they began acting out there they could have received a mental health evaluation and intervention. Due to the severity of the charge and lack of major mental illness, these boys would

probably not have gone to mental health court. At sentencing, however, the juvenile judge would have had more treatment oriented alternatives available. Even if both were again sentenced to corrections, the availability of community alternatives might have brought the one boy back to the community sooner. These current attempts to bridge the gap between the mental health and juvenile justice systems can increase the hope of many young offenders and reduce the despair for them and their families.

IV. CONCLUSION

Using Therapeutic Jurisprudence as a lens, it is apparent that juvenile courts, as presently structured, function in both therapeutic and antitherapeutic capacities. Some of the antitherapeutic effects are unavoidable given the natures of the legal and mental health systems. More disturbing is the fact that the juvenile justice and mental health systems do not work well together even when there are opportunities to do so. The two systems remain far from a comprehensive system of care. This article reviewed current theories of juvenile justice and community mental health as well as programmatic attempts to integrate mental health care with juvenile justice that allow these systems to work more closely. The best hope for therapeutic jurisprudence lies in the use of community based programs for the mentally ill juvenile offenders.

