

Juvenile Mental Health Court: Rationale and Protocols

BY DAVID E. ARREDONDO, M.D., KURT KUMLI, J.D., LARRY SOTO, LCSW,
ENRIQUE COLIN, J.D., JILL ORNELLAS, B.A., JUDGE RAYMOND J. DAVILLA, JR.,
JUDGE LEONARD P. EDWARDS, AND JUDGE EUGENE M. HYMAN

A B S T R A C T

INTRODUCTION

On Feb. 14, 2001, the nation's first juvenile mental health court processed its debut calendar in Santa Clara County (San Jose), California. This debut was the culmination of nine months of judicially convened meetings to establish ground rules and develop relationships. It took the efforts of many contributors—from multiple disciplines under strong judicial sponsorship and leadership—to realize the goal of becoming the first county in the nation aimed at making mental health concerns a priority in dealing with certain juvenile offenders. Although the court required

Under the sponsorship of the judiciary, the Santa Clara County, California Juvenile Court, in partnership with the Juvenile Mental Health Department and a technical assistance agency (SOLOMON), has pioneered a Juvenile Mental Health Court for seriously mentally ill children who have become involved in the criminal justice system. The judiciary, probation department, district attorney, public defender, county counsel, and service providers have collectively embarked upon the implementation of a modern approach to mental health diagnosis, triage, and treatment services for youth and families who come in contact with the justice system as a result of the combination of serious mental illness and juvenile delinquency. This article presents the court's rationale and protocols.

the realignment of existing resources, it did not require significant new financial resources or personnel for its operation.

This court represents the long overdue systemic interaction of two primary stakeholders that play an integral role in the lives of a growing segment of today's

delinquent youth: mental health and juvenile justice. It operates on the principle that neither institution has the exclusive solution to the complex problems presented by mentally ill children who commit delinquent acts, a principle that is confirmed by the abysmal track record of both in dealing with the issue independently.

David Arredondo, M.D. is the director of SOLOMON, a pro bono psychiatric consulting service for juvenile and family court judges and the Medical Director of EMQ Children and Family Services.

Kurt Kumli, J.D. is the head of the Juvenile Delinquency Division of the Santa Clara County District Attorney's Office. He is the co-author of California Juvenile Courts Practice and Procedure and serves on the faculty for the American Prosecutors Research Institute, the California District Attorneys Association, and San Jose State University.

Larry Soto, LCSW is the Assistant Division Director of the Department of Family and Children's Services of the Santa Clara County Mental Health Department. He has extensive experience providing and developing program services for adults, children, and families.

Jill Ornellas is the Supervising Probation Officer of the Santa Clara County Juvenile Domestic and Family Violence Unit and the Juvenile Mental Health Court (CITA).

Enrique Colin, J.D. has been with the Santa Clara County Public Defender's Office since 1991. His assignments have included misdemeanor trial team, felony trial team, research, and supervising attorney of the juvenile division.

Judge Raymond J. Davilla, Jr. has served as Supervising Judge of the Family Court and currently serves as Supervising Judge of the Santa Clara County Juvenile Delinquency Court. He presides over the Juvenile Mental Health Court.

Judge Leonard Edwards is the Supervising Judge of the Santa Clara County Juvenile Dependency Court. He is the President Elect of the National Council of Juvenile and Family Court Judges.

Judge Eugene M. Hyman is a judge of the Superior Court for Santa Clara County where his legal interests have been in the areas of delinquency substance abuse, mental health, and domestic violence. He has lectured, presented, and written on these topics in Canada, Australia, and the U.S.

Since its inception, the court has been a source of remarkable cross-disciplinary teaching and learning. It has transcended the “silo effect” of different vocabularies, approaches, training, and habits with the sincere desire to better serve youth, victims, and the community. Eligibility criteria were narrowly and formally defined. Mental illness was restricted to biologically determined illness.

Contributors to the court have learned many lessons. Ongoing attitude adjustments were required to assess each youth from multiple points of view simultaneously. Participants had to learn the different vocabularies and “bottom lines” of each discipline involved. Certain “kinds” of kids were surprisingly over-represented. From the mental health perspective, it was the kids with affective illness (depression, bipolar disorder) and borderline mental retardation. From a prosecutor’s point of view, it was the number of kids charged with making threats that was surprisingly high. Public defenders were surprised at how much resistance there was to the “mental health” label, so the name of the court was subsequently changed to CITA—*Court for the Individualized Treatment of Adolescents*. Probation

officers were surprised to see how many young people had clearly documented personal and family histories of biological mental illness and how many girls were charged with family violence.

The interdisciplinary learning continues at a rapid pace. Remarkably, it is rare when a balance between the best interests of the child, his or her family, the victim, and the community is not reached. Although the court is still a work in progress and protocols will be reviewed at least annually, two essential ingredients have emerged as prerequisites to implementation: strong judicial leadership and the unrelenting determination to better serve the best interests of each child, their families, and the community. Jurisdictions throughout the country have expressed an interest in adapting Santa Clara County’s model to meet their needs.

Others will look for reasons why a similar court would not work in their jurisdictions. The fact is, with minimal resources, the CITA model can work virtually anywhere. The most important contributions necessary are an open mind and a desire to prevent mentally ill kids from getting mired in a system that is ill-equipped to rehabilitate them.

Case #1 — Art M.

Art, 14, was one of many “frequent flyers” in Santa Clara County’s juvenile justice system — a young person who committed one offense after another: auto theft, possession of stolen property, assault.

Traditional rehabilitative efforts meted out by the court, juvenile counselors at the county’s rehabilitation facility (The Ranch), and probation officers seemed ineffective for Art. He ran from the ranch several times and repeatedly violated the conditions of his probation.

Then his case was screened for mental health court, and he qualified because it was discovered he had severe attention deficit hyperactivity disorder (ADHD), learning disabilities, and was still a bedwetter. That alone answered a host of questions, including why he couldn’t be successful in the highly disciplined, close-quarters ranch environment. He was petrified that the other boys would find out that he still wet the bed.

Art was committed to six months in juvenile hall (where he was given a separate room) and was made eligible for days away with his family at his probation officer’s discretion. Since being given appropriate medication, Art has stopped wetting the bed for the first time ever. He is now on medication, his ADHD is very much improved, and he is seeing a therapist weekly with his mother and stepfather.

Art admitted that if he were confined at the ranch, he would have continued to run. He was ashamed of his bedwetting problem, and because of his severe ADHD, he had much difficulty understanding and following through on the complex instructions that were part of daily life at the facility. If Art had not been diagnosed and treated as an individual by the system, he would have continued to escalate and would have “failed his way to the top.” Oftentimes, young teenage bedwetters will become more and more aggressive in order to mask their shame. In Art’s case, his predictable trajectory of increasingly serious delinquency and system involvement was interrupted by an informed individualized intervention. Because of their stage of development, adolescents are establishing identities they will carry well into adulthood. Art was quickly establishing a self identity of “delinquent loser.” Without individualized interventions, he would have most assuredly gotten worse, not better.

Rationale

Like fever, delinquent behavior in juveniles is a non-specific symptom with many possible causes. Among these causes are biologically-based brain disorders and cognitive disabilities. The rate of serious mental illness among juvenile offenders is conservatively estimated to be 15% to 20%. Estimates of less serious illness are in the range of 40% to 70% (Pumariega et al., 1999; Steiner, Garcia & Matthews, 1996). The rate of substantially diminished cognitive ability is unknown, but experience indicates that it is high. All three estimates point to a serious failure of the mental health community and the juvenile justice system to effectively screen, triage, and treat youth with co-morbid behavioral, developmental, and psychiatric problems (Butterfield, 2000; National Council of Juvenile and Family Court Judges, 2000).

This situation is legally and medically indefensible. From a legal point of view, undiagnosed and untreated serious mental illness or incapacity may constitute a circumstance of diminished competence or culpability. Locking up a child who is hallucinating or delusional may also be a violation of the constitutional right to be free from cruel and unusual punishment. From a juvenile justice perspective, failure to treat mental illness that causes, or contributes to, delinquent behavior is antithetical to the goals of offender rehabilitation and community safety.

From a medical point of view, undiagnosed and untreated brain disorders in children are especially intolerable because of their long-term impact on normal psychological and social development. Furthermore, unnecessary and preventable suffering is sometimes prolonged rather than diminished. From both medical and legal perspectives, undiagnosed psychiatric conditions are a clear impediment to effective and humane intervention to prevent further delinquency.

The juvenile justice system is not a mental health service delivery system for kids with severe mental illness. Its charge is to provide swift and sure consequences to young people who have broken the law and to help them turn away from delinquent behaviors by holding them accountable for their actions and helping them develop the skills and strategies necessary to become productive citizens. Nevertheless, the delinquency court has become a final common pathway for many youth with biologically-based brain disorders that

manifest as severe emotional and behavioral disturbance. This is unfortunate for two reasons: First, it often represents ineffective—and sometimes inhumane—treatment of mentally ill offenders in juvenile detention facilities. Second, it represents a misuse of detention beds in facilities—like juvenile halls—that are already often overcrowded.

The Santa Clara County Court for Individualized Treatment of Adolescents (CITA) is a multidisciplinary response to the difficult issue of mentally ill juvenile offenders who have been referred to the delinquency system. A specialized Juvenile Mental Health Court, CITA, holds adolescent offenders strictly accountable for their behavior while matching them to appropriate diagnostic, therapeutic, and aftercare interventions. It provides many benefits to all parties involved in the system.

Early identification of youth with serious mental illness opens the door for more effective and humane treatment of these children. And it provides for the development of constructive working relationships between the court and the treatment providers' coordinated and effective plans. Probation and juvenile hall staff are equipped with increased safety planning and resources to respond to self-harm and suicidality issues in the youths under their care. The system benefits from decreased recidivism, an improved match of resources to needs, fewer unnecessary detentions, and better use of expensive juvenile detention beds. The court benefits from expedited processing of its caseload and the satisfaction that individualized dispositions are realized for each child.

Families benefit from enhanced communication and working relationships with mental health, probation, the court, and community service providers. Families are provided with accurate identification and education regarding biologically-based brain disorders, which manifest as emotional and behavioral disturbance in their children. Clinical outcomes are improved when youth and families understand the context of a disability as it applies to both the behavior of the child and the family environment.

Other positive program impacts of CITA include better identification of mental health resource needs for seriously mentally ill children in the juvenile justice system; clarification of rates of dual diagnosis (substance

abuse and mental illness); and documentation of prevalence rates for diagnostic categories in detained populations. Better matching of treatment needs to available resources, and identification of priorities for resource development, will produce more effective longitudinal coordination of care and rehabilitation services. Additionally, there is enhanced involvement of family members and the incorporation of parent perspectives in the juvenile court process, aftercare, and mental health treatment services.

The goal is to increase humane and effective services for seriously mentally ill juvenile offenders while enhancing community safety. There have been expressions of interest in this approach from other counties in California, and other states and national experts are watching closely. It is hoped that CITA can serve as a model for other jurisdictions struggling with the problem of seriously mentally ill juvenile offenders.

Scope of the Problem

a) Emerging and Urgent Needs

Well-designed studies throughout the nation reflect a prevalence rate of mental disorders among youths in juvenile justice facilities as very high. The Coalition for Juvenile Justice in Washington, a federally financed group appointed by the nation's governors, estimates that 50% to 75% of teenagers in the juvenile justice system nationwide have a diagnosable mental disorder. Many are mentally retarded. It is estimated that 15% to 20% of them suffer from a severe biologically-based mental illness like bipolar disorder or schizophrenia. Most experts agree that *at least* one out of every five youths in the juvenile justice system have serious mental health problems (Wilson, 2000; Teplin, 2001; Seltzer, 2001; Pumariega et al., 1999; Steiner et al., 1996; Lyons, Baerger, Quigley, Erlich, & Griffin, 2001). Santa Clara County's data is consistent with the national projections. The Massachusetts Youth Screening Instrument (MAYSI) (Grisso & Barnum, 2000)—a validated and normed probation screening tool—was utilized to assess 1,700 youth admitted to Santa Clara County juvenile detention. The MAYSI, which measures nine domains, found detained youth to be significantly impaired compared to the general juvenile population.

Among youth detained in Santa Clara County during 2001:

- 37% had experienced severe traumatic experiences (had seen someone severely injured or killed);
- 19% were significantly depressed;
- 10% had given up hope for their life;
- 9% had symptoms consistent with psychosis; and
- 8% reported thinking of suicide.

b) Service System Gaps

In the initial stages of designing CITA, service gap analyses were conducted by representatives from the county's mental health, probation, district attorney, and public defender's offices.

The team found significant gaps, primarily in screening and assessing young offenders with severe mental illness early in the court process. They found that the system didn't do a good job identifying juveniles with mental illness, and when it did identify those problems, there was a disconnect when it came to delivering mental health services.

Lack of adequate resources was a problem. There was virtually no access to short-term (14- to 90-day) beds in appropriate psychiatric diagnostic facilities as an alternative to putting young, mentally ill offenders in juvenile hall or another county facility. Linkage to community services was unreliable. Departmental efforts—between mental health, probation and aftercare providers—were often fragmented, and communication across disciplines was inadequate.

Youths and families, for a variety of reasons, often wouldn't get—or stay—connected to services. Young people with medication or treatment needs would often re-offend and be back in custody before any coordinated treatment plan could be developed. Community-based workers and wrap-around services¹ (EMQ, 2001) for families in the community were in short supply. Those services—which provide therapy, parent partners, and behavioral specialists to assess the family's needs—are critical for a family's long-term success, and the

team's task was to find a way to get families connected with those resources.

Getting families connected with community-based resources accomplishes a number of things: It empowers parents and provides intervention for at-risk younger siblings prior to the offender returning home. The therapeutic component also works with minors in custody to help them begin to address issues without many of the community stressors that impact behavioral issues in the home. Home visits with a therapist enable the family to simulate reunification at home. Community workers also substantially bolster the intensive supervision that probation officers provide to Juvenile Mental Health Court minors, providing another set of eyes and ears, all working in the best interest of the minors and their families.

Each service provided to the juvenile offenders becomes another thread in the safety net—which is the ultimate goal of a mental health court. By combining all these resources in the true spirit of

“wraparound” services, the minors have the added benefit of the support of other adults who are trained to help minors work through the ebbs and flows in their daily lives.

Creating Santa Clara County's Juvenile Mental Health Court forced team members from all departments to open their minds, look for creative solutions, and work together in a way they hadn't before.

Under the juvenile court's oversight, it has become clear that professionals can work as treatment team members relaying their expertise and delivering services effectively. As a result, the treatment and service needs for youth and their families have become an integral part of the court process. And ultimately, young people benefit by timely access to services, increased follow-up and case management by multiple professionals, and a reduction in mental health or crime-related setbacks.

Case #2 — Melissa G.

When Melissa told her parents about the hallucinations that haunted her, they assumed the hallucinations were a by-product of their daughter's methamphetamine abuse. After all, she had been arrested for being under the influence of amphetamines, vandalism, and petty theft—common criminal activity for young users with serious drug problems.

When Melissa was screened for mental health court and diagnosed with schizophrenia with obsessive-compulsive symptoms, her parents were embarrassed and ashamed. In addition to hearing frightening voices, Melissa's obsessive-compulsive symptoms were so severe that after having a cigarette, she would wait at least five minutes—continually checking to be sure the cigarette butt was no longer smoldering. She also had paranoid delusions. Incarceration of children who are delusional makes their thoughts and behavior become even more bizarre. Most often, kids with this diagnosis are terrified by their delusions and hallucinations.

With the help of the mental health court multidisciplinary team, a mental health clinician, and Melissa's probation officer, the judge and family began to understand Melissa's severe and chronic mental illness. Her parents were able to see Melissa's drug abuse for what it was—a method of self-medicating her symptoms. Her judge devised an alternative approach to hold her accountable for her behaviors while supporting her desperately needed psychiatric treatment.

Melissa, 17, was returned home on an electronic monitoring program and continued to take her medication as prescribed. She was placed in individual psychiatric treatment, family therapy, and a substance abuse recovery program. She is working toward a high school diploma. Both Melissa and her mother have said that, for the first time in her teenage years, they have a relationship they both cherish. None of this would have been possible without the accurate diagnosis, medication follow-through, and an individualized treatment approach designed by the mental health court.

c) **Description of Target Population**

1) General Population Demographics

Minority youth are highly over-represented in the entire juvenile justice system and also within the target population of the CITA. Santa Clara County, like most locales throughout the nation, struggles with the pressing issue of disproportionate minority confinement in secure juvenile facilities. In Santa Clara County, Latino and African American youth accounted for 63% of the FY1999 admits into juvenile hall, although they comprised only 33% of the total child population ages 10-17 (Kids in Common, 2000).

From a geographic perspective, juvenile law violation in Santa Clara County is most prevalent in the Child Poverty Zones (Community Benefits Coalition, 1998). These areas are characterized by: lower income and educational achievement levels; higher proportions of substandard housing; higher levels of health risk behaviors and poorer overall health indicators; and higher percentages of monolingual and limited-English-speaking households than the county norm.

2) Specific Target Population Demographics

Any young person arrested in Santa Clara County is potentially eligible for the mental health court. Between July 1, 2000 and June 30, 2001, there were 12,955 referrals to the county's juvenile justice system. This includes 4,730 cases that resulted in minors being placed in Juvenile Hall, the majority for less than 48 hours.²

3) Diagnostic Criteria

CITA's target population is juveniles with a serious mental illness (SMI) that has contributed to their criminal activity, and likely, to their involvement with the juvenile justice system. For project purposes, the definition of SMI includes:

- Brain conditions with a genetic component, including major depression, bipolar disorders,

schizophrenia, severe anxiety disorders, severe ADHD³;

- Developmental disabilities such as pervasive developmental disorders, mental retardation, and autism;
- Brain syndromes, including severe head injury.

Unless complicated by another condition, adjustment reactions, oppositional defiant disorders, conduct disorder, and personality disorders would not qualify juveniles for CITA.

4) Offense Criteria

CITA serves delinquent wards of the court who have been diagnosed with severe mental illness. Minors may be referred to the court upon a violation of probation or commission of most crimes. Certain serious or violent felonies would preclude a minor from participating in the program.⁴

Positive Program Impacts of CITA

Positive program impacts were anticipated to include:

- More humane and effective treatment of children suffering from mental illness;
- Decreased recidivism;
- Improved matching of mental health and community resources to the needs of juvenile offenders;
- More efficient use of juvenile detention beds and decreased overcrowding of detention facilities;
- Better identification and clarification of mental health resource development needs, such as community-based programs as alternatives for children with serious mental illness and delinquent behaviors;
- Identification of prevalence rates for diagnostic categories in detained populations such as dual diagnosis, substance abuse, and mental illness;
- Increased safety around self-harm and suicidality issues;
- More accurate education about biologically-based mental illnesses for families;
- Enhanced communication and working relationships between mental health, probation, and the

Case #3 — Pablo D.

Pablo, 16, is the perfect example of a young man with mental health issues who becomes mired in the juvenile justice system.

Initially arrested for misdemeanor assault, vandalism, and brandishing a deadly weapon, Pablo was sentenced to three months in juvenile hall and sent home on electronic monitoring after 30 days. Pablo failed to show up for reviews, tested positive for drugs, and wasn't following the electronic monitoring conditions. He was arrested again for assault and sent to the county rehabilitation facility (The Ranch).

Pablo spent more than more than eight months trying to complete a four-month program. Once Pablo was kicked out of the program for making suicidal statements. After being cleared by mental health workers, Pablo was returned to The Ranch and promptly escaped again.

This scenario continued for months, and Pablo seemed to be failing dismally. He escaped from placement numerous times. He assaulted another ward when he was mocked for being "psycho." Each time, Pablo would go back to court, and judges would keep sending him back to The Ranch.

Nearly a year after his initial arrest, Pablo's case was screened for mental health court eligibility. He was found to be suffering from bipolar disorder (manic-depression—a biological condition). With this information from the multidisciplinary team, the judge could be sure that more detention would not work. Bipolar disorder is a condition which gets progressively worse if left untreated. The juvenile mental health court judge placed Pablo on an electronic monitoring program for 90 days and sent him home.

After returning home, and with clear directives from the judge, Pablo made great strides in complying with the conditions of his probation and psychiatric treatment. He began to see a therapist to work on managing his rollercoaster emotions and a psychiatrist for medication. He began taking responsibility for his illness and accepting consequences for his behaviors. He enrolled in his local high school and went out for the football team. When he started to lag behind in school, Pablo approached his probation officer and asked for help. Together, Pablo, his probation officer, and a school counselor created an education plan.

His relationships with his family, teachers, judge, and his probation officer continue to improve. Had this change in approach not occurred, Pablo would be worse, not better. In fact, instead of helping him, the system could have harmed him. Pablo's case demonstrates that adding the mental health perspective provided critical information for devising an individualized plan that worked. Without this information from the multidisciplinary team, there is little doubt that Pablo would have remained in detention until he aged out or the system gave up.

- juvenile justice system and improved linkages and relations with community mental health providers;
- More effective longitudinal coordination of children's care and/or rehabilitation;
- Enhanced involvement of family members in both the juvenile court process and mental health treatment services;
- Expedited court processing of youth with serious mental illness;
- Increased dispositional alternatives for judges.

Cultural Competence

Children and families from different cultures and ethnicities respond differently to serious mental illness and legal entanglement. Some of these differences are in response to social stigmas, which remain stubbornly

associated with mental illness even though science has shown that these illnesses are biologically based. Because different cultural subgroups express and experience stigma differently, it is of paramount importance that juvenile mental health courts strive for cultural competence and the ability to successfully provide services to culturally diverse populations. This competence first requires a genuine respect for the culture being served. Accordingly, a knowledge of historical factors that impact attitudes of subgroups—such as immigration patterns, psychosocial stressors, trauma, acculturation and economic pressures—is desirable. Furthermore, there must be an understanding of cultural relationships to both legal and medical service providers. This requires the skill and motivation to understand children and families using a strength-based

perspective (Dunst, Trivette, & Deal, 1994; Rutter, 1987; Saleebey, 1997) while incorporating psychological, social, cultural, political, and spiritual dimensions. And it requires formulating treatment plans that are culturally attuned to the individual and family concept of mental health and illness (Arredondo, 2001).

One of the earliest experiences of the juvenile mental health court was many adolescents' resistance to the term "Mental Health Court." Hence, the name was changed to the less stigmatizing "Court for the Individualized Treatment of Adolescents" or CITA.⁵

General Roles Defined

Members of the CITA Multi-Disciplinary Team (MDT) play individual roles as well as act collectively. Members of the MDT include representatives from mental health, probation officers, prosecutors, and defense counsel. As team members, they work together to reach a common understanding of how the best interests of the child with mental illness, his or her family, victims, and the community might be served. This process is challenging and intense, as barriers of language and professional culture must be transcended in order to make the wisest recommendation to the court. The interchanges are virtually always educational across disciplines as each disciplinary representative struggles to understand the perspectives of the others' roles. Although consensus is not guaranteed, the process almost always results in greater understanding and better recommendations to the court. Below are short descriptions of the roles of different team members and the disciplines they represent:

Mental Health

The mental health coordinator is responsible for presenting the mental health assessment findings—psychological, behavioral, social, familial, educational issues—to the MDT team. The mental health coordinator is an active participant who works collaboratively to coordinate overall assessment, treatment planning, and disposition of the minor. This includes case management of youthful offenders and maintaining contact with community mental health providers in order to monitor progress and treatment compliance.

The mental health coordinator conducts compre-

hensive mental health assessments of the adolescents and their families to determine whether they are eligible for CITA. Based on the assessment, youth are referred, when clinically indicated, to a child and adolescent psychiatrist⁶ for a medication evaluation. The coordinator also offers a clinical impression about the youth's readiness to reintegrate into the community. In addition, the youth's educational needs are assessed, which may include identification of youth who are eligible for special education services.

Probation

The probation department's role is to implement the directives of the court and supervise each minor while assisting in the development of the minor's treatment plan. The CITA probation officer acts as a liaison to community mental health treatment programs to provide for a continuum of service for minors suffering serious mental illness. The probation officer also coordinates with educational advocates to ensure that the minor's academic needs have been identified and that appropriate services are being rendered. The probation officer also facilitates the presentation of information at the CITA Multi-Disciplinary Team meeting and provides information and recommendations to the court when appropriate.

District Attorney

Multi-Disciplinary Team Member

A prosecutor is specially assigned to the CITA Multi-Disciplinary Team for the purpose of assessing minors' current conduct and criminal history relative to their suitability for the program. If a minor is deemed suitable and acceptable to the program, the prosecutor contributes to the formulation and implementation of the treatment plan.

It is imperative that the information discussed in the context of the MDT is shared solely for the purpose of assessing the minor and implementing his or her treatment plan for CITA. In this regard, the role of the prosecutor in the MDT is significantly different than that of the conventional trial advocate. To this end, the information discussed in the MDT is not to be transmitted outside of the team or used against the minor in subsequent court hearings.

CITA Prosecutor

Once placed in CITA, the minors' cases are handled vertically⁷ by a specially assigned prosecutor, not a member of the MDT. This attorney, like the prosecutor assigned to the MDT, is trained in mental health issues with an emphasis on a multi-agency collaborative approach.

Public Defender/Defense Attorney

Multi-Disciplinary Team Member

The deputy public defender assigned to the MDT is trained to recognize and handle issues in CITA. In addition, it is essential that the assigned attorney plays a role as a member of the MDT that advocates for a treatment plan which is in the best interest of the minor. Like other MDT members, the deputy public defender educates other members about relevant defense considerations.

Minor's Attorney

The deputy public defender, retained counsel, or conflicts panel attorney assigned to the individual minor's case reviews whether the minor meets CITA eligibility. The minor's attorney reviews the minor's psychiatric history and seeks a psychological evaluation, if necessary. Once the minor's attorney has the needed information, the attorney determines whether it is in the minor's legal interest to participate in CITA. Once minors are accepted into CITA, their attorneys continue to represent them throughout the process.

Court

The Superior Court judge assigned to the Juvenile Delinquency Mental Health Court calendar handles the case from acceptance through dismissal. In the case of Santa Clara County, the judge requested the assignment and expressed an interest in the specialized court. Judges who wish to serve in a court such as CITA should have—or be willing to develop—a sensitivity to mental health issues.

Operating Protocols

Confidentiality and Sharing of Information

In order to encourage juveniles to voluntarily participate in CITA, the Juvenile Court and partner agencies must agree that sharing confidential information about a juvenile between agencies is vital. Moreover, to protect

the psychotherapist-patient privilege, they must agree that the extent of mental health information to be shared is limited to the diagnosis, medication, and treatment plan. In particular, if any content-based information is disclosed, it shall not be used against the juvenile in any delinquency proceeding.

Any juvenile and parent or guardian of a juvenile who wishes to be considered for CITA will execute a Consent to Share Confidential Mental Health Information.⁸ The juvenile's attorney will also sign the form to indicate approval of the juvenile's participation in CITA. The form is provided to the CITA probation officer, who will obtain the particular information for use by the Multi-Disciplinary Team. The court and the Multi-Disciplinary Team will use this confidential mental health information to consider a juvenile's eligibility for CITA and also to check a juvenile's attendance and progress in treatment and recovery.

If a minor is not accepted by CITA, all mental health records will be returned to the respective providers. Agencies that do not provide mental health services will not retain any of the mental health records or information.

The authorization to share a juvenile's mental health information will be revoked upon the successful completion of, termination, or withdrawal from CITA, or one year from the date the consent form was executed, whichever is sooner.

Eligibility

CITA's goal is to target juveniles with serious mental illness (SMI) that has contributed to their delinquent conduct or protracted involvement with the juvenile justice system, or those who have not been successfully engaged by community mental health treatment agencies.

CITA currently accepts mentally ill juveniles petitioned with a range of misdemeanors and/or felony offenses. CITA accepts juveniles with prior adjudications. However, juveniles 14 and older at the time of the offense who are currently charged with or have previously sustained petitions for serious violent felonies are not eligible. The previously sustained violent offense must have been committed when the minor was 14 or older.

Juveniles who have committed certain violent

Juvenile Mental Health Court Screening, Assessment, and Aftercare

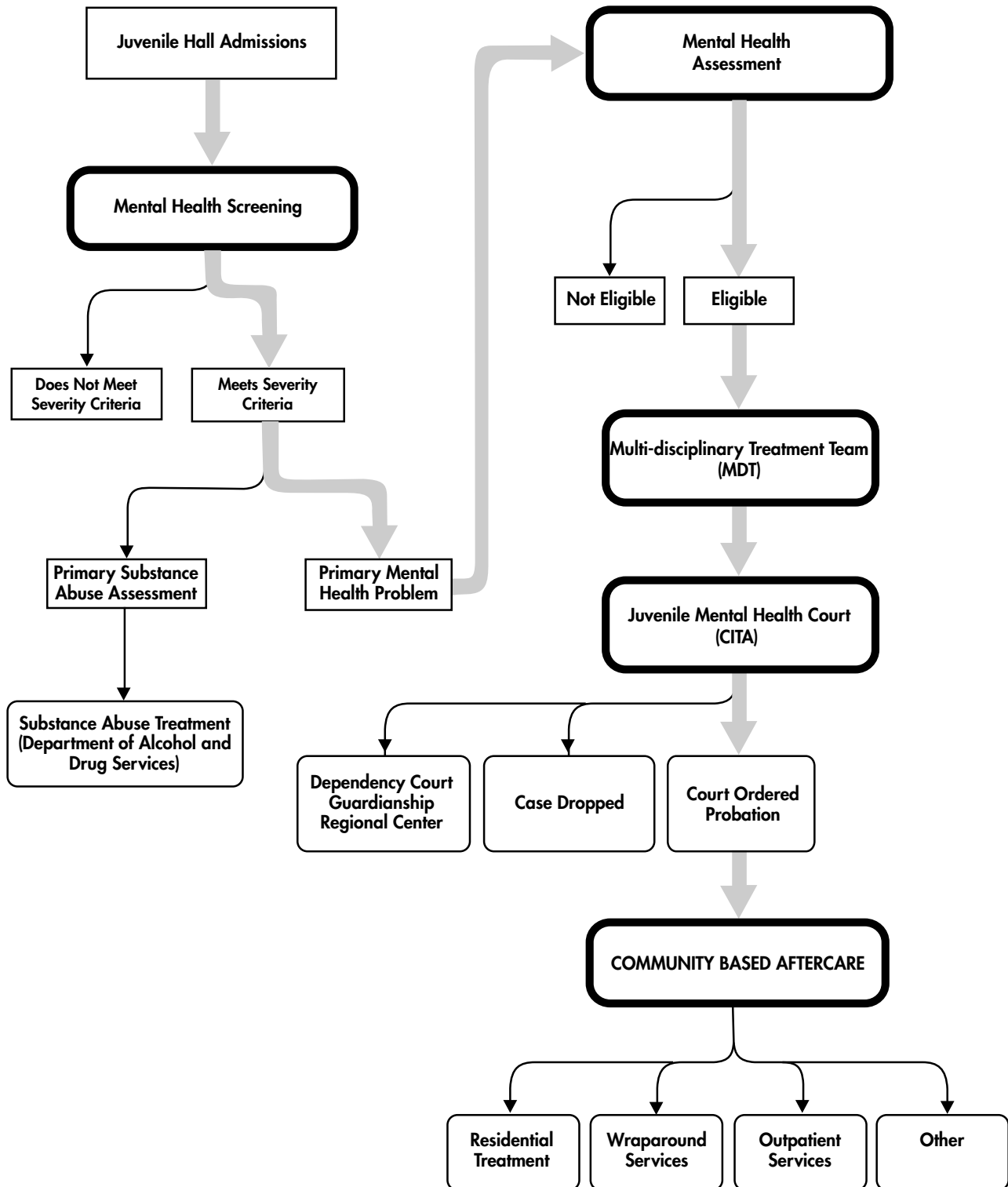


Fig. 1 — Flowchart of juvenile screening, assessment, and processing from the perspective of mental health providers.

offenses prior to their 14th birthday and other minors suspected of committing serious offenses are not automatically ineligible for the program. All matters referred to the MDT program will be reviewed on a case-by-case basis and may be included or excluded from the program based on the nature of conduct underlying the offense or the risk the minor presents to the safety of others.

Potential candidates must have been diagnosed with a biologically-based and serious mental illness, be developmentally disabled, or have an organic brain injury or head trauma. CITA uses these clinical criteria in order to concentrate its resources on juveniles who are seriously mentally ill or disabled.

A primary mental health diagnosis includes major depression, bipolar disorders, schizophrenia, mood or anxiety disorders, and certain impulse control disorders such as severe ADHD. Developmental disabilities include pervasive developmental disorders, mental retardation, and autism. Organic brain syndromes include severe head injury, severe cognitive deficit, and degenerative diseases of the brain.

Juveniles diagnosed with conduct disorder, oppositional defiant disorder, impulse control disorder, adjustment reactions or personality disorders will not be eligible for CITA unless the disorders are otherwise complicated by another (biologically-based) diagnosis.

Screening

a) Mental Health Screening

Mental health clinic staff at juvenile hall will screen all minors who are brought into custody and remain in juvenile hall.⁹ The mental health screening assists in identifying high-risk concerns, suicide indicators, other mental health symptoms, and substance abuse. If the screening reveals mental health concerns, a CITA referral may be made. Clinicians will also review existing caseload for potential referrals.

Minors will be identified for CITA referral through one or more of the following avenues:

- The Massachusetts Youth Screening Instrument (MAYSI 2) (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001), which is utilized for all new custody admissions;
- A search of the Mental Health Department's data

and information system of all new admissions;

- Chart reviews of new and existing minors on the clinician's caseload;
- Clinical interviews;
- Information provided by outside mental health professionals, parents, and school personnel.

Should the minor meet diagnostic and severity criteria for CITA, a referral form will be completed by the clinician and forwarded to the Mental Health Court coordinator for consideration.

The Mental Health Court coordinator will screen the referral with the CITA probation officer for offense suitability, and review additional available information that may assist with determination of CITA eligibility, such as psychological evaluations. In highly complex cases, where questions regarding the clinical diagnosis may exist, the mental health coordinator will seek consultation with:

- a clinic psychologist or psychiatrist;
- the minor's psychiatrist—if the minor was under a psychiatrist's care prior to detention;
- a licensed clinical psychologist; and
- an experienced, well-trained, senior licensed mental health clinician.

Once the minor is considered eligible for CITA, the CITA probation officer will present the information at the Multi-Disciplinary Team meeting, and a decision will be reached regarding acceptance to the program. This information will subsequently be provided to the CITA judge and a court date set.

Minors deemed eligible for CITA will receive a complete, comprehensive assessment. This may include the use of other psychological instruments, such as the computerized Diagnostic Interview Schedule for Children (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) or the Behavioral and Emotional Rating Scale (Epstein & Sharma, 1998). A thorough clinical interview, discussions with parents and/or guardians, and home visits—whenever possible—will also be performed.

When substance abuse is severe and determined to be the predominant disorder, youths will be referred to a concurrent diversion and treatment effort by the Santa Clara County Department of Alcohol and Drug Services

Probation Forensic Screening for Juvenile Mental Health Court Eligibility

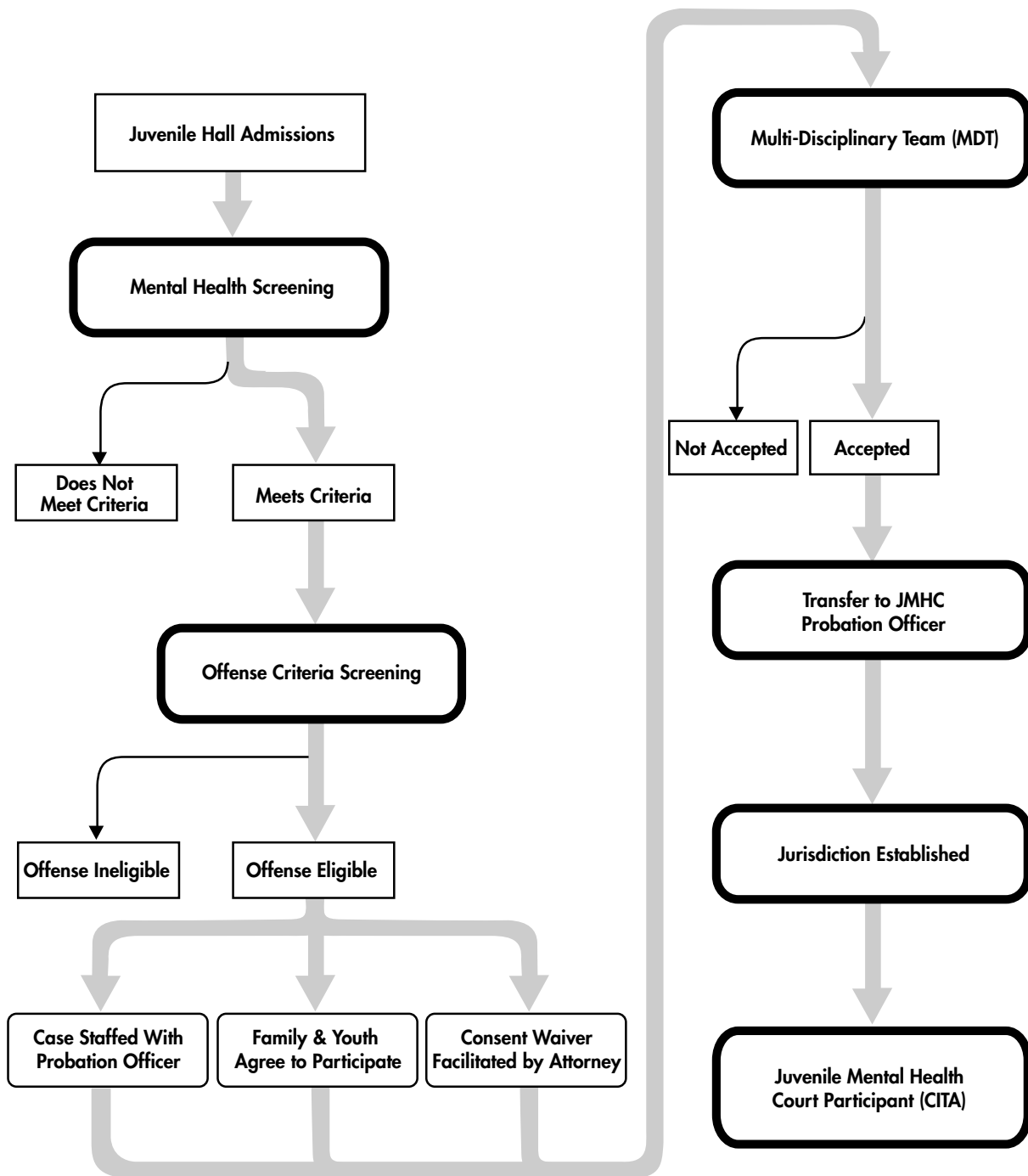


Fig.2—Flowchart of case processing from perspective of the departments of probation, prosecutor, and defense counsel.

within the juvenile justice system. CITA recognizes that the best approach is simultaneous treatment of all disorders by a dually-trained clinician or a cross-trained treatment team, whose members are competent to treat both the substance abuse and mental health disorder.

Based on the findings of the different multi-disciplinary team members, and in collaboration with the youths and their families, a treatment plan that addresses the critical needs of the minor will be developed. An Individualized Case Plan will be developed by the CITA multi-disciplinary team and signed by the treatment team, the minor, and his or her parents.

b) Probation Screening

The CITA probation officer coordinates with the juvenile mental health coordinator regarding in-custody minors who meet the court's eligibility criteria. The probation officer reviews the petitioned offense and prior conduct with the district attorney in order to determine eligibility. Once eligibility is determined, the CITA probation officer staffs the case with the originally assigned probation officer regarding mental health issues and then contacts the family to determine their willingness to participate in CITA.

The CITA probation officer facilitates a meeting with the minor and the parent to explain the CITA process and benefits. The CITA probation officer also evaluates the willingness of the minor and the parent to participate in the court. When a consent form is signed by the family and counsel, the CITA probation officer works in tandem with the mental health care clinician to gather further information from the minor, the family, and/or any treatment agencies who may have provided services to the minor and family.

The CITA probation officer then presents the minor's case to the CITA multidisciplinary team to determine acceptance into the program. Once the minor's case has been found eligible and is accepted, it is officially transferred to the CITA probation officer.

c) District Attorney Screening

The district attorney is responsible for reviewing police and probation reports prior to filing the petition on behalf of the minor. If a petition is filed, the prosecutor has the initial role in determining the minor's eligibility for the program based upon the seriousness of the

offense. This information is subsequently shared with the other members of the multi-disciplinary team when the minor's case is discussed for screening.

If the offense alleged is significantly different than the offense sustained, the district attorney is responsible for resubmitting the matter to the multi-disciplinary team in the event that prior ineligibility was based exclusively on the criminal activity. As a member of the multi-disciplinary team, the prosecutor considers each case in terms of statutory eligibility and the threat the minor presents to public safety.

d) Public Defender/Defense Attorney Screening

The assigned deputy public defender or defense counsel advises an eligible juvenile about whether he should participate in CITA or proceed under the regular juvenile court process. In addition to advising the minor about the nature of the offense, the consequences of entering an admission to the offense, and the constitutional rights, the defense attorney discusses with the minor the CITA process, including eligibility requirements, screening, assessment, the treatment plan, and appearances in court.

If the minor volunteers to participate in CITA, the defense attorney has the minor sign the Consent to Share Confidential Mental Health Information form. The defense attorney also signs the form to indicate his or her approval.

The defense attorney forwards the consent form to the Mental Health Department, which informs the CITA probation officer about the diagnosis, medication, and treatment plan. The CITA probation officer also receives a copy of the consent form.

Multi-Disciplinary Team Operating Values

In working together, each professional must understand and respect the others' perspectives, terminology, resources, and goals. Mental health professionals must accept the fact that accountability has a sound basis in an effective treatment for this population. Juvenile justice professionals must acknowledge that appropriate treatment for mentally ill youths is both humane, and ultimately, in the best interest of community safety.

The Juvenile Mental Health Court is based on the "Children's System of Care Core Values" (Stroul & Friedman, 1986, 1994). All of the "system of care"

practices have been fully integrated into the court's principles and standards. These include:

- The system of care is child-centered and family-focused.
- The system of care is community-based whenever possible.
- The system of care program is culturally competent.
- The families or caregivers of these children are full participants in all aspects of the planning and delivery of services.
- Children with serious emotional disabilities (SED) have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs in the least restrictive and normative environment that is clinically appropriate.
- Children with SED receive integrated and coordinated services with linkages among those agencies

involved in the development and implementation of these services.

- The program promotes early identification and intervention of children with SED.
- Children with SED will be ensured smooth transitions to the adult service system as they reach maturity.
- The rights of children with SED are to be protected.
- Children with SED receive services without regard to race, religion, national origin, sex, or physical disability.

Court Procedure

The judge will not be involved in the MDT or confidential decisions until the juvenile petition has been sustained. The judge's primary function is to fashion the most effective dispositions for the juvenile after carefully considering the needs of the minor, the safety of the community, and accountability for the inappropriate behavior.

Case #4 — David R.

If a picture paints a thousand words, the satanic images in David's vandalism should have screamed, "Help me!"

At 14, he was sent to juvenile hall for six months after vandalizing his school with satanic images, making threats, and downloading bomb-making instructions off the Internet.

Halfway through his juvenile hall detention, David's case was screened for juvenile mental health court eligibility. His diagnosis: major depression. David had previously been diagnosed with this biological condition, but had stopped taking his medication and began a spiral into deep despair, including isolation and self-mutilation. By the time he was arrested, David's parents were at their wits' end.

During his time in juvenile hall, David underwent an amazing transformation, both mentally and physically. Armed with information from the multi-disciplinary team, his judge, probation officer, and the facility mental health worker aligned to direct and support an individualized approach to David's behavior and his illness. He became engaged in therapy and resumed taking his medication. He successfully returned home (after he was evaluated as safe) and continued to make strides in taking responsibility for his behaviors and in addressing his mental health needs.

David began earning high marks in school and joined a boxing club through the local Police Athletic League. He is now brimming with self-esteem rather than self-loathing.

David can now speak openly and without shame about his illness. He also accepts responsibility for his behaviors and is beginning to understand what motivated them. He shares a special bond with his father who also suffers from depression. Had his brain disorder not been recognized, David's behaviors would have continued to escalate, and he would have continued to spiral deeper into the system. If children like David are not detected and treated early, they get progressively worse. Sometimes, if they fail to negotiate critical developmental processes in learning self-control and socialization, by the time they are adults, it is too late to help.

Conflict Resolution

While it is understood that traditional roles and interests may result in differences of opinion that will preclude a minor's involvement in CITA, or, at a minimum, delay the process, participants should strive to resolve such conflicts whenever possible. The hallmark of a successful mental health program is a multi-agency collaborative approach, which demands that traditional juvenile justice stakeholders adopt non-traditional roles to serve the best dispositional interests of the child. In the case of children with biologically-based mental disorders, the best interest of the child often includes encouraging treatment that might otherwise be resisted.

Probation Supervision/Intensive Specialized Community-Based Aftercare

a) Treatment Plan Implementation

Probation Conditions

The CITA probation officer participates in the development of an individual treatment plan for the minors and their families, along with the Mental Health Court coordinator and the court's MDT. Treatment plans will be incorporated into a comprehensive probation social study. The probation study will include appropriate recommendations, based on standard probation conditions, as well as conditions individualized to minors' needs and the petitioned offense.

Throughout the term of probation, the CITA probation officer and treatment providers will assist minors in complying with the treatment plan. The treatment plan will be revised based on minors' needs and progress in addressing their mental health issues.

Mental Health Treatment Plan

The Mental Health coordinator will develop a treatment plan with the adolescents and their families. The treatment plan will be consistent with the philosophy of the Mental Health Department, which is to provide services that are strength-based, family-focused, culturally proficient, and delivered in the least restrictive environment consistent with regard for safety.

The treatment plan will be comprehensive,

specific to the individual youth, and will include measurable goals and objectives. Specific target areas will be identified, and interventions and treatment strategies will be planned to address these needs. The treatment plan will be reviewed regularly.

A full range of mental health services will be made available to adolescents and their families as deemed clinically appropriate. Services may include:

- Individual supportive therapy or specialized psychotherapy;
- Family therapy;
- Group therapy;
- Emergency services/crisis intervention;
- Medication evaluation and support;
- Wraparound services;
- Other individualized services.

Judicial Review

Once the disposition has been ordered, the court will review the minor's progress every 30 to 90 days at review hearings. The court will inquire about the minor's schooling, medications, therapy, and counseling as well as any special probation conditions.

b) Probation Supervision

Juveniles with mental health issues face added familial, educational, and therapeutic stressors when returning to the community. Maximum supervision is provided for all CITA minors to assist with a positive transition, and maintenance, on all fronts. Department criteria defines maximum supervision as no less than two face-to-face visits a month with the minor and two collateral visits with other involved community members and/or family. The probation officer is responsible for face-to-face visits with each minor at home, school, or in any other appropriate community setting. In addition, the probation officer is expected to make at least two collateral contacts each month, keeping in constant contact with school personnel, treatment providers, psychiatrists, wraparound treatment team members, and most importantly, the minors' parents.

The majority of Mental Health Court minors have educational difficulties. Often, they are identified through the Individual Education Plan (IEP) process for severe emotional disabilities and/or learning disabilities. The probation officer is expected to attend yearly IEPs held for a minor, many of which have 30/60/90-day follow-up IEPs for assessing compliance with mental health services incorporated into the IEP goals and objectives. Contacts at each minor's school should include assistant principals, attendance secretaries, and behavioral specialists.

The probation officer is expected to work with minors and their families to help ensure that the mental health services being provided can sufficiently address the complexities of each minor's issues. Through constant contact with treatment providers, the probation officer should stay abreast of whether services need to be augmented, or whether additional, more intensive services are needed to help the minor maintain progress and be successful in the community. The probation officer should also attend family meetings for minors with wraparound and/or meet with other mental health service providers to participate in treatment planning and updates.

c) **Intensive Specialized Community-Based Aftercare**

Historically, prognosis is poor for youths returning to the same family dynamics, peer pressures, and negative community influences. Youths can easily fall back into harmful behavior patterns if they do not have the ability to make sound decisions, lack consistent support, or don't possess essential social skills. The likelihood of success is highly dependent upon consistent and effective treatment and support measures. With this in mind, the aftercare program will begin with a treatment planning meeting prior to releasing the adolescent into the community.

The treatment planning meeting should involve not only all CITA professionals and family members, but associated community members, such as school officials, extended family, and support personnel.

The meeting's purpose is to:

- Identify internal and external resources for the youth and family;
- Determine the least restrictive level of care that will meet the needs of the adolescent;
- Identify issues and concerns;
- Determine how these issues should be addressed and by whom;
- Coordinate so that all needed services will be in place without delays.

The treatment plan resulting from this meeting will be written into a contract and signed by all parties.

d) **Court Reviews**

- *Prior Orders Remain in Full Force and Effect*
Each juvenile will appear before the court for consistent reviews so that the court may be kept abreast of his progress. This allows juveniles to be commended on their progress, allows issues to be addressed as they arise, and allows therapists/community mental health treatment agencies to participate in court reviews if appropriate. Reviews are set according to each minor's needs, no more than biweekly and no less than every 90 days. Unless a violation of probation is alleged, all prior orders will remain in full force and effect, and a subsequent review will be set.

- *Revise Treatment Plan*

A treatment plan is established when the court's multi-disciplinary team screens a case and finds the juvenile eligible and acceptable to participate in CITA. The multi-disciplinary team assesses the services currently received by the juvenile and his or her family and seeks creative solutions to augment the treatment already in place. During the course of supervision, it may become necessary to review the initial treatment plan. The initial plan could be reviewed as a result of both strides and declines made by the juvenile on the path to healthy adaptation. The probation officer will consult with the juvenile's treatment providers to better define what changes—positive or negative—have

taken place. The providers will be invited, and encouraged, to participate in the multi-disciplinary team round table. A revised treatment plan will be developed as a result of input from all multi-disciplinary team participants. Follow-up MDT meetings—to assess the effectiveness of the newly implemented treatment plan—may be necessary.

- *Graduated Interventions*

During the supervision of juveniles participating in CITA, graduated interventions may be necessary to address violations of probation and/or deterioration of a juvenile's mental health. Interventions may include the additional structure and supervision of the electronic monitoring program, a period of time in juvenile hall or county rehabilitation facility to provide accountability, medication review-assessment-stabilization, and securing appropriate mental health services prior to returning home. Intervention may also result in the probation officer working with the juvenile's family to secure inpatient treatment through the family's insurance.

- *Completion/Dismissal*

The initial goal is for juveniles to successfully complete a minimum of one year on probation, unless placed on court-ordered informal probation. During the probation period, juveniles must demonstrate the ability to consistently participate in psychological counseling, medication compliance, and maintaining a generally positive attitude. They must comply with all general terms and conditions of probation as well as work with their families to develop stable, healthy relationships and living environments.

- *Program Termination*

This may occur when:

- The juvenile has successfully completed probation;
- The juvenile's mental health issues have stabilized;

- The program has been successfully completed;
- The juvenile commits a new crime or fails to follow court orders;
- The minor and/or parent withdraw from program.

Annual Protocol Review

The protocols will be reviewed annually by the Mental Health Court Team to ensure they are consistent with current law and best mental health intervention practices. The review of the protocol annually will additionally provide the opportunity for team building, an awareness of the protocol, educational opportunities for team members, and an introduction to the CITA process for new team members.

Conclusion

A more modern approach to juvenile delinquents with serious mental disorders is mandated by a convergence of interrelated factors. The neurobiological and genetic understanding of mental illness that has been achieved over the last quarter century makes it possible to detect and treat these illnesses earlier. The developmental consequences of not treating these conditions are becoming more obvious. The stigma associated with mental illness is decreasing, as the biological bases of these disorders are becoming better understood. The impacts on public safety and social order are becoming clear. The Santa Clara experience has demonstrated that, with judicial leadership, it is possible to overcome the interdisciplinary silo effect and transcend the barriers of language and tradition that have historically separated mental health and juvenile justice professionals. Inasmuch as the juvenile justice system must serve the interests of every child, victim, and community, active sponsorship and leadership are incumbent upon the juvenile and family court judge faced with the challenge of the mentally ill juvenile offender.

AUTHORS'
ADDRESSES:

David E. Arredondo, M.D.
251 Llewellyn Avenue
Campbell, CA 95008
E-mail: david@childrensprogram.org
www.childrensprogram.org

Kurt Kumli, J.D.
County Government Center, West Wing
70 W. Hedding Street
San Jose, CA 95110

Larry Soto, LCSW
828 S. Bascom Ave., Ste. 200
San Jose, CA 95128

Enrique Colin, J.D.
Public Defender Office
South County Facility
12429 Monterey Highway
San Martin, CA 95046

Jill Ornellas
Supervising Probation Officer
840 Guadalupe Parkway
San Jose, CA 95110

Judge Raymond J. Davilla, Jr.
Superior Court of California
191 N. First Street
San Jose, CA 95113

Judge Leonard P. Edwards
Superior Court of California
191 N. First Street
San Jose, CA 95113

Judge Eugene M. Hyman
Superior Court of California
191 N. First Street
San Jose, CA 95113

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END NOTES

- 1 Wraparound services are a community-based alternative to institutional care. They are individualized to meet the needs of an individual child and family where they live. In the case of CITA, these services also serve safety needs of mentally ill juvenile offenders and their communities.
- 2 Probation Department, Santa Clara County (2001). Internal departmental statistics.
- 3 For the purpose of CITA, severe ADHD is defined as serious enough to require institutional (residential) care or its equivalent—mental health wraparound services.
- 4 These offenses are specifically enumerated in California Welfare and Institutions Code Section 707(b). These offenses include most violent crimes that would generally result in a prison term if committed by an adult.
- 5 CITA means “quilt, blanket, or protective covering” in Latin. In Spanish it means “appointment.”
- 6 If a child psychiatrist is not readily available, oftentimes an adult psychiatrist with adolescent experience is sufficient.
- 7 One attorney handles the same case for the entirety of its duration in the delinquency process.
- 8 Original drafts of this document referred to a “Consent to Release of Confidential Mental Health Information.” Early experiences with the CITA multi-disciplinary team revealed that this term was over-broad and misinterpreted to mean giving the clinical record (client) *prior* to the youth being accepted in a CITA case.
- 9 MAYSI 2 (Massachusetts Youth Screening Instrument 2) screening occurs almost immediately after admission.

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