

Breaking the Cycle of Juvenile Justice: A Review of Juvenile Mental Health Courts

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Abstract

Juvenile mental health courts (JMHCs) are problem-solving courts devoted to serving youth offenders with mental illnesses. This current study offers a comprehensive review of JMHCs, linking the establishment of JMHCs to a broader historical context. Recent U.S. Supreme Court decisions (*Roper v. Simons*, 2005; *Graham v. Florida*, 2011; *Miller v. Alabama*, 2012; *Montgomery v. Louisiana*, 2016) and a brief history of reform in juvenile justice are discussed to highlight the context in which JMHCs emerged. The implementation of JMHCs and their empirical status, as well as their potential problems, are summarized. After reviewing empirical evidence of mental health courts (MHCs), the current research concludes that the appearance of JMHCs signals the possibility of breaking the cycle of juvenile justice, which has been often guided by the public sentiment.

Keywords

Juvenile Mental Health Courts, *Montgomery v. Louisiana*, 2016

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INTRODUCTION

On January 25, 2016, President Obama signed an executive order that banned solitary confinement of juvenile inmates in federal prisons (Eilperin, 2016). This announcement was significant because it followed the U.S. Supreme Court decision in *Montgomery v. Louisiana* (2016). The *Montgomery* decision settled the question regarding the retroactivity of *Miller v. Alabama* (2012), which addressed mandatory life without parole sentences. The current trends involving the landmark decisions reflect that juveniles are fundamentally different from adults, in part because their brains are not fully developed (The Sentencing Project, 2016). Current findings from collaborations between law and neuroscience fields highlight how different juveniles' brains are, thereby advocating for changes in the way juveniles are perceived in applications of law (Bonnie & Scott, 2013; Casey & Caudle, 2013; Steinberg, 2008). That is, juveniles are not as culpable as adults are, and they are susceptible to external factors, such as peer pressure (*Roper v. Simmons*, 2005).

In this regard, the ongoing enhancement and expansion of juvenile mental health courts (JMHC) are noteworthy; and the change aligns with the U.S. Supreme Court decisions. Because juveniles are characterized by a "lack of maturity and an underdeveloped sense of responsibility" (*Roper v. Simmons*, 2005, p. 569; see also *Miller v. Alabama*, 2012), it is difficult to ignore juveniles who have mental disorders in the justice system. Studies have reported that the percentage of juveniles in the justice system (e.g., correctional facilities and juvenile detention) suffering from mental disorders is estimated to be 65% to 70% across the U.S. (Shufelt & Coccozza, 2006; Wasserman, Ko, & McReynolds, 2004). While there are no statistics about national recidivism rates for youth offenders in the U.S., studies based on states show that the average rearrest rate for juveniles within one year of release from an institution is 55 percent (Snyder & Sickmund, 2006). The high proportion of juveniles with mental disorders in the justice system may account for high recidivism rates among youth offenders. Unfortunately, evidence indicates that there are not proper diagnostic and treatment services available in juvenile facilities (Callahan, Coccozza, Steadman, & Tillman, 2012). Additionally, many adolescents have been placed in juvenile facilities for minor and nonviolent offenses just because there have been insufficient

community-based services, making far-reaching collateral consequences for their future (General Accounting Office, 2003).

We have noted that because there is a lack of mental health services for youth in the juvenile system in general and in juvenile facilities (Snyder & Sickmund, 2006), there should be a system that can provide mental health services for the best interests of adolescents with mental health needs. JMHCs can serve as an alternative to the traditional juvenile justice approach by offering rehabilitation focused community-based mental health programs. Despite its importance, there have been only a few studies that are available owing to the recent adaptation to JMHCs from adult mental health courts (AMHCs) (Behnken, Bort, & Borbon, 2017; Callahan et al., 2012; Davis, Peterson-Badali, Weagant, & Skilling, 2015; Heretick & Russell, 2013). While the prospect of JMHCs is promising considering the findings from AMHCs, the juvenile justice policy has been often driven not only by logical reasoning such as the effectiveness of policy but also by the emotional whims that swing radically in reaction to media (Bernard & Kurlychek, 2010; Feld, 2013). Bernard and Kurlychek (2010) observed that juvenile justice policies are often following a cyclical pattern between lenient and harsh punishments according to how justice officials and the general public perceive juvenile crime. Based on this observation, Benard and Kurlychek coined the term, the cycle of juvenile justice.

This study aims to review JMHCs and how the advent of JMHCs fits the cycle of justice. In the next section, the U.S. Supreme Court decisions and a brief history of reform in juvenile justice are discussed to connect the establishment of JMHCs to a broader historical context. Then, the implementation of JMHCs and their empirical status are presented. Additionally, the potential problems of JMHCs are examined. After reviewing empirical evidence of mental health courts (MHCs), the current research concludes that the appearance of JMHCs signals the possibility of breaking the cycle of juvenile justice.

THE TIDE OF REFORM IN JUVENILE JUSTICE BEFORE ROPER V. SIMMONS

The American legal system dealt with juveniles who committed crimes as adult offenders before the end of the 19th century (Feld, 2013). This paradigm faced challenges from environmental factors like industrialization, urbanization, and population growth (Bernard & Kurlychek, 2010). The ideological shift in the explanation of crime from the classical school, which was based on the rationality of human beings, to positive criminology that stressed innate disposition, also contributed to the new paradigm to solve juvenile delinquency issues (Feld, 2013). The role of juvenile court was to provide an individually tailored treatment to meet juveniles' specific needs (Frost-Tift, 2013). The purpose of juvenile courts was different from traditional courts; these courts highlighted treatment for rehabilitation of juvenile delinquents. Juvenile courts used different terms in trials from those in the criminal court to avoid "a sense of fault, blame, accusation, guilt, and punishment" (Bernard & Kurlychek, 2010, p. 78). Instead, terms that were used in juvenile courts have symbolized a caring and a helping voice.

Procedural rights in juvenile courts were also dissimilar to those in criminal courts (Feld, 2013; Merlo, Benekos, & Champion, 2016). For instance, proceedings were confidential in juvenile courts, and they had no right to have a lawyer and jury court as well as public trial. Along with restraints, the rules of evidence were employed differently from criminal courts. While trials at criminal courts were held based on the probable cause, trials at juvenile courts were more like civil courts that are based on reasonable doubt (Feld, 2013).

A new tide of reform started followed by a series of court decisions that applied the same procedural protection and due process to juveniles as criminal courts (Frost-Tift, 2013; Shitama, 2013). This shift was closely related to the failures of the juvenile court. Regardless of original intent, abuses of discretion in juvenile court were pointed out (Merlo, Benekos, & Cook, 1997). After *In re Gault* (1967), adjudication hearings incorporated many elements of the adult criminal justice system (Bernard & Kurlychek, 2010).

The shift that intended to protect juveniles by providing rights produced unpredicted results. When juvenile crimes increased in the 1990s, a dramatic shift occurred. The guaranteed rights of juveniles led juvenile courts to punitive

decisions, and more juveniles were tried as adult offenders (Shitama, 2013). Using the concept of “amenability to treatment” as justification (Fagan, 2002, p. 11), more juvenile waiver decisions were made (Griffin, Addie, Adams, & Firestine, 2011). Simultaneously, most states passed punitive laws that enhanced sentencing options for juvenile courts and modified confidentiality provisions that characterized the traditional court (Snyder & Sickmund, 2006). Similarly, diverse ways to waive juveniles to adult courts and to relinquish the rights of juveniles surfaced (Griffin et al., 2011). The public also asked for harsher punishment against juveniles. This trend was accelerated as media portrayals of juvenile delinquents prevailed (Benekos & Merlo, 2006).

THE TIDE OF REFORM IN JUVENILE JUSTICE AFTER ROPER V. SIMMONS

The turn of the punitive trend started from the narrower issue of the juvenile justice system. The U.S. Supreme Court called the death penalty and juvenile life imprisonment without parole into question (Sickmund & Puzzanchera, 2014). The landmark decisions made during the twenty-first century have enforced the constitutional conditions for imposing sentences on juveniles (*Roper v. Simmons*, 2005; *Graham v. Florida*, 2010; *Miller v. Alabama*, 2012; *Montgomery v. Louisiana*, 2016). *Roper v. Simmons* (2005) was a prelude to this change. A seventeen-year-old boy, *Simmons*, was sentenced to the death penalty for the murder that he committed. The landmark court decision in *Atkins v. Virginia* (2002), however, provided the basis for *Simmons* to file an appeal. In *Atkins v. Virginia* (2002), the U.S. Supreme Court ruled that punishing persons with intellectual disabilities is unconstitutional.

Simmons used the same logic from *Atkins* arguing that the immaturity of juveniles reduces their culpability and increases their susceptibility to influence from external factors (The Sentencing Project, 2016). Furthermore, the personalities of juveniles are assumed not fully formed, but somewhat transitory (Bernard & Kurlychek, 2010). Accordingly, blameworthiness for juveniles, which originated from responsibility, should be diminished. The U.S. Supreme Court ruled that the death penalty is a disproportionate punishment for juveniles (*Roper v. Simmons*,

2005). This case established that the guiding philosophy of law should prioritize juveniles' inherent flaws.

The U.S. Supreme Court ruling in *Graham v. Florida* (2010) confirmed the consistent tendency in key decisions reflecting biological differences in juveniles. In writing for the majority, Justice Kennedy stated that "the concept of proportionality is central to the Eighth Amendment" (*Graham v. Florida*, 2010, p. 2021). In *Miller v. Alabama* (2012), Justice Kagan wrote once again that characteristics that are derived from being juveniles diminish their culpability; thereby, the status of being a juvenile should be an important mitigating factor in deciding the sentence. *Montgomery v. Louisiana* (2016) confirmed that the direction of the juvenile justice system should be founded on their differences from adults. These decisions imply that there should not be discordance between responsibility and the severity of punishment. The Court's decision in *Miller v. Alabama* (2012) explicitly mentioned that juveniles should be provided an "individualized consideration before sentencing a juvenile to life imprisonment without possibility of parole" (p. 2470).

The tendency in recent Supreme Court cases can be connected to the prospect of JMHCs in three ways. First, the fact that the U.S. Supreme Court has consulted psychological science to address legal questions involving adolescent maturity signals that the U.S. criminal justice system has been moving toward embracing the findings from psychology (Icenogle et al., 2019). The juvenile justice system has been marked by the cyclical patterns between lenient and harsh punishment, and public perceptions, not science, have often guided these patterns. However, the recent U.S. Supreme Court rulings involving legal status of juveniles suggest that psychological evidence related to the functional capacities of juveniles (e.g., mental health issues) can be taken more seriously at various stages of criminal justice, which coincides with the advent of juvenile mental health courts (Underwood & Washington, 2016). Second, if juveniles are considered as less culpable, punishing adolescents as if they are adults is not just. If juveniles are different from adults, it demands much attention to juveniles with mental illness (*Miller v. Alabama*, 2012). The decision from *Roper v. Simmons* (2005) leaves room for the correction of juveniles with mental disorders because this decision is based on the belief that characteristics of juveniles can change. Third, evidence from neuroscience that was included in the majority opinion in *Miller v. Alabama*

(2012) suggests that knowledge from neuroscience and developmental psychology should be considered to rehabilitate juvenile delinquents.

The trend of using psychological research in the U.S. Supreme Court indicates that lawmakers and policymakers are more willing to rely on science to guide and make their decisions (Steinberg, 2017). Simultaneously, scholars have provided a mountain of evidence that youth offenders are more likely to suffer from mental health disorders compared to general populations and adult offenders (Gilbert, Grande, Hallman, & Underwood, 2015; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Therefore, the discussions of recent US Supreme Court cases are important to understand the context in which juvenile mental health courts appeared, showing that scientists have weighted in guiding juvenile justice policies. Juvenile mental health courts will be viewed as a key juvenile justice policy in light of accumulating evidence involving juvenile offenders with mental disorders.

THE ADVENT OF THERAPEUTIC JURISPRUDENCE

The reasoning in *Miller v. Alabama* (2012) indicated that juveniles can commit crimes because of malfunction in the cognitive control system that governs and exercises the executive function (Steinberg, 2008). The executive function is responsible for deliberative thinking and impulse control, which can cause crime when it performs poorly. In discussing *Miller*, even the dissenting justices admitted that juveniles can be immature, reckless, and impetuous (*Miller v. Alabama*, 2012). The recognition of adolescents' limited brain functioning emphasizes the importance of neuroscience and developmental science to juvenile cases. Our understanding of the relationship between juveniles' brain development and mental health issues should be further investigated, and the findings should be employed in treatment. The mental health needs in the juvenile justice system has been reported as an urgent issue to address (Hoeve, McReynolds, Wasserman, & McMillan, 2013); 65% of incarcerated juveniles and 60% of detained juveniles were documented to exhibit one or more mental disorders, and also met the criteria for one or more mental disorders (Wasserman, McReynolds, Schwalbe, Keating, & Jones, 2010).

One recent meta-analysis shows that about 13% of children and adolescents are suffering from mental disorders around the world (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015), and this number peaks at 65% when it comes to incarcerated juveniles in the U.S. (Wasserman et al., 2010). These figures illuminate why criminal justice professionals started to look for alternatives to incarceration (Shufelt & Cocozza, 2006; Wasserman et al., 2004). MHCs are alternatives that reflect therapeutic jurisprudence (Slate, Buffington-Vollum, & Johnson, 2013). Therapeutic jurisprudence focuses on understanding therapeutic and anti-therapeutic consequences from substantive law, procedural law, and stakeholders (Winick & Wexler, 2003). This movement started from introspection about the traditional criminal defense model (Winick, 1997). Unlike the traditional model, therapeutic jurisprudence principles avoid “finding fault, assessing blame,” but rather they underline the “consideration for the consequences of decisions rendered by the justice system” (Slate et al., 2013, p. 384).

Therapeutic jurisprudence is the foundation of MHCs, avoiding punishment and the deterrence model so that rehabilitation of the offenders and restoration of the harm can be maximized (Lanni, 2005; Strong, Rantala, & Kyckelhahn, 2016). MHCs are specifically designed problem-solving courts for individuals with mental illnesses (Wolff, 2018). According to Goodale, Callahan, and Steadman (2013), MHCs have three core characteristics: (1) “a problem-solving orientation,” (2) “interdisciplinary collaboration,” and (3) “a focus on accountability” (p. 298). A rapidly increasing number of AMHCs and JMHCs demonstrate the paradigm shift from traditional jurisprudence to therapeutic jurisprudence.

In sum, the expansion of JMHCs is aligned with the signs of breaking the cycle of juvenile justice. First, the criminal justice system is gradually shifted from traditional jurisprudence to therapeutic jurisprudence. Second, the U.S. Supreme landmark decisions in juvenile justice allude to the importance of understanding juvenile mental health (*Roper v. Simons*, 2005; *Graham v. Florida*, 2010; *Miller v. Alabama*, 2012; *Montgomery v. Louisiana*, 2016). Finally, the evidence from empirical studies also indicates the efficacy of JMHCs in reducing recidivism and the cost of the system (Behnken, Arredondo, & Packman, 2009; Kubiak, Roddy, Comartin, & Tillander, 2015).

The establishment of JMHCs reflects major changes in the social understanding of mental health issues or capacities rather than a temporary or

cyclical phenomenon. Notable changes in criminal justice policy can support this argument. For instance, the Patient Protection and Affordable Care Act (ACA) helps individuals with a severe mental illness who are released from jails and who are eligible for Medicaid. Simultaneously, recent legislation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) ensures that mental illness is no longer less covered than physical illness (McGinty et al., 2015). These two acts allow those who have a mental illness to gain more accessible mental health services. A series of enactments of the legislation suggests that the public has better awareness concerning mental health issues.

THE OPERATION OF JMHCs AND THEIR EMPIRICAL STATUS

The tendency toward non-adversarial and rehabilitation-oriented juvenile court is not surprising given the tide of juvenile justice reform. This trend corresponds with empirical findings that demonstrate the ineffectiveness of the traditional approach to those with mental illness. For instance, a Miami-Dade County, Florida judge reported that 97 persons with a diagnosis of schizophrenia were arrested about 2,200 times and spent approximately 27,000 days in jail, which cost \$13 million during only five years (as cited in Slate et al., 2013, p. 271).

Studies about JMHCs have not been fully developed (Behnken et al., 2017), and little is known about their actual operation due to the recent adjustment for juveniles (Davis et al., 2015). It is thought that York County, Pennsylvania, first initiated the JMHC in 1998 (Callahan et al., 2012). Approximately 40 JMHCs were established from 2000 to 2010, and some JMHCs were discontinued (Callahan et al., 2012). The advent of mental health courts for adults (AMHCs) preceded JMHCs by approximately ten years. Therefore, the empirical findings of JMHCs are limited in comparison to AMHCs (Behnken et al., 2009; Heretick & Russell, 2013). When a national survey was conducted in 2009-2010, 15 states were operating JMHCs (Callahan et al., 2012). On the other hand, AMHCs are operating in nearly every state (Goodale et al., 2013) and that this number reaches over 300 (Strong et al., 2016).

JMHCs share the same features with AMHCs: (1) separate dockets, (2)

community supervision to check compliance with court order, (3) judicial review to keep track of the progress of participants, (4) and an interdisciplinary team that monitors cases and makes recommendations to the judge (Callahan et al., 2012). The general description of JMHCs reveals that there are diverse pathways to referrals to JMHCs, including defense lawyers, attorneys, bail programs, probation officers, doctors, court workers, and judges (Davis et al., 2015; Heretick & Russell, 2013). Although it is difficult to find uniform procedures in JMHCs, in general, once juveniles are referred, mental health court workers conduct the screening process using a diagnostic tool (e.g., MAYSI-2). Following the results, court workers make a recommendation about whether juveniles are eligible for the program. A judicial determination is then made whether juveniles seek treatment and have mental health needs. Upon considering these mental health factors and other variables (e.g., the seriousness of the offense, victim impact), juveniles are sent to diversion or sentencing (Davis, Peterson-Badali, & Skilling, 2016; Slate et al., 2013).

Once juveniles are accepted into programs, court dates are assigned, and JMHCs workers develop a treatment plan that can match juveniles to community-based services (Davis et al., 2015). Multi-disciplinary agencies are engaged in treatment services. As juveniles receive treatment services, case monitoring is ongoing. JMHCs workers update the progress of juveniles to the judicial authority. After completion of the treatment, further case tracking and dispositions are followed. Depending on the progress that juveniles make, different dispositions can be imposed. Specifically, some juveniles can have charges dismissed, while some receive charge suspension; some are sentenced to probation.

JMHCs often incorporate empirically supported therapies that are found to be effective in reducing recidivism rates in youth offenders, including Multisystemic Therapy (MST) (Henggeler, 1999; Jonson & Cullen, 2011) and Functional Family Therapy (FFT) (Alexander, Pugh, & Parsons, 1998; Skowrya & Coccozza, 2007). Briefly, Multisystemic Therapy is based on the assumption that human development is embedded in multiple systems, such as home, school, and neighborhood contexts (Henggeler, 1999). MST clinicians diagnose the risk factors that each of multiple systems presents to troubled youth (e.g., poor relationship with parents, and conflict with teachers). They then design and provide interventions or therapy (e.g., parent training or cognitive behavioral therapy based

on the unique needs of youth at risk. FFT focuses more on parental management interventions to reduce the offending of youth (Alexander et al., 1998). The FFT therapist engages at-risk families and antisocial youth and focuses on improving poor parenting skills and negative communication patterns. At-risk families learn how to listen and interact with each other, and adults in the family learn how to use praise, to monitor, and to intervene effectively. Because JMHCs target mentally disordered youth, they also consider therapeutic interventions for youth with mental illnesses, such as drug treatment, pharmacotherapy, and cognitive behavioral therapy (Ramirez, Andretta, Barnes, & Woodland, 2015).

JMHCs share many features with AMHCs, including use of a multidisciplinary approach, use of rewards and sanctions to elicit compliance, acceptance of participants with a mental disorder, use of treatment services, and the mission of preventing offenders with mental disorders from extensive involvement in the justice system (Callahan et al., 2012). However, JMHCs often have unique features that are designed to serve the specific needs of youth with mental disorders compared to AMHCs. These features include the use of a screening device for youth and the use of treatment programs to address youth mental health functioning. For instance, JMHCs use treatment programs involving schools (e.g., educational programs to improve academic achievement and reduce truancy) and families (e.g., family counseling for family functioning challenges).

The empirical status regarding the effectiveness of AMHCs seems robust (Honegger, 2015). Researchers have compared criminal offenders with mental illness who were assigned to MHCs to those who were sent to traditional courts (e.g., Anestis & Carbonell, 2014). Evaluation research based on different methodologies (random assignment of programs, follow-up study, and retrospective observational design) pointed to the reductions in violence among MHC clients (Anestis & Carbonell, 2014).

Using 18 experimental or quasi-experimental studies, Sarteschi, Vaughn, and Kim (2011) conducted a meta-analysis to evaluate the effectiveness of AMHCs. They reported that the aggregate effect size for recidivism outcome was moderate (Hedges's g , -.54), supporting the clinical effectiveness of AMHCs. A more recent evaluation based on 20 articles on MHCs also found a positive and statistically significant decrease in recidivism among MHC participants (Honegger, 2015). Additionally, Honegger's (2015) review showed that MHCs can be relevant to

participants' psychiatric functions.

Currently, only four peer-reviewed studies are available regarding the effectiveness of JMHCs (Behnken et al., 2009; Behnken et al., 2017; Heretick & Russell, 2013; Ramirez et al., 2015). First, Behnken et al. (2009) examined recidivism rates using 64 youth who entered the Court for the Individualized Treatment of Adolescents (CITA) in California Santa Clara County. They conducted t-tests to compare the mean number of offenses before youth participated in CITA and the mean number of offenses after youth enrolled in the program. The results indicated a reduction of arrests in a variety of offenses, including assault and battery, possession of dangerous weapons, making violent threats, theft, and vandalism. Second, Heretick and Russell (2013) used data from a sample of 61 youth who participated in a Colorado JMHC and from other groups of youth who were assigned to other forms of probation and diversion. In their research, recidivism was defined as new charges filed for offenses, including technical violations or new offenses. They compared recidivism rates between youth who completed JMHC and those who completed a different form of probation/diversion program and found that youth who completed the JMHC tended to show lower recidivism rates compared to those who completed other juvenile probation programs.

Third, Ramirez et al. (2015) studied a JMHC in the District of Columbia by comparing reconviction and rearrest rates of JMHC participants to youth who did not participate in JMHC but were supervised by probation officers. They employed a stratified random sampling to develop the control group and treatment group. The control group was clinically and legally similar to JMHC participants before treatment. Results indicated that JMHC youth were less likely to be rearrested and reconvicted compared to the control group. Importantly, youth who participated in the JMHC experienced a significant reduction of psychiatric symptoms after treatment. Lastly, Behnken et al. (2017) investigated whether youth who were adjudicated in the JMHC displayed lower recidivism rates after treatment using a sample of 63 youth on probation in Santa Clara County, California. The results showed that participation in the JMHC can reduce the chance of rearrest among mentally disordered juveniles. Importantly, reductions in recidivism were observed regardless of gender and racial/ethnic group.

In short, the findings from these studies appear consistent with the findings

from AMHCs. JMHCs significantly reduced the recidivism rate of juvenile delinquents who attended JMHCs (Behnken et al., 2009; Heretick & Russell, 2013; Ramirez et al., 2015), and this reduction in recidivism occurred while controlling for different race and gender (Behnken et al., 2017). The potential benefits of JMHCs were not confined to a reduction in recidivism and arrest. As Ramirez et al. (2015) showed, mentally disordered juveniles can experience improvement regarding psychiatric symptom severity from JMHCs. Cocozza and Shufelt (2006) described that there are five positive outcomes that can be acquired from JMHCs: (1) “leverage of court,” (2) “multi-disciplinary approach,” (3) “increased option,” (4) “monitoring strategies,” and (5) “increased awareness of the problem” (p. 4). Compliance from juveniles and their families following JMHC requirements can increase their willingness to participate in treatment services. Davis et al. (2015) found that participants in JMHCs used the treatment service more often than other youth.

While there is no cost-benefit analysis on JMHCs, considering the operation of JMHCs is equivalent to that of AMHCs, the findings from AMHCs can be instructive. The evidence on cost-effectiveness also favors MHCs over the traditional courts (Kubiak et al., 2015; Ridgely et al., 2007; Wolff, 2018). Although the instrumental consideration should not dictate juvenile justice policy (Sandel, 2009), cost savings from JMHCs can be a practical issue from the point of administrators’ and taxpayers’ viewpoints (Burriss, Breland-Noble, Webster, & Soto, 2011). According to the report from the RAND Corporation that conducted with the Allegheny County MHC in Pennsylvania, the fiscal impact of MHC turned out to be positive (Ridgely et al., 2007). The cost of traditional adjudication and processing was compared with the cost of MHC, including treatment service, the juvenile justice system, and subsidies. Ridgely et al. (2007) reported that even though initial investment can be costly, given the diminished jail costs, MHC is a much more cost-effective program. Kubiak et al. (2015) provide further support for MHC by focusing on the long-term cost saving from MHC. Washington State Institute for Public Policy (2016) estimated that for every tax dollar spent to pay for MHC, about 6 dollars is saved.

The CONCERNS ASSOCIATED WITH JMHCs AND FURTHER DIRECTION FOR JMHCs

Several cautions and concerns around JMHCs are noteworthy. By discussing the concerns regarding JMHCs, the current study creates a further direction for juvenile justice policy. Some argue that although JMHCs highlight offenders more than offenses, classification of offenders according to types of offenses excludes some youth from eligibility (Callahan et al., 2012; Davis et al., 2015). It is important that JMHCs are open to juveniles who have mental health needs (i.e., Axis I disorders from DSM-IV); some juvenile offenders can benefit most from participation in the programs even though they are not eligible due to their type of offense.

The voluntariness of JMHCs has also been questioned. The decision to participate in JMHCs can be made “when the defendant is likely to be under considerable stress, having been arrested and taken into custody and perhaps having spent some time in a jail cell, often without treatment of any kind” (Seltzer, 2005, p. 574). Redlich, Hoover, Summers, and Steadman (2010) documented that the majority of enrolled MHC clients did not know their rights to participate before they enlisted voluntarily. Participants should be notified of potential outcomes if they fail to complete the programs and their rights in JMHCs to ensure the voluntariness of their decision (Callahan et al., 2012).

The limited functions of JMHCs have been pointed out (Slate et al., 2013). The court does not have the power to create new services (Boothroyd, Mercado, Poythress, Christy, & Pettila, 2005). Instead of designing new programs, JMHC judges have to navigate available treatment services and make a final decision. It is critical for JMHC judges to learn what kinds of treatment programs are available. The screening process to participate in JMHCs should also be examined. Researchers have implemented the Massachusetts Youth Screening Instrument-2 (MAYSI-2) in juvenile detention centers and probation departments to examine the eligibility of juveniles for JMHCs (Skowrya & Coccozza, 2007). While the use of a standardized screening process is well documented from some JMHCs (Arredondo et al., 2001; Davis et al., 2015), there is no uniform protocol regarding screening instruments, and this can impede successful identification of

JMHC clients.

Scarce funding and the lack of accumulated data should be noted as concerns about JMHCs. The empirical studies about JMHCs are limited, and this can be, in part, due to the limited funding (Davis et al., 2015). Callahan et al. (2012) reported that funding sources of JMHCs are diverse and include state governments, local governments, Medicaid, the federal government, private insurance, grants, and program fees. Even though federal funding of the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) has been increased and reauthorized since it was signed into law in 2004, the initial costs associated with JMHCs can be burdensome (Slate et al., 2013). Steadman (2005) estimated that it might take more than 18 months to confirm the positive outcomes from diversionary programs such as MHCs. Likewise, Slate et al. (2013) illustrated that the initial expenditures needed to establish MHCs might outpace the current total cost for incarcerated individuals with mental illnesses. The history of juvenile justice illustrates the cyclical and capricious shift related to political movements or sub-structural changes (Bernard & Kurlychek, 2010; Feld, 2013). To prevent policy decisions from being influenced by transient ideologies, a long-term policy based on evidence and efforts to incorporate the traditional justice system with therapeutic jurisprudence should be pursued (Slate et al., 2013).

Several concerns discussed above reveal that some challenges (e.g., participants' rights and competency and limited quality treatment services) that administrators will encounter before and during implementing JMHCs. Still, they also inform of further directions for JMHCs. First, considering that there is a growing body of evidence showing that a JMHC model can reduce recidivism and psychiatric symptoms (Ramirez et al., 2015), more funding from federal legislation should be available to provide financial support in the implementation and continuing operation of local JMHCs. The increased funding is particularly important to establish evidence-based practice. Second, it would be critical to identify and examine which therapeutic interventions under JMHCs are most effective in reducing recidivism and psychiatric symptoms by research. JMHCs often use a wide array of therapies and services, but it remains unclear which set of programs are worth investing more funding to avoid criminalization of youth offenders with a mental disorder (Slate et al., 2013). JMHC administrators can keep mechanisms in place to record and report outcomes to establish more

evidence-based practices.

Finally, there should be more adequate services available for JMHCs. Considering that JMHCs often rely on existing community resources for adolescent participants and that the courts may not be able to identify proper treatment resources or services, judges or case coordinators should be provided the resources and authority to create and implement the services for youth with unique needs and risks. The new services created can be applicable to general youth participants in JMHCs, but they can be more specific for youth with a unique situation. For example, trauma-informed treatment can be incorporated into the treatment programs of JMHCs (Benekos & Merlo, 2016). Even though traumatic experiences can have detrimental effects on juveniles and adults, the research indicates that posttraumatic stress disorder (PTSD) can be particularly harmful to juveniles because it can permanently alter brain development (Black, Woodworth, Tremblay, & Carpenter, 2012). Treatment programs under JMHCs can incorporate some elements of trauma-informed treatment.

JMHCs can also provide services for general JMHC participants. For instance, JMHCs can consider recent evidence involving the relationship between nutrition and mental health outcomes when developing mental health services for high-risk juveniles. Researchers have found that symptoms of depression, anxiety-related disorders, bipolar disorder, schizophrenia, and obsessive-compulsive disorder can be reduced by using nutritional supplements (Gajos & Beaver, 2016; Lakhan & Vieira, 2010). Recent studies also demonstrate that inadequate nutrition can influence behavioral patterns (Lumley, Stevenson, Oaten, Mahmut, & Yeomans, 2016) and that childhood malnutrition is a critical risk factor for later antisocial behavior (Jackson, 2016). Conversely, several experimental studies have shown that providing dietary nutrients through supplementation (e.g., omega-3 fatty acids, vitamin E) can significantly prevent various types of antisocial behaviors, such as fighting, vandalism, and aggression (Gesch, Hammond, Hampson, Eves, & Crowder, 2002; Hallahan, Hibbeln, Davis, & Garland, 2007; Zonarini & Frankenburg, 2003). Considering the benefits of nutrition for mental health and aggression found in research, JMHC service providers can incorporate nutritional components (e.g., omega-3 fatty acid and micronutrient supplementation) into their treatment strategies.

CONCLUSION

Many scholars have documented the direction of the juvenile system in the 21st century and its future (Benekos & Merlo, 2016; Bernard & Kurlychek, 2010; Butts & Mears, 2001; Welsh, 2005). Welsh (2005) proposed that a public health perspective is required to solve the problem of juvenile criminal violence. According to his review, the interest in juvenile violence in the public health field has increased, and this attention has had positive outcomes for understanding youth who are involved in delinquent acts. Butts and Mears (2001) reviewed empirical evidence on punitive policy such as juvenile transfer and introduced innovative prevention and early intervention programs, highlighting signs of changes in a “get-tough” era. Juvenile justice policies seem to be moving away from punitive measures considering the landmark decisions of the Supreme Court (*Roper v. Simons*, 2005; *Graham v. Florida*, 2010; *Miller v. Alabama*, 2012; *Montgomery v. Louisiana*, 2016). The implications of these key rulings align with some researchers’ predictions that the punitive and get-tough policies would fall out of favor with administrators and taxpayers (Merlo & Benekos, 2010).

The advent of JMHCs reflects the escalating demand for consideration of psychological factors in the juvenile justice system, echoing the historical context of juvenile justice and scientific findings of the adolescent brain (Steinberg, 2008). The cycle of juvenile justice raised concerns about whether this shift is temporary or an authentic transformation (Bernard & Kurlychek, 2010). Bernard and Kurlychek (2010) pointed out that incorrect assumptions about the identification of juvenile delinquents have dictated changes in the juvenile justice system. To break the cycle, they suggested that juvenile delinquents should be perceived as “naïve risk takers” (Bernard & Kurlychek, 2010, p. 216). This proposal is consistent with the reasoning of the recent decisions of the Supreme Court, and it is in accordance with empirical findings from neuroscience and developmental findings that juveniles’ reasoning abilities are not fully formed yet, and that they are still developing into adults (Frost-Tift, 2013; Scott & Grisso, 2005; Shitama, 2013).

However, we also pointed out that JMHCs are not without concerns. Greater efforts should be made to address the paucity of empirical studies on JMHCs (Davis et al., 2016). To accomplish successful research, valid data should be

gathered; prospective data collection strategies that are pre-planned can ensure high-quality data (Heretick & Russell, 2013). Along with efforts to collect comparable and useful data, rigorous evaluation research design should be employed. Quasi-experimental and random assignments have frequently been employed in the adult mental health court literature (Dirks-Linhorst & Linhorst, 2012; Steadman et al., 2011). Future studies conducted with JMHCs should reference earlier efforts from studies on AMHCs.

A growing body of evidence shows that JMHCs can reduce recidivism rates and psychiatric symptoms among youth participants (Behnken et al., 2009; Behnken et al., 2017; Ramirez et al., 2015). Additionally, JMHCs can benefit juveniles by helping them to dismiss charges for their future. A conviction or adjudication record can adversely influence adolescents and their lives in unpredicted ways. For instance, youth with an offense record may not be eligible for federal student loans, and their employment prospect can be limited. They may not be qualified for public housing or other social programs. JMHCs can give youth participants the opportunity to avoid far-reaching collateral outcomes by giving them chances to dismiss charges when completing the programs successfully. These benefits have clear policy implications, highlighting the importance of continuing efforts to develop JMHCs as a stable form of diversion from the justice system (Callahan et al., 2012). More systematically collected data and rigorous analyses will present an evidence-based foundation to address diagnostic and treatment challenges in JMHCs. The current study contributes to and extends the literature on the juvenile justice system by examining JMHCs, an emerging diversion program for youth offenders with mental disorders. By linking the trend of using psychological science to guide legal decisions in the U.S. Supreme Court to the advent of JMHCs, our study suggests that JMHCs may signal the changes in the problematic cyclical patterns of the juvenile justice that were often guided by the public sentiment, not scientific findings.

The current review of JMHCs is not without limitations. First, few empirical studies were introduced (Behnken et al., 2017; Heretick & Russell, 2013), which mirrors the lack of available studies on JMHCs. While the replicated findings of AMHCs suggest the potential for positive outcomes from JMHCs, the conclusive answer should be qualified since there can be possible differences. Second, the current study may not provide an accurate picture of the shift in the juvenile

justice system. To test the shift in the juvenile justice system, statistical methods (e.g., time-series analysis) that allow an opportunity to examine it more rigorously can be helpful.

To bolster policy decisions based on empirical evidence, society should abandon the idea that there will be a panacea for solving juvenile delinquent problems (Bernard & Kurlychek, 2010, p. 234). As the history of juvenile justice demonstrates, a radical shift will worsen the cycle of juvenile justice. Additionally, designing programs based on evidence rather than good intentions is a lesson from history. Recently, the drastic paradigm shift in understanding law not just from accumulated human knowledge, but also from neuroscience illuminates the difference in the functioning of juveniles and adults (Bonnie & Scott, 2013; Casey & Caudle, 2013). Incorporating the efforts from different fields into treatment programs will ultimately help us to understand complex dynamics in the development of juveniles and further intervention to deter criminality.

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