I. INTRODUCTION

In Heidi Camp’s monologue, *Anne*, we learn of the struggles of one mother dealing with the traumatic mental health problems of her daughter. Camp discovers that her daughter has become increasingly isolated from the world, and has turned to self-mutilation and suicide attempts in order to alleviate her mental and emotional suffering. Camp then describes her own experiences of isolation, alienation, and helplessness while dealing with the situation. The unfortunate reality is that this story, and others like it, are not isolated incidents or rare occurrences. As the Department of Health and Human Services (HHS) reported: “[m]any children have mental health problems that interfere with normal development and functioning. In the United States, one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment.” Additionally, the juvenile admission rates to mental health facilities “have rapidly escalated over the past several decades as well.” But not every child is lucky enough to have a parent catch the signs of their mental distress, as evidenced by another HHS statistic: “in any given year, it is estimated that [only] about one in five children receive mental health services.” First, this Note will discuss the prevalence of mental illness among youth in the juvenile justice system. Second, it will explore possible programs that might help states better deal with these issues. Finally, it will examine the approach taken in Utah, and the successes of that program.

The problem of youth affected by mental disorders is compounded when viewed in conjunction with the juvenile justice system. As pointed out by Patrick
Geary, one of the nation’s most preeminent juvenile mental health and justice scholars, “[y]ouths in contact with the juvenile justice system are significantly more likely than other youths to have mental disabilities.”

He further notes, “[t]he juvenile justice system has in some ways become a dumping ground for mentally ill, learning disabled, [and] behaviorally disordered juveniles.”

Many juvenile offenders have a history of involvement with the mental health system, but end up transitioning to the justice system after the mental health system failed to adequately resolve their problems. In contrast to the general population of children—where the diagnosis rate of serious emotional disturbances ranges from two to seven percent—estimates for the “delinquent population range from sixteen to fifty percent.”

To further illustrate this problem, many juvenile delinquency reports show:

- Among delinquent youth, between one and six percent suffer from psychotic disorders, and at least twenty percent are estimated to suffer from serious mental disorders generally (including schizophrenia, major depression, and bipolar disorder). In addition, fifty-five percent of youth in the juvenile justice system show symptoms of clinical depression, and up to nineteen percent of youth in the juvenile justice system may be suicidal.

These reports suggest that juvenile mental and psychiatric disorders are even more prevalent for children detained in the juvenile justice system. Not only are these youths dealing with serious mental disturbances, but some estimates show that more than eighty percent are also affected by less severe mental disabilities such as “attention deficit disorder, attention deficit hyperactivity disorder, substance abuse and dependence, learning disabilities, mental retardation, anxiety disorders, and conduct disorders.”

These studies show that there is an increasing relationship between a lack of mental health care and the disproportionate presence of youth with mental disorders in the juvenile justice system. The problem is that

\[\text{5 Geary, supra note 3, at 677.}\]
\[\text{6 Id. at 677 (internal citations and quotations omitted).}\]
\[\text{7 Id.}\]
\[\text{8 Id. at 677–78.}\]
\[\text{9 Id. at 678; see also Douglas E. Abrams, Reforming Juvenile Delinquency Treatment to Enhance Rehabilitation, Personal Accountability, and Public Safety, 84 OR. L. REV. 1001, 1087 (2005) (stating that “the National Mental Health Association estimated that as many as sixty percent of youths in the juvenile justice system have mental health disorders”).}\]
\[\text{10 Geary, supra note 3, at 678 (noting “a far greater proportion of children in the juvenile justice system suffer from a serious emotional disturbance than in the general population”).}\]
\[\text{11 Id.}\]
these youths, if not properly screened, end up in contact with the juvenile justice system for far too long; and, without treatment, are much more likely to reoffend.

II. JUSTICE AND TREATMENT: A COMPREHENSIVE APPROACH

People often look to the courts as a method of dispensing justice, and the justice system is seen as being a mechanism for holding people accountable for wrongs that they are responsible for causing. The juvenile justice system presents unique challenges, however, because youths have not yet fully developed a sense of right or wrong. They have not yet fully matured to understand the consequences of their actions. Therefore, retribution is incompatible with the rehabilitative goals of the juvenile justice system. The U.S. Supreme Court specifically noted a distinction between the culpability of an adult defender as compared to a juvenile offender in the 2005 case \textit{Roper v. Simmons}, which struck down the use of the death penalty in cases where the crimes were committed by juveniles.\footnote{Roper v. Simmons, 543 U.S. 551, 578 (2005).}

In an article examining the cycles of the juvenile justice system, Professor Erik Luna, one of the nation’s leading experts in criminal law and theories of punishment, discussed research suggesting that “[a]lthough adolescents may display some of the intellectual capacities of adults, there is an ‘immaturity gap’ in their cognitive faculties, impeding the assessment of risk, understanding of future consequences, power of self-management, and capacity for independent choice.”\footnote{Erik Luna, \textit{Cycles of Juvenile Justice: An Introduction to the Utah Criminal Justice Center Distinguished Lecture}, 10 J. L. & FAM. STUD. 1, 2 (2007).} If this is true of ordinary juvenile offenders, then these factors would warrant even less culpability for the punishment of juveniles with mental disorders. If punishment is not the best course of action, which is likely the case, then states should move toward a more comprehensive treatment and rehabilitation scheme for the juveniles affected by these disorders.

Because the juvenile justice system has evolved into an institution designed to treat and rehabilitate youth, not necessarily punish them, it “offers a unique opportunity to intervene in the lives of children with mental disabilities before any negative behavior or psychological patterns take hold.”\footnote{Geary, supra note 3, at 688.} The prevalence of mental health problems in juvenile courts, and the desire to treat and rehabilitate, has led some states to consider the concept of “Therapeutic Jurisprudence,”\footnote{Id. at 681.} by setting up

\footnote{The formation of specialty ‘problem-solving’ or ‘treatment’ courts to better address specific categorical concerns and common needs of certain types of offenders is perhaps the best example of the application of therapeutic jurisprudence concepts in the justice system. These courts have emerged in both the criminal and juvenile justice systems and demonstrate an institutional capacity to address the substance abuse and mental health needs of offenders.}
specific problem-solving courts to help deal with root causes of juvenile offenders’ behavior, and to lower recidivism rates. The desire to implement these juvenile mental health courts comes from a recognition that mental disabilities often cause, or contribute to, delinquent behavior.\(^{16}\)

Professor Luna discussed a research study, conducted in Utah, which identified youth offenders at risk for psychiatric problems, recidivism, and suicide.\(^{17}\) The participants of the study were divided into two groups: one group received psychiatric assessment and treatment, in-home services, and case management; the other group received only existing juvenile justice system services.\(^{18}\) The researchers found that the first group, those who received the more comprehensive treatment program, “had an overall increase in mental health status and a reduction in recidivism . . . .”\(^{19}\) More importantly, members of that group spent less time in detention and medical facilities, resulting in substantial financial savings to the state.\(^{20}\) Professor Luna suggests that “early identification of mental health issues in juvenile offenders, combined with the provision of necessary treatment services, may reduce both crime and costs in the long run while improving (and even saving) the lives of young people today.”\(^{21}\)

The need for treatment of juveniles with mental disorders is often best illustrated through examples of offenders who received no such treatment. Another article dealing with youth, justice, and mental illness, discussed the case of Barton Gaines.\(^{22}\)

Gaines, suffering from several mental disorders including anxiety disorder and manic depression, was never properly diagnosed or treated for his mental illness . . . . After feeling humiliated in school, Gaines dropped out of ninth grade and began abusing drugs to self-medicate. The [state] did not adequately help Gaines with his mental disease, and as a result, he is now locked up in prison for a crime that was committed as a result of his mania disorder.\(^{23}\)


\(^{17}\) Luna, *supra* note 13, at 4.

\(^{18}\) Id.

\(^{19}\) Id.

\(^{20}\) Id.

\(^{21}\) Id.


\(^{23}\) Id. at 274–75. The prevalence of substance abuse is also commonly linked to juvenile offenders with mental health issues. The NCMHJJ reports: *[A]mong youth with at least one mental health diagnosis, approximately 60 percent also met criteria for a substance use disorder. Co-occurring substance
Gaines is a perfect example of how “the ‘problem’ of psychopathology among juvenile justice detainees can be regarded as a public health ‘opportunity’.” 24 Had the juvenile justice system identified the causes of Gaines’ offenses as mental illness and treated him, it is likely that those efforts would have been successful before Gaines reoffended, which cost him his freedom, and the government extra tax dollars.

Unfortunately, for many involved in the juvenile justice system, the Gaines scenario is likely to repeat itself as many states struggle with the multi-faceted problem of juvenile justice and mental health reform. “Rather than confront the pediatric mental health crisis with positive measures . . . many states have been moving in the opposite direction.” 25 Even when confronted with staggering numbers of youth with mental illness in the justice system, state and federal budget cuts have closed or severely limited access to mental health facilities. 26 “As a result, several thousand mentally ill children are incarcerated each year because the juvenile corrections system provides their only access to treatment, frequently in facilities that offer little semblance of meaningful therapy.” 27 Because these states do not have the ability to separate and treat these juvenile offenders from the general population, “the state fails the public, which remains at risk when the disturbed youth is released without effective mental health intervention.” 28

All of this suggests that many of these minors who end up incarcerated in the juvenile justice system would not be there but for their mental disorder. Because these juveniles do not receive adequate mental health care, they often self-medicate through abuse of drugs and alcohol, 29 which in turn leads many of them into contact with the juvenile justice system. Once there, if the underlying cause of these minor’s criminal behavior (their mental illness) is not treated, then they will be released to the outside world in no better shape than when they arrived. In fact, because they will have been in contact with other juvenile offenders, likely learning more antisocial and criminal behaviors, and still without treatment for

use disorders were most common for youth with a diagnosis of disruptive disorder, although significant proportions of youth with anxiety disorders (52.3%) and mood disorders (61.3%) also had a co-occurring substance use disorder.


24 Luna, supra note 13, at 5 (internal citations omitted).
25 Abrams, supra note 9, at 1086 (2005).
26 Id.
27 Id. at 1090–91.
28 Id. at 1090–91.
their mental disorders, they will likely be released in worse shape than when they arrived.

III. UTAH: A COMPREHENSIVE APPROACH IN ACTION

In response to the problem of juvenile offenders in need of specialized mental health treatment, many states have set up specialized programs to deal with these unique issues. Utah has taken an approach similar to Los Angeles County, California. In L.A. County, juvenile justice officials set up a specific juvenile mental health court in 2001. The court is described as a comprehensive program consisting of a partnership between the “judge, district attorney, public defender, an alternate public defender, Department of Mental Health (DMH) psychologist, school liaison, probation officers, and a psychiatric social worker.” The psychologist functions as a case manager to form connections with providers and oversee treatment and progress. The participating youth then receives individualized attention and access to community-based mental health services including mediation and therapy.

In Utah, the program is much more modest, but set up in a similar way. The program, called the Coordination of Care Court (C3 Court), is a collaborative project between Utah’s Third District Juvenile Court and various partners. Involved agencies include: “Valley Mental Health, Division of Child & Family Services, Division of Juvenile Justice Services, Salt Lake County District Attorney’s Office, Salt Lake County Sheriff’s Office, Salt Lake County Division of Substance Abuse Services, Pappas & Associates, Jordan School District, and the Utah Chapter of the National Alliance for the Mentally Ill (NAMI).”

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31 The country’s first juvenile mental health court was the Santa Clara Court for the Individualized Treatment of Adolescents (CITA). CITA sought to “administer swift and concrete consequences to juveniles who have broken the law and to help them address their mental issues in order to avoid future delinquent behavior.” Harvey, supra note 29, at 193.


33 Id.

34 Id.

35 Involved agencies include: “Valley Mental Health, Division of Child & Family Services, Division of Juvenile Justice Services, Salt Lake County District Attorney's Office, Salt Lake County Sheriff's Office, Salt Lake County Division of Substance Abuse Services, Pappas & Associates, Jordan School District, and the Utah Chapter of the National Alliance for the Mentally Ill (NAMI).” Utah State Courts, Coordination of Care Court, http://www.utcourts.gov/courts/juv/juv/sites/3rd/coord_care_court.html (last visited Apr. 9, 2009).
year.\textsuperscript{36} The C3 Court, by contrast, only served fifty-three youths since its inception in 2006.\textsuperscript{37}

In one Utah study, a team of medical researchers described and tested a model for treating juvenile offenders who suffer from mental illness.\textsuperscript{38} The program established in that study gave participants family-centered treatment including in-home services, psychiatric assessment and treatment, as well as case management.\textsuperscript{39} The in-home services consisted of a trained specialist teaching the parents specific skills, and efforts were made to work with the youth and mentor them.\textsuperscript{40} The psychiatric services included a full bio-psychological assessment of the participant, as well as a family assessment, a treatment plan (with or without medication), and psychotherapy if needed.\textsuperscript{41} The current Coordination of Care Court was a restructuring of a previous initiative known as the Continuum of Care, which was implemented by Utah’s Juvenile Justice Services but was criticized as being ineffective.\textsuperscript{42}

The existing C3 program offers “individualized treatment plans [that] focus on providing services that are strength-based, family-focused, evidenced-based and culturally sensitive. The plan has measurable goals and objectives that address target behaviors in the areas of school, home and therapy.”\textsuperscript{43} There are two main methods for providing treatment to youth currently in the C3 program. The first, and more intensive, is the day treatment program; a day treatment program is “a highly structured, community-based, postadjudication program for serious juvenile offenders.”\textsuperscript{44} The goals of day treatment are to provide intensive supervision to ensure community safety, as well as provide necessary treatment to the youths.\textsuperscript{45} Intensive supervision is fulfilled by requiring the offender to report to the facility on a daily basis at specified times for a certain length of time. Generally, programs are provided at the facility during the day, evening, or both at least five days a

\textsuperscript{36} Michelle A. Moskos, et al., \textit{Utah Youth Suicide Study: Evidence-Based Suicide Prevention For Juvenile Offenders}, 10 J. L. & FAM. STUD. 127, 132 (2007).
\textsuperscript{37} Interview with Scott Curry, Coordinated Care Court program manager, in Salt Lake City, Utah (Feb. 10, 2009).
\textsuperscript{38} Moskos, \textit{supra} note 36, at 134.
\textsuperscript{39} \textit{Id.}
\textsuperscript{40} \textit{Id.}
\textsuperscript{41} \textit{Id.}
\textsuperscript{42} Moskos suggested that “the Continuum of Care...[did] not appear to include appropriate mental health screening, referral, and delivery of treatment services.” \textit{Id.} at 144.
\textsuperscript{43} Utah State Courts, \textit{supra} note 35.
\textsuperscript{44} Office of Juvenile Justice and Delinquency Prevention, Model Programs Guide—Day Treatment, http://www.dsgonline.com/mpg2.5/day_treatment_intermediate.htm (last visited Apr. 9, 2009).
\textsuperscript{45} \textit{Id.}
week. The second, and less intensive means of providing treatment is weekly monitoring and treatment sessions.

The research indicated that when a plan—such as the one suggested in the article, and the one currently utilized by the C3 Court—is implemented properly, suicide and recidivism rates decreased, while the overall mental health of the participants increased. Although it is still too early to see specific research studies documenting the results from the C3 Court, court records “indicate a significant reduction in charges for C3 clients while also recording an improvement in their school attendance and GPA’s. Therapists, families, and participants have reported an increased compliance with therapy, skill building and medication compliance.”

One of the most important aspects of the type of program described by the Utah Youth Suicide Study, and implemented by Utah’s C3 court, is the involvement of the juvenile’s family. No matter how good the treatment is while a juvenile is in custody, the treatment plan as a whole will not succeed if the progress does not continue at home. Juveniles must remain compliant with medication and treatment regimens, and in order for that to occur, parents and other family members must understand the underlying problems, and how to best deal with the affected youth’s behavior.

As other states struggle with the best way to deal with the growing problem of mental illness in the juvenile justice system, it is important that the role of these collaborative individualized mental health courts are considered as options. This is even more true in troubled economic times, when many states are being forced to make tough decisions regarding judicial funding. The needs of these troubled youths as well as the safety of the general public are better served through early identification and treatment of mental illness in juvenile offenders, rather than detention or incarceration.

One large criticism of adding a mental health element to juvenile justice courts is the prospect of additional cost. This cost, however, can be offset. Looking to states that have implemented drug courts as an example, it has been shown that they are saving millions of dollars. Savings to these states’ taxpayers came mostly in the form of decreased recidivism rates, which helps the juvenile justice system avoid costly prison and prosecution expenses for repeat offenders. And if these savings are not enough to offset budgetary concerns, the Mentally Ill

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46 Id.
47 Interview with Scott Curry, supra note 37.
48 Moscos, supra note 36, at 140–43.
49 Utah State Courts, supra note 35.
50 Some states may find it too daunting a task to implement a separate mental health court program. For suggestions on how to supplement existing juvenile drug court programs see Harvey, supra note 29, at 209–20.
51 Id. at 212.
52 Id.
Offender and Crime Reduction Act of 2004 has made available millions of dollars in federal grant money to “communities that integrate mental health treatment and detection into [their] justice system.”

VI. CONCLUSION

Depression, suicidal thoughts, and other serious mental illnesses are not limited to the adult population. Youth throughout the country are suffering greatly, and many are still not receiving treatment. Anne tells the story of a depressed adolescent girl who was lucky enough to have a mother notice the mental illness as it progressed, and was able to provide treatment for her daughter before it was too late. But for many youths, especially those in contact with the juvenile justice system, the story is a different one. In contrast to the general population of youth in America, those in the juvenile justice system suffer from mental illness at an alarmingly higher rate.

Giving juveniles and their families access to these mental health courts will greatly increase the chances of successfully rehabilitating offenders because there is an intervention at the earliest opportunity. These mental health courts also strive to give accelerated service, individualized attention to discover the most appropriate treatment, and consistent monitoring of and feedback to participants. These are the same principles that other problem-solving courts, including juvenile drug courts, rely on for their success.

Unless states can provide a way to identify these youth at an earlier stage, intervene, and provide meaningful and effective treatment, the future of those youths as well as the public safety is in jeopardy. Research has shown, as illustrated by Utah’s C3 Court, that a comprehensive and collaborative approach to treating these kids can “reduce both crime and costs in the long run while improving (and even saving) the lives of young people today.” If states do nothing however, not only do those states fail the youth that they are supposed to rehabilitate, but the state also “fails the public, which remains at risk when the disturbed youth is released without effective mental health intervention.”

53 Id.
54 See generally SURGEON GENERAL’S CONFERENCE REPORT, supra note 2.
55 Id.
56 Geary, supra note 3, at 677–78.
57 Harvey, supra note 29, at 192.
58 Luna, supra note 13, at 4.
59 Abrams, supra note 25, at 1090–91.