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# Theories of Therapeutic Evolution for Juvenile Drug Courts in the Face of the Onset of the Co-occurrence of Mental Health Issues and Substance/Alcohol Abuse

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THEORIES OF THERAPEUTIC EVOLUTION FOR JUVENILE  
DRUG COURTS IN THE FACE OF THE ONSET OF THE CO-  
OCCURRENCE OF MENTAL HEALTH ISSUES AND  
SUBSTANCE/ALCOHOL ABUSE

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#### I. INTRODUCTION

Hidden beneath her bed lie four kitchen knives, three large and one small, each of them kept in order to protect herself from the shadowy men whom she believes she sees in the corner of her room.<sup>1</sup> These men threaten to kill her and often tell her to harm others.<sup>2</sup> This is the unfortunate story of sixteen-year-old Monique Murray, who was born, addicted to drugs, to a schizophrenic mother who abandoned Monique at birth.<sup>3</sup> Her childhood and teenage years were marked with unexplained fits of violence and rage until she was charged with felonious assault at age fifteen and placed in a juvenile detention center.<sup>4</sup> Once Monique was diagnosed with schizophrenia, she was then transferred to the Wayne County Juvenile Detention Facility where she was provided with a strict regimen of schooling, meals, therapy, and other supervised activities.<sup>5</sup> Monique's story is not an unfamiliar one. Every night, 2,000 children across the country are needlessly going to bed in juvenile detention centers because they do not have access to proper mental health care in

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<sup>1</sup>Laura Potts, *Monique: Teen With History of Mental Problems Fights the Shadows, Voices in a Youth Offender Facility*, DETROIT FREE PRESS, Sept. 7, 2004, at D2.

<sup>2</sup>*Id.*

<sup>3</sup>*Id.*

<sup>4</sup>*Id.*

<sup>5</sup>*Id.*

their communities.<sup>6</sup> Thankfully, new trends in the justice system are helping to combat some of these issues.

Beginning in the late 1980s and early 1990s, a new trend in the juvenile justice system emerged. This trend, known as the therapeutic justice system, was introduced as an alternative to the traditional, punishment-based justice systems that have dominated juvenile justice for many years. Therapeutic systems work on the notion that judges, attorneys, probation officers and other court personnel are to act like counselors in a team-like setting.<sup>7</sup> Therapeutic systems place an emphasis on problem-solving, rather than simply distributing punishment to the juvenile offenders that enter its system.<sup>8</sup>

The purpose of this Note is to review two specific and newly emerging therapeutic courts: juvenile mental health courts and juvenile drug courts. It will explain how and why a mental health element should be implemented into the juvenile drug court system. Part II of this Note will give a historical and procedural overview of juvenile drug courts. These procedures will draw mainly from the newly formed Medina County Juvenile Drug Court, located in Medina, Ohio.<sup>9</sup> Part III will explain the origination and procedures currently employed by juvenile mental health courts, as they relate specifically to Santa Clara's Court for Individualized Treatment for Adolescents. Part IV will explain why juvenile drug courts should implement certain elements of mental health courts because of the significant co-occurrence of juvenile substance use and accompanying mental health problems that occur in a significant number of juveniles.<sup>10</sup> Studies have shown, and court personnel agree, that up to 70% of juveniles with substance abuse or alcohol problems have at least one mental health issue that needs to be addressed.<sup>11</sup>

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<sup>6</sup>*Id.* (citing Susan McParland, executive director of the Michigan Association for Children with Emotional Disorders, as stating that too many children are being detained because they exhibit behaviors symptomatic to mental illness that are mistaken for delinquent acts).

<sup>7</sup>Charity Scott, *Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts*, 25 J. LEGAL MED. 377 (2004) (stating that the offender is viewed more as a client in a therapeutic model, since therapy provides a rich opportunity to reduce recidivism and to make a positive difference in people's lives before it is too late).

<sup>8</sup>*See id.* (problem-solving courts use active judicial involvement and explicit use of judicial authority to motivate individuals to accept needed services and to monitor their compliance and progress).

<sup>9</sup>*See* Judge John L. Lohn, *Participant Handbook, Medina County Juvenile Drug Court* (2003) [hereinafter "*Handbook*"]; *see also* David E. Arredondo, Enrique Colin, Raymond J. Davilla, Leonard P. Edwards, Eugene M. Hyman, Kurt Kumli, & Jill Ornellas, *Juvenile Mental Health Courts: Rationale and Protocols*, JUVENILE AND FAMILY COURT J. 78, 78-102 (2001) [hereinafter "*Arredondo et al.*"]. Medina County Juvenile Drug Court was formed in early 2003, and CITA was formed in 2002.

<sup>10</sup>*See* Susan M. Gordon, *Teen Drug Abuse: Underlying Psychological Disorders and Parental Attitudes Have a Big Effect on Teens Addictive Behaviors*, 23 BEHAV. HEALTH MGMT. 25, 25-30 (Sept. 2003).

<sup>11</sup>*See* President's New Freedom Commission on Mental Health, <http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport.htm> (last visited Feb. 21, 2006) (government studies have shown that 75% of girls and 66% of boys in juvenile detention centers have at least one mental disorder).

Part V of this Note will examine the proposed integration of a mental health element into the juvenile drug courts in light of several pieces of recent and pending legislation, with a special view towards the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, which supports mental health treatment for criminal offenders in place of traditional incarceration.<sup>12</sup> Finally, Part VI will explain how and why the juvenile drug court system should integrate a mental health element into its current procedures. Like any system in its infancy, the juvenile therapeutic justice system faces many challenges and issues as it attempts to gain more widespread acceptance. This Note strives to help the legal community embrace the therapeutic alternative as a means to improve the lives of juvenile substance abuse offenders with co-occurring mental health problems, while also increasing public safety in communities throughout the United States.

## II. BACKGROUND AND PROCEDURES OF THERAPEUTIC COURTS

### A. *Therapeutic Justice System Background*

Therapeutic justice systems, often referred to as “problem-solving courts,” were developed almost fifteen years ago in response to society’s decreasing confidence in the justice system due to the continued rise in crime rates, especially among repeat offenders.<sup>13</sup> Problem-solving courts are not simply neutral arbitrators that determine winners and losers, as traditional courts have done in the past. Rather, therapeutic courts and its personnel work as a team, emphasizing the treatment of a juvenile offender rather than strictly focusing on punishment of the juvenile offender.<sup>14</sup> In therapeutic courts, participants are seen as clients instead of as defendants, with graduation ceremonies and program completion certificates replacing sentencing and incarceration hearings.<sup>15</sup>

Experts believe that the therapeutic justice is truly innovative because it represents the justice system’s use of social science to promote the psychological and physical well-being of its participants, while also keeping safe the communities that they serve.<sup>16</sup> Due to the initial success of the first therapeutic drug courts, many communities have begun to adopt additional problem-solving courts to deal with problems such as DWI, parental drug dependency treatment, drug reentry programs, campus drug offenses, and domestic violence.<sup>17</sup> Even though these courts seem

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<sup>12</sup>Mentally Ill Offender Treatment and Crime Reduction Act of 2004, S. 2789, 108th Cong. § 2 (2004), <http://www.theorator.com/bills108/hr2387.html> (last visited Feb. 21, 2006).

<sup>13</sup>Scott, *supra* note 7.

<sup>14</sup>*Id.*

<sup>15</sup>*Id.* Juvenile offenders earn their freedom by attending drug counseling sessions, participating in community service, and regularly reporting their progress to juvenile drug court judges.

<sup>16</sup>Gene Griffin & Michael Jenuwine, *Using Therapeutic Jurisprudence to Bridge the Juvenile Justice and Mental Health Systems*, 71 U. CIN. L. REV. 65, 65-81 (2002) (defining therapeutic justice as the use of social science to study the extent to which a legal rule or practice promotes the psychological or physical well-being of the people it affects).

<sup>17</sup>DONNA L. BOONE, C. WEST HUDDLESTON, & KAREN FREEMAN-WILSON, *PAINTING THE PICTURE: A NATIONAL REPORT CARD ON DRUG COURTS AND OTHER PROBLEM SOLVING*

facially different, they all share the common factor: attempting to address the underlying social or psychological problems that face an offender instead of solely acting as a distributor of punishment.<sup>18</sup>

Problem-solving courts are relatively new, but they can no longer be considered a novelty in the justice system. The American Bar Association, judges across the nation, court personnel, and the federal government are all endorsing problem-solving courts as a key component in the future of the American justice system.<sup>19</sup> Judge Jonathon Lohn, of the newly formed Medina County Juvenile Drug Court, likened the emergence of problem-solving courts to that of the Mother's Against Drunk Driving (MADD) movement in the 1980s, which called attention to the serious problem of drinking and driving in this country.<sup>20</sup> Judge Lohn remarked, "judges new and old must embrace therapeutic ideals because they are going to become more and more prevalent in the future."<sup>21</sup> The following is an overview of two specific problem-solving courts currently in place today: the juvenile mental health courts and the juvenile drug courts.

### B. Drug Court History

The first drug court was established in 1989 in Dade County, Florida.<sup>22</sup> The drug court concept was developed in Florida in response to a federal ultimatum that Florida act to reduce the number of its incarcerated inmates or face losing valuable federal funding.<sup>23</sup> As a result, Supreme Court of Florida member Herbert Klein was directed to research the emerging problem of inmate over population.<sup>24</sup> Through his research, Klein discovered that a majority of inmates were incarcerated because of drug offenses.<sup>25</sup> He further discovered that many of these inmates continued to recycle back into the criminal justice system because of their drug addiction problems.<sup>26</sup> He then decided that, in order to break this pattern of criminal recycling, additional drug treatment services must be coupled with traditional criminal justice

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COURTS IN THE UNITED STATES 6 (Nat'l Drug Court Inst. 2004) [hereinafter "Boone et al.,"] (the use of therapeutic justice has extended into other areas, such as family dependency treatment court, reentry drug court, tribal healing to wellness court, community court, and teen court).

<sup>18</sup>Scott, *supra* note 7, at 4 (describing several essays calling court proceedings as teaching moments or therapeutic opportunities to instill self-confidence in the offender).

<sup>19</sup>*Id.*

<sup>20</sup>Interview with Judge John Lohn, Medina County Juvenile Drug Court in Medina, Ohio (Dec. 7, 2004) [hereinafter "Judge Lohn Interview"].

<sup>21</sup>*Id.*

<sup>22</sup>Scott, *supra* note 7 (Pennsylvania, California, Ohio, and many other states quickly followed this trend).

<sup>23</sup>Florida State Courts, *Drug Court Program*, [http://www.flcourts.org/gen\\_public/family/drug\\_court/index.shtml](http://www.flcourts.org/gen_public/family/drug_court/index.shtml) (last visited Feb. 21, 2006) [hereinafter "Florida State"].

<sup>24</sup>*Id.*

<sup>25</sup>*Id.*

<sup>26</sup>*Id.*

procedures.<sup>27</sup> With the help of then-district attorney Janet Reno, Klein implemented the first drug court.<sup>28</sup> Since the inception of the drug court in 1989, almost 1,700 new problem-solving courts have emerged in the United States as of December 2003.<sup>29</sup>

### C. Today's Juvenile Drug Court

The National Criminal Justice Reference Service defines a juvenile drug court as "a special court given the responsibility to handle cases involving drug addicted offenders through extensive supervision and treatment programs."<sup>30</sup> More specifically, juvenile drug courts represent a coordinated effort among judges, prosecutors, defense attorneys, probation officers, law enforcement officers, the mental health and social service community, and members of the local community.<sup>31</sup> In order for the juvenile drug court system to operate properly, these groups must actively and forcefully work to intervene and to break the cycle of abuse, addiction, and crime that plague many of today's juvenile offenders.<sup>32</sup>

While not every one is the same, juvenile drug courts across the United States share several key components that have led to their overwhelming success.<sup>33</sup> The first component is its use of a non-adversarial approach to integrate alcohol and other drug treatment services with the justice system's traditional case proceedings.<sup>34</sup> This involves the use of alcohol and drug treatment clinicians in almost every phase of the drug court's proceedings in order to help the juveniles confront and eventually to overcome their addiction and abuse problems.<sup>35</sup> The next crucial step in almost all drug courts is to identify potential participants who may be eligible for the drug court program and quickly place them into the program's treatment process.<sup>36</sup> Due to the individualized treatment of each drug court participant, quick placement of an eligible juvenile helps that youth receive necessary treatment as soon as possible.

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<sup>27</sup>*Id.*

<sup>28</sup>Florida State, *supra* note 23.

<sup>29</sup>Boone et al., *supra* note 17. The following states having the most problem-solving courts: California, 248; Arizona, 84; Florida, 140; New York, 95; Ohio, 64; Missouri, 100; North Carolina, 73; and Indiana, 43.

<sup>30</sup>National Criminal Justice Reference Service, *In the Spotlight Drug Courts-Summary*, [http://www.ncjrs.org/drug\\_courts/summary.html](http://www.ncjrs.org/drug_courts/summary.html) (last visited Feb. 21, 2006) (stating that the three primary goals of drug courts are 1) to reduce recidivism, 2) to reduce substance abuse among its participants, and 3) to rehabilitate its participants) [hereinafter "*Spotlight*"].

<sup>31</sup>*Id.*

<sup>32</sup>Boone et al., *supra* note 17. While all drug courts across the United States may vary, these components are essential to keeping the fidelity of the drug court model.

<sup>33</sup>*Id.*

<sup>34</sup>*Id.*

<sup>35</sup>*Id.*

<sup>36</sup>Scott, *supra* note 7. The completion of North Dakota's juvenile drug court program will result in expungement of the offender's juvenile record if the offender is able to stay drug and offense free for two years.

Juvenile drug courts often receive many applicants because the participation and completion of the drug court program often lead to a complete dismissal of all charges brought against the juvenile offender.<sup>37</sup> Due to this appealing potential outcome, juvenile drug courts must be carefully selective when choosing who participates in the program, especially in light of the very finite resources that many drug court programs are forced to deal with.<sup>38</sup>

Another common component of drug courts nationwide is the constant monitoring and drug or alcohol testing of its participants.<sup>39</sup> The constant testing and monitoring ensures that participants are reforming their drug or alcohol problems while also helping to gauge the effectiveness of the drug court program in general.<sup>40</sup> Finally, on-going judicial interaction with each participant is vital to the success of juvenile drug court programs.<sup>41</sup> This innovative component requires judges to partially abandon their traditional role in the court system and to act more as a guidance counselor, providing encouragement when necessary while actively disciplining the juvenile when they incur setbacks.<sup>42</sup> Juvenile drug court proceedings may differ nationwide, but each program incorporates these important components in one form or another. The following section outlines the specific procedures that Medina County, Ohio's juvenile drug court implements to reform juvenile drug users.

#### D. Medina County Juvenile Drug Court

In order to get a firm understanding of the therapeutic justice system and how it needs to evolve, one should understand how therapeutic courts like juvenile drug courts currently operate. The following procedures are based primarily on the Medina County Juvenile Drug Court model, on interviews of its personnel, and on the author's own experience observing the court in action.<sup>43</sup> Additional procedures are also referenced from several other juvenile drug courts across the United States.<sup>44</sup>

The first step for a juvenile in the drug court process is to gain acceptance into the juvenile drug court program. To be eligible for acceptance, the applicant must have committed a non-violent, drug or alcohol related offense.<sup>45</sup> Most, if not all

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<sup>37</sup>Judge Lohn Interview, *supra* note 20. Judge Lohn commented his frustration with not being able to help all juveniles in need due to a lack of resources.

<sup>38</sup>Boone et al., *supra* note 17.

<sup>39</sup>*Id.*

<sup>40</sup>*Id.*

<sup>41</sup>*Id.*; see also Scott, *supra* note 7.

<sup>42</sup>*Handbook*, *supra* note 9. Medina County Juvenile Drug Court's mission is to offer a compelling, innovative, and forward-thinking alternative to juveniles and their families whose criminal justice involvement stems from alcohol and other drug usage by using immediate and comprehensive judicial monitoring.

<sup>43</sup>Superior Court of California, Nevada County Juvenile Drug Court Homepage, [http://court.co.nevada.ca.us/services/family\\_law/drug\\_court.htm](http://court.co.nevada.ca.us/services/family_law/drug_court.htm) (last visited Feb. 21, 2006).

<sup>44</sup>*Handbook*, *supra* note 9.

<sup>45</sup>*Id.*



juvenile drug courts will not accept an applicant if the applicant has any current or past drug trafficking or sex related offenses.<sup>46</sup> Other courts grant eligibility to applicants with histories of drug or alcohol abuse or are at risk for out-of-home placement due to the applicant's substance abuse.<sup>47</sup>

If an applicant fits the drug court program's necessary criteria, then either a drug court probation officer or a case manager will decide if the applicant should be referred to participate in the juvenile drug court program.<sup>48</sup> Due to the drug court's limited resources, it is important that applicants are chosen very carefully.<sup>49</sup> Drug courts must take many steps to ensure that the applicants chosen to participate will be the ones who will benefit the most from the program's valuable, yet limited resources.<sup>50</sup>

Once a juvenile is accepted, the next step involves an informational meeting with a drug court officer, the juvenile, and the juvenile's parents.<sup>51</sup> At this stage, the juvenile and the juvenile's parents are given a full explanation of the drug court program's goals and its processes.<sup>52</sup> An important aspect of the program is that it is strictly voluntary; so, at this point, the applicant and her parents must decide whether or not to participate in the very time-intensive program.<sup>53</sup> If the applicant accepts the offer to participate, then a drug court clinician will administer a "Comprehensive Clinical Assessment" to decide whether the applicant will need to enter the intensive or non-intensive component of the juvenile drug court program.<sup>54</sup> Factors involved in this decision include the participant's history of drug or alcohol use, the age of the participant, and the current offense that has brought the juvenile into the drug court process.<sup>55</sup> The following will explain the differences between the intensive and non-intensive phases of the juvenile drug court.

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<sup>46</sup>Florida State, *supra* note 23.

<sup>47</sup>Interview with Tony Miller, Probation Officer of Medina County Juvenile Drug Court, in Medina, Ohio (Dec. 28, 2004) [hereinafter "Miller Interview"]. Mr. Miller stated that the factors for acceptance into the drug court program include: the present offense committed, past offenses, and the probability that participation in the program will yield successful results by helping the juvenile stop using drugs or alcohol.

<sup>48</sup>*Id.*

<sup>49</sup>*Id.* (stating that at this point many applicants and their parents are overwhelmed by the intensity of the program and often take several days to decide whether to participate).

<sup>50</sup>*Id.*

<sup>51</sup>*Id.*

<sup>52</sup>Miller Interview, *supra* note 47 (stating that this initial drug screen is conducted to quickly demonstrate that drug screens indeed will be performed).

<sup>53</sup>*Handbook*, *supra* note 9, at 6. The three goals of the non-intensive program are to motivate change, to receive alcohol and drug education, and to learn and apply skills to manage problems without alcohol or drug abuse.

<sup>54</sup>*Id.*

<sup>55</sup>*Id.*

### 1. Non-Intensive Phase

In Medina County, the non-intensive component lasts for approximately four months.<sup>56</sup> This component requires the juvenile to attend a weekly, three-hour group session with an Alcohol and Drug Dependency Services (ADDS) clinician.<sup>57</sup> During these sessions, the clinicians emphatically teach anger awareness and management skills, problem solving skills, drug and alcohol refusal skills, and other skills in areas that will help the juvenile terminate her use of drugs or alcohol. A common component in both the intensive and non-intensive phase is a weekly, mandatory meeting that each parent of a participating juvenile must attend.<sup>58</sup> The same clinicians that meet with the juveniles facilitate the ten-week parent meetings.<sup>59</sup> In addition, the non-intensive program requires the juveniles to attend a monthly review hearing in front of the juvenile drug court judge.<sup>60</sup> The last element of the non-intensive phase requires participants to be subject to random drug testing at any time during the program.<sup>61</sup> Random and frequent testing is done in order to ensure that drug court participants are strictly complying with the ban on the use of drugs or alcohol while participating in the program.<sup>62</sup> The random drug test can be performed virtually anywhere, including at the juvenile's school, work, home, or anywhere else the juvenile can be found.<sup>63</sup> In order to conduct such drug testing, the juvenile and the juvenile's parents must sign a "random drug test" consent form in order to participate in the drug court program.<sup>64</sup>

### 2. Intensive Phase

Medina County Juvenile Drug Court's intensive component is comprised of three phases, each lasting at least four months.<sup>65</sup> The first and most intense phase requires the child to attend three weekly meetings with an ADDS clinician. Like the non-

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<sup>56</sup>*Id.*

<sup>57</sup>*Id.* Other programs reviewed by clinicians include motivation building, goal-setting, increasing pleasant activities, planning for emergencies, coping with relapses, effective communication, coping with cravings and urges to use substances, depression management, and managing thoughts about substance abuse.

<sup>58</sup>*Id.*; see also Miller Interview, *supra* note 47 (stating that the juvenile drug court program stresses the importance of the parental meetings because they help parents better to cope with and to understand their children so that they can stop the child's drug or alcohol use).

<sup>59</sup>Miller Interview, *supra* note 47.

<sup>60</sup>*Id.*

<sup>61</sup>*Id.*

<sup>62</sup>*Id.* (stating that, as a probation officer, drug screening is one his most important duties to the drug court); see also *Handbook*, *supra* note 9.

<sup>63</sup>See *Handbook*, *supra* note 9.

<sup>64</sup>*Id.* at 2.

<sup>65</sup>*Id.* at 8. The intensive program can be completed in nine months; however, practical experience has shown that the completion time is closer to at least twelve months.

intensive component, each meeting lasts three hours.<sup>66</sup> “Phase one” also requires the participant and the parents to attend weekly review hearings in front of the juvenile drug court judge.<sup>67</sup> As with the non-intensive component, parents are required to attend weekly meetings for a ten week period.<sup>68</sup> During phase one, drug screening is often very intense, sometimes calling for a participant to be tested bi-weekly.<sup>69</sup> Frequent drug screenings are very important and common among juvenile drug courts during the early intervention period of the program to ensure that the participants are willing to commit to the program by abstaining from alcohol and drugs.<sup>70</sup> A positive drug screen during this period can result in expulsion from the program.<sup>71</sup> However, other courts require multiple positive drug screens before a participant is expelled from the drug court program.<sup>72</sup>

If a participant completes all of the requisites of phase one, under the discretion of the drug court, the participant graduates into “phase two” of the drug court program.<sup>73</sup> Phase two requires the participant to attend two three-hour sessions per week, while also requiring to attend a drug court review twice a month.<sup>74</sup> Drug screening is not as intense as it was in phase one but can still be administered at any time in the probation’s office’s discretion.<sup>75</sup> If the participant satisfies all of the requirements of phase two, then the participant graduates to “phase three,” which is substantially similar to the non-intensive phase described above.<sup>76</sup> Upon successful completion of phase three, the participant graduates from the program.<sup>77</sup> Even though much of a juvenile drug court participant’s time is spent outside of the court room, the time that a juvenile spends in front of the drug court judge is very important because it reinforces many of the lessons that the participant is learning during the clinician and probation departmental meetings.

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<sup>66</sup>*Id.* These meetings place an emphasis on stabilizing the child’s current situation while providing increased guidance, supervision, support, and encouragement to the participant and the participant’s family.

<sup>67</sup>*Id.*

<sup>68</sup>*Handbook, supra* note 9.

<sup>69</sup>Miller Interview, *supra* note 47.

<sup>70</sup>Boone et al., *supra* note 17.

<sup>71</sup>*Handbook, supra* note 9, at 19. The termination of the drug court program can also occur at the court’s discretion for excessive absenteeism or tardiness for program events, curfew violations, non-completion of required community service, major disruptive or disrespectful behavior, or negative reports from parents or teachers.

<sup>72</sup>Miller Interview, *supra* note 47.

<sup>73</sup>Judge Lohn Interview, *supra* note 20.

<sup>74</sup>Miller Interview, *supra* note 47.

<sup>75</sup>*Id.*

<sup>76</sup>*Id.*

<sup>77</sup>*Id.*

### 3. Drug Court Hearings

In Medina County, juvenile drug court is held weekly.<sup>78</sup> Even though the actual proceeding only lasts about an hour, drug court personnel accomplish much in the time before a juvenile appears with parents before the judge. On the day of review hearings, probation officers, clinicians, and other court personnel hold various meetings where they share the information compiled on each specific juvenile since the juvenile's last review hearing.<sup>79</sup> The probation officer's information includes reports from a child's teachers, bosses, school counselors, and the results from any drug screenings that were administered during that time.<sup>80</sup> The clinician then provides input concerning how the juvenile is progressing in weekly counseling meetings in regards to reforming substance or alcohol use issues.<sup>81</sup> Based on this meeting, the clinicians and the probation officers form separate recommendations concerning each individual to give to the juvenile drug court judge.<sup>82</sup>

Before the review hearings are held, the clinicians and probation officers meet with the drug court judge to review each individual's progress.<sup>83</sup> Based on the recommendations of the clinicians, probation officers, and on the judge's own judgment, the judge decides whether to reward or to sanction the juvenile during the drug court review hearing.<sup>84</sup> Some of the available sanctions to a drug court judge include increased community service, a decrease in the juvenile's curfew, temporary assignment to a juvenile detention center, or a verbal reprimand.<sup>85</sup> Rewards can include an increase of curfew, release from a detention center or similar facility, verbal praise, or, most importantly, the granting of a right to graduate to the next phase of the program.<sup>86</sup>

The last step of hearing day is the formal drug court review proceeding.<sup>87</sup> One caveat to this proceeding is that each participant's review hearing is held in front of

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<sup>78</sup>*Id.*

<sup>79</sup>*Id.* During these meetings, the perspectives of a probation officer and that of a clinician on a juvenile participant's progress often vary due to the different roles that each plays in the juvenile's drug court experience. Differing views also stem from the different perspectives one must take in order to perform a particular job successfully.

<sup>80</sup>*Id.*

<sup>81</sup>*Id.*

<sup>82</sup>*Id.* (stating that sometimes the clinician and probation officer will have two completely different recommendations concerning a participant, but believing that these varying perspectives and opinions are a strength of the program because it allows for alternative points of views when evaluating treatment methods).

<sup>83</sup>*Id.* In an average drug court review hearing, approximately twenty juveniles may be up for review.

<sup>84</sup>Miller Interview, *supra* note 47.

<sup>85</sup>*Handbook*, *supra* note 9, at 18. Other sanctions available are: fines, increased drug testing, increased court appearances, electronic monitoring, written assignments, loss of driver's license, and attendance and reporting to adult court proceedings.

<sup>86</sup>*Id.* Other rewards available include reinstatement of driving privileges, reduction in required community service hours, or less frequent drug screening.

<sup>87</sup>Miller Interview, *supra* note 47.

all other participants and their parents that are scheduled for an appearance that day.<sup>88</sup> Judge Lohn feels this is very important because it reinforces the idea of accountability.<sup>89</sup> He states, “this way, every other child can see that both good and bad consequences can result from their behavior, that these are just not idle threats or promises dangled above the children’s heads.”<sup>90</sup> The review hearing also represents where the traditional authoritarian role of a judge must be modified.<sup>91</sup> Here, a judge must act as a quasi-counselor, giving praise when merited but also handing out sanctions if necessary.<sup>92</sup>

During the hearing, each juvenile and her parents are called forward to sit in front of the judge.<sup>93</sup> The judge then hands down his decision to sanction or to reward the juvenile.<sup>94</sup> The decision to sanction or reward a participant is very important and demonstrates precisely why a mental health element is needed within the juvenile drug court system. As Judge Lohn commented, “I can’t properly determine whether or not to sanction a juvenile if I don’t know if she is mentally responsible for her actions or the way she is currently responding to the court’s treatment. This is where a mental health report from a specialist would help me determine just how culpable the juvenile is for her behavior.”<sup>95</sup> The therapeutic justice system’s goal is that of rehabilitation and reform.<sup>96</sup> However, for a juvenile drug court system to deal properly with a child that has an undiagnosed or untreated mental disease, it is nearly impossible to reform the child without first addressing the child’s mental health needs.<sup>97</sup> This is not an easy task, but it is a necessary one in order for therapeutic courts like juvenile drug courts to continue to succeed in the future. This Note will address later other issues facing the addition of a mental health component into the juvenile drug court system.

#### E. Drug Courts Results: Recidivism, Costs and Community Impact

The therapeutic justice system is a fresh and innovative approach to treating juvenile offenders, in that it seeks to rehabilitate and reform juveniles into productive members of society rather than simply sending them to jail or detention centers.<sup>98</sup>

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<sup>88</sup>*Id.*

<sup>89</sup>Judge Lohn Interview, *supra* note 20.

<sup>90</sup>*Id.* (commenting that the drug court review hearing may be a judge’s most important role in the drug court process).

<sup>91</sup>Scott, *supra* note 7.

<sup>92</sup>*Id.*

<sup>93</sup>Miller Interview, *supra* note 47.

<sup>94</sup>*Id.* The reports given by the probation officer and clinicians to the drug court judge will be almost exactly the same report given during the pre-trial meeting.

<sup>95</sup>Judge Lohn Interview, *supra* note 20 (stating that, in the near future, he would like to incorporate a mental health element into the current drug court procedures).

<sup>96</sup>Scott, *supra* note 7 (emphasizing the necessity of active judicial involvement and the explicit use of judicial authority in order to motivate individuals to accept needed services).

<sup>97</sup>*See* Scott, *supra* note 7.

<sup>98</sup>Boone et al., *supra* note 17, at 2.

Due to the relative novelty of this approach, it is important to analyze whether or not the current therapeutic systems are effective in their goals of rehabilitating and reforming the juvenile offenders that the programs engage. Although a uniform national study does not exist, many independent studies show that juvenile drug courts out-perform their traditional counterparts in recidivism rates, rates of reformation, and in overall cost of operation.<sup>99</sup>

### 1. Recidivism Rates

Researchers and commentators alike agree that drug courts out-perform virtually all other strategies that have been instituted in rehabilitating and reforming both juvenile and adult criminal drug offenders.<sup>100</sup> According to a National Institute of Justice study of 17,000 drug court graduates nationwide, only 16.4% of those graduates have been re-arrested and charged with a felony within a year of graduation from a drug court program.<sup>101</sup> Another study conducted by the Center for Court Innovation showed similar results.<sup>102</sup> This study showed that, among 2,135 drug court participants, the re-arrest rate was 29% lower than that of non-participants.<sup>103</sup> Research among drug court participating counties shows similar results.<sup>104</sup> In Dallas, Texas, drug court participants have a 15.6% re-arrest rate versus a 48.7% for non-participants.<sup>105</sup> Dade County, Florida reported a 33% re-arrest rate versus a 48% rate for non-participants.<sup>106</sup>

These numbers indicate that drug courts are currently accomplishing their goals of rehabilitation while also preventing their participants from simply recycling back into the criminal justice system.<sup>107</sup> The therapeutic system, with its emphasis on reformation, clearly helps its participants to confront and overcome their previous substance abuse problems that may very well have plagued them for the rest of their lives if gone untreated or undetected.<sup>108</sup> As this Note will later demonstrate, the incorporation of a mental health element into current drug court procedures will further increase the efficiency in which drug courts continue to successfully rehabilitate their participants.

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<sup>99</sup>*Id.*

<sup>100</sup>*Id.* at 2 (based on Vera Institute of Justice report, which stated that the body of literature on recidivism is now strong enough to conclude that completing a drug court program reduces the likelihood of future arrest).

<sup>101</sup>*Id.*

<sup>102</sup>*Id.*

<sup>103</sup>Boone et al., *supra* note 17 (suggesting that drug court cases reach initial disposition more quickly than conventional court cases).

<sup>104</sup>*Id.*

<sup>105</sup>*Id.*

<sup>106</sup>*Id.* In Chester County, Pennsylvania, drug court graduates had a re-arrest rate of 5.4% versus a 21.5% rate for the control group.

<sup>107</sup>*Id.*

<sup>108</sup>*See* Scott, *supra* note 7.

## 2. Drug Courts Save Money

One may be led to believe that the therapeutic approach to justice, based on its individualistic approach by offering treatment and other rehabilitative services, is necessarily more expensive than traditional system. Studies have shown, however, that a community's investment in juvenile and adult drug courts pays off significantly in the long run in the form of lower crime rates among its participants.<sup>109</sup> A study of six drug courts in Washington State reported that the 13% reduction of the recidivism rates of the court's participants equates to nearly \$6,800 savings per participant to taxpayers in that State.<sup>110</sup>

These figures are based primarily on two cost avoiding factors:<sup>111</sup> first, the expense of having to prosecute an offender for a crime that was avoided because of the previously received drug court rehabilitative services;<sup>112</sup> and second, the costs to the victims of the crimes that were avoided.<sup>113</sup> A study conducted by the Center for Court Innovation estimated that New York State saved \$254 million by diverting non-violent drug offenders into drug treatment programs rather than to jails.<sup>114</sup> Researchers in California estimated that its \$14 million investment into drug court programs created a total cost avoidance of \$43.3 million over a two-year period.<sup>115</sup> Finally, researchers at the Department of Economics at Southern Methodist University reported that, for every dollar spent on drug courts in Dallas, \$9.43 in tax dollar savings per participant was realized over a 40-month period.<sup>116</sup> These studies demonstrate that treatment and support for non-violent drug offenders is often more cost effective in the long run than the traditional punitive based systems.<sup>117</sup> Drug court participants not only cost less to taxpayers, but the participants are given a chance to rehabilitate themselves and become more productive members of a safer society.

The therapeutic justice system, which began with drug courts, has shown success in other areas as well. The following discussion of juvenile mental health courts demonstrates that the therapeutic model is applicable to many other areas of justice as well.

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<sup>109</sup>Boone et al., *supra* note 17.

<sup>110</sup>*Id.*

<sup>111</sup>*Id.*

<sup>112</sup>*Id.*

<sup>113</sup>Boone et al., *supra* note 17. A study of six drug courts in Washington State attributed the savings by \$3,020 in avoided costs to potential victims and \$3,759 in avoided criminal justice system costs to citizen taxpayers of the state.

<sup>114</sup>*Id.* These conclusions are based on a \$254 million savings by diverting almost 18,000 non-violent drug offenders into treatment instead of to prison.

<sup>115</sup>*Id.* (concluding that the savings were based on over 425,000 prison days avoided in addition to the fees and fines paid by participants of the drug court program).

<sup>116</sup>*Id.*

<sup>117</sup>*See id.*

## III. JUVENILE MENTAL HEALTH COURTS

A 2003 Senate Committee Report on Governmental Affairs reported that approximately 15,000 children with mental illnesses were improperly incarcerated in detention centers because of a lack of necessary mental health treatment.<sup>118</sup> This same report further determined that 33 of this nation's states detained children with mental illnesses in juvenile detention centers, children who faced no criminal charges.<sup>119</sup> In addition to these disturbing facts a Senate committee found that 117 detention centers incarcerated children under the age of eleven with mental disorders, that 7% of children in detention centers (2,000) remain incarcerated because of a lack of access to treatment, and that 66% of detention centers reported that they incarcerated children with mental illnesses because there is no other place for them to go.<sup>120</sup> These statistics demonstrate the unfortunate trend of juvenile detention centers becoming "*de facto*" psychiatric hospitals for mentally ill youth.<sup>121</sup> Unfortunately, juveniles with mental illnesses pose special problems for the juvenile justice system.<sup>122</sup>

Due to the fact that juvenile mental illnesses are difficult to detect, oftentimes juveniles are released from detention facilities without treatment and recycle back into the juvenile criminal justice system because of this lack of treatment.<sup>123</sup> Unlike criminal adult offenders with mental illnesses, extra attention must be directed to the detection and treatment of juvenile mental illnesses because a juvenile's mental illness symptoms will only increase as the juvenile matures and becomes an adult. The addition of a mental health element into juvenile drug courts will not completely eradicate this problem, but it represents a step in the right direction when it comes to detecting and treating juvenile mental health issues. The following section demonstrates the federal government's concern for mentally ill offenders, both juvenile and adult alike.<sup>124</sup>

A. *Mental Health Court Program and SAMSHA*

In response to the problem of mentally ill juvenile offenders recycling back into the juvenile justice system, America's Law Enforcement and Mental Health Project created the Mental Health Courts Program.<sup>125</sup> The Bureau of Justice Assistance runs

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<sup>118</sup>Robert Pear, *Many Youths Reported Awaiting Mental Help*, N.Y. TIMES, July 8, 2004, at A18 (according to a report released by a Senate Judiciary on Governmental Affairs hearing).

<sup>119</sup>*Id.* These findings were based on information found from a survey of 524 juvenile detention centers nationwide in 2003.

<sup>120</sup>*Id.*

<sup>121</sup>*Id.* This finding was based on witness testimony that children with mental illnesses are incarcerated in mental facilities because their parents do not have access to treatment in schools or lack health coverage for such treatment.

<sup>122</sup>*Id.*

<sup>123</sup>Pear, *supra* note 118. In testimony, Judge Ernestine Grey stated that it is a "miscarriage of justice" to detain children with mental health illnesses who have committed no crimes. *Id.*

<sup>124</sup>*See* America's Law Enforcement and Mental Health Act, 42 U.S.C. § 3711 (2000).

<sup>125</sup>*Id.* (passed by President Bill Clinton on November 13, 2000, and authorizing 100 grants to state and local governments to create mental health court programs).



the Mental Health Courts Program in coordination with the Substance Abuse and Mental Health Services Administration (SAMHSA).<sup>126</sup> This program funds projects to help communities implement innovative and collaborative efforts that bring system-wide improvements to the manner in which the needs of mentally ill juvenile offenders are addressed.<sup>127</sup>

The Mental Health Courts Program suggests that communities use their educational system, recreational programs, mental health systems, and drug or alcohol treatment programs to help solve the issues that face juvenile, non-violent offenders with mental illnesses.<sup>128</sup> More specifically, the Bureau of Justice Assistance seeks to fund programs that emphasize periodic judicial review and supervision of non-violent juveniles with mental illnesses, mental retardation or co-occurring mental illness and substance abuse disorders.<sup>129</sup> The Mental Health Program recommends that prospective community programs employ the use of specially trained criminal justice personnel to identify and address the unique needs of mentally ill offenders.<sup>130</sup> The Mental Health Court Program requires court personnel to consolidate cases specifically involving mentally ill, non-violent offenders and to provide these juvenile offenders with specific mental health treatment plans and social services so that they do not simply recycle back into the juvenile justice system.<sup>131</sup>

In response to increased juvenile recidivism rates, juvenile mental health courts have sought to provide expedited service, individualized and appropriate treatment, and consistent monitoring of each participant during the mental health court process.<sup>132</sup> These are the same principles that other problem-solving courts, including juvenile drug courts, rely on for their success.<sup>133</sup> To demonstrate the rising prevalence of juvenile offenders mental health concerns, such as the ones the Mental Health Courts Program seeks to address, one should look to this country's first juvenile mental health court.

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<sup>126</sup>Bureau of Justice Assistance Website, Mental Health Courts, <http://www.ojp.usdoj.gov/BJA/grant/mentalhealth.html> (last visited Jan. 19, 2005) [hereinafter "Bureau"].

<sup>127</sup>*Id.*

<sup>128</sup>*Id.* The goal of the grant program is to decrease the frequency of a client's contact with the criminal justice system by providing stable employment, housing, treatment, and support services.

<sup>129</sup>*Id.*

<sup>130</sup>*Id.*

<sup>131</sup>Bureau, *supra* note 126. The programs authorized by this grant should carry on this voluntary program in the least restrictive manner possible.

<sup>132</sup>*Id.*; *see also* Florida State, *supra* note 23.

<sup>133</sup>Boone et al., *supra* note 17.

*B. Santa Clara's Court for the Individualized Treatment of Adolescents*

On February 14, 2001, Santa Clara, California debuted the nation's first juvenile mental health court.<sup>134</sup> The Santa Clara County Court for Individualized Treatment of Adolescents (CITA) was created in response to the difficulties that the juvenile criminal justice system has encountered in handling mentally ill, juvenile offenders.<sup>135</sup> Studies have shown that 15-20% of juvenile offenders suffer from severe biological mental disorders, such as schizophrenia or bipolar disorder.<sup>136</sup> Furthermore, research suggests that less serious mental illnesses, such as attention deficit hyperactivity disorder (ADHD), occur in 40-70% of the juvenile, criminal offenders.<sup>137</sup>

These numbers suggest that both the mental health community and the juvenile justice system are failing to screen and treat youths with co-morbid behavioral, developmental, and psychiatric problems.<sup>138</sup> Mental health detection and treatment services in therapeutic courts, such as drug courts, are very important because undiagnosed psychiatric conditions are a substantial impediment to effective treatment of juvenile offenders.<sup>139</sup> For example, it is difficult to help a juvenile stop abusing drugs or alcohol if the underlying reason they are doing drugs is to cope with a mental disorder or illness.<sup>140</sup>

Based on the above data, CITA seeks to hold juvenile offenders strictly accountable for their behavior while matching them with the appropriate diagnostic, therapeutic, and aftercare programs in order to decrease the likelihood that the juvenile will commit another crime.<sup>141</sup> It should be noted, however, that this system is not meant to be a delivery system for severely mentally ill juveniles.<sup>142</sup> Instead, mental health courts seek 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.<sup>143</sup> This program seeks to divert children from juvenile detention centers, where they are not only receiving inadequate treatment, but also are taking up valuable space for more serious juvenile offenders.<sup>144</sup>

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<sup>134</sup>Arrendondo et al., *supra* note 9, at 7. CITA was formed with the goal of becoming the first court in the nation aimed at making mental health concerns a priority by dealing with certain juvenile offenders that showed possible signs of mental illnesses.

<sup>135</sup>*Id.*

<sup>136</sup>*Id.* at 3.

<sup>137</sup>*Id.* at 7.

<sup>138</sup>*Id.* at 3.

<sup>139</sup>*Id.* at 7.

<sup>140</sup>*See* Judge Lohn Interview, *supra* note 20.

<sup>141</sup>Arredondo et al., *supra* note 9.

<sup>142</sup>*Id.*

<sup>143</sup>*Id.* With the coordinated efforts of the courts and mental health treatment providers, early identification of mental health issues can help youths with serious mental illnesses.

<sup>144</sup>*Id.*

CITA, just like juvenile drug courts, seeks to provide individualized and expedited dispositions of the juvenile participants.<sup>145</sup> The processes that CITA uses are similar to those of other problem solving courts.<sup>146</sup> Additionally, CITA utilizes innovative personnel techniques that other therapeutic courts can learn from.<sup>147</sup> It should be noted that the following positions in the mental health court are to act as a team, with the best interests of the mentally ill offender in mind while also keeping the best interests of the community in close sight.<sup>148</sup>

#### 1. CITA's Key Personnel

The first key actor in the mental health court is the mental health coordinator.<sup>149</sup> The coordinator is responsible for administering and presenting the mental health assessment findings to the mental health court team.<sup>150</sup> These findings can include any psychological, behavioral, social, familial, or educational issues that were discovered in the initial assessment of the juvenile.<sup>151</sup> As the title of the position might indicate, the mental health coordinator must also conduct comprehensive mental health assessments to determine whether or not a juvenile is eligible for CITA.<sup>152</sup>

Ultimately, this role is responsible for coordinating the overall assessment, treatment planning, and disposition of the minor throughout the mental health court process.<sup>153</sup> This position is important because it has the power to refer the juvenile to psychologists, special education programs, or any other programs which will help the minor become a productive, non-criminal member of society.<sup>154</sup> As the Note will later discuss, this position provides a model of what juvenile drug courts should employ into their current systems in order to deal with participants with co-occurring mental health and substance abuse issues.

The next role in the juvenile mental health court system is the probation department.<sup>155</sup> A probation officer's role is to implement the directives of the court and to supervise the development of the minor's treatment plans.<sup>156</sup> A probation officer acts as a liaison for the court to outside mental health treatment programs and

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<sup>145</sup>*Id.*

<sup>146</sup>Arredondo et al., *supra* note 9; *see also Handbook*, *supra* note 9.

<sup>147</sup>Arredondo et al., *supra* note 9.

<sup>148</sup>*Id.* at 8. Possible barriers to court personnel's teamwork include language and cultural barriers.

<sup>149</sup>*Id.*

<sup>150</sup>*Id.*

<sup>151</sup>*Id.*

<sup>152</sup>Arredondo et al., *supra* note 9.

<sup>153</sup>*Id.*

<sup>154</sup>*Id.*

<sup>155</sup>*Id.*

<sup>156</sup>*Id.*

ensures that the juvenile is receiving proper care for the mental illness.<sup>157</sup> Lastly, the probation officer is responsible for the presentation of findings to the CITA multi-disciplinary team meeting.<sup>158</sup> This position should sound very similar to that of the probation department of the juvenile drug court system.<sup>159</sup> CITA's probation department demonstrates that it is not out of the realm of its expertise to deal with co-occurring mental health disorders.<sup>160</sup>

Next a prosecutor is specially assigned to work with a mental health court.<sup>161</sup> The prosecutor assesses whether or not a candidate is suitable for the CITA program, based on the juvenile's current conduct and past criminal history.<sup>162</sup> The prosecutor who fills this role must be specially trained in mental health issues, with an emphasis on multi-agency collaborative approaches to treatment.<sup>163</sup> One interesting feature of the prosecutor's role is that the information that she uses to evaluate the candidacy of a juvenile cannot be used for any other purposes outside of the multi-disciplinary team's meetings.<sup>164</sup> This means that any mental health information disclosed cannot be used against the minor in subsequent court hearings.<sup>165</sup>

Once a candidate is accepted into the program, the prosecutor is then responsible for the formulation and implementation of the participant's treatment plan.<sup>166</sup> What this special prosecutor role represents in the overall therapeutic scheme is a model of a position that could be used unilaterally for all therapeutic courts in a geographic region. For example, if only a few therapeutic courts exist in a given region, then a therapeutic prosecutor could be utilized as a traveling court agent of the therapeutic court system. This in turn would allow the costs of the position to be shared by existing and upstart therapeutic courts alike, while also allowing for the expansion of the problem-solving court system in general.<sup>167</sup>

The last participant in CITA's process is the court itself.<sup>168</sup> In CITA, the same judge handles a case from acceptance through dismissal,<sup>169</sup> ensuring that

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<sup>157</sup>*Id.* A probation officer's duties also include coordinating with educational advocates in order to ensure that the juvenile's academic needs have been identified and that appropriate mental health services are being rendered.

<sup>158</sup>*Id.*

<sup>159</sup>Miller Interview, *supra* note 47.

<sup>160</sup>Arredondo et al., *supra* note 9.

<sup>161</sup>*Id.*

<sup>162</sup>*Id.* (stating that, if a prosecutor deems the minor acceptable for the program, the prosecutor then can contribute to the implementation of the treatment plan).

<sup>163</sup>*Id.*

<sup>164</sup>*Id.*

<sup>165</sup>*Id.*

<sup>166</sup>*Id.*

<sup>167</sup>See Judge Lohn Interview, *supra* note 20 (stating his emphatic belief that therapeutic courts are a necessary and vital approach to juvenile justice in the future).

<sup>168</sup>Arredondo et al., *supra* note 9, at 14.

<sup>169</sup>*Id.*

individualized treatment and consideration is given to the minor at all times.<sup>170</sup> The court's primary function is to fashion the most effective disposition for a minor by considering the needs of the minor, safety to the community, and reinforcement of accountability for the delinquent behavior of the minor.<sup>171</sup> To do so, the judge will review the minor's progress every thirty to ninety days so that he can inquire about the progress of the minor's schooling, medication, therapy, and counseling, as well as any special probation conditions that exist.<sup>172</sup>

As with any of the other member of the CITA multi-disciplinary team, participating judges should have or should be willing to develop a sensitivity to mental health issues of juvenile offenders.<sup>173</sup> This role differs from the traditional role of judges because a participating judge's emphasis must be placed more on "repentance, education, reform, catharsis, and healing," instead of on efficiency in case processing.<sup>174</sup> Also, as with the special prosecutor position, the therapeutic judicial position can be one that is interchanged into other newly forming therapeutic courts within the same region in order to realize therapeutic economies of scale.

## 2. CITA Eligibility

The last element of the mental health court system to be discussed is how a participant becomes eligible for the program and how the program terminates.<sup>175</sup> This will demonstrate how a juvenile drug court can integrate its eligibility criteria for admitting substance-abusing juveniles with a proposed mental health element. For instance, CITA targets youth with serious mental illnesses that contributed to either the youth's criminal conduct or the youth's protracted involvement in the juvenile justice system.<sup>176</sup> Admission is limited to juveniles ages fourteen and above who are not currently or who have never been charged with a serious violent felony.<sup>177</sup> Potential candidates must have been or must be currently diagnosed with a biologically based, serious mental illness.<sup>178</sup> Such illnesses and disorders include major depression, bipolar disorders, schizophrenia, and severe ADHD.<sup>179</sup> Juveniles with conduct disorders, such as impulse control disorder or oppositional defiant disorder, will not be eligible unless these disorders are accompanied by another biologically based diagnosis.<sup>180</sup> As with juvenile drug courts, assessing a juvenile's

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<sup>170</sup>*Id.*

<sup>171</sup>*Id.*

<sup>172</sup>*Id.* at 15.

<sup>173</sup>*Id.* at 9.

<sup>174</sup>Scott, *supra* note 7, at 2.

<sup>175</sup>Arredondo et al., *supra* note 9, at 9.

<sup>176</sup>*Id.* at 11. CITA also targets youth who have not been approached successfully by community mental health treatment agencies.

<sup>177</sup>*Id.* Eligibility is considered on a case-by-case basis, and minors who have committed violent offenses before their fourteenth birthday are not automatically ineligible.

<sup>178</sup>*Id.*

<sup>179</sup>*Id.*

<sup>180</sup>*Id.*

eligibility is very important in determining whether or not to spend a court's valuable and finite resources on a particular child.<sup>181</sup>

Program termination can occur in several ways, including when a minor successfully completes all of the requirements of the program and her mental health issues have been stabilized, when the juvenile commits a new crime while participating in CITA, or when the minor or her parents withdraw from the program.<sup>182</sup> As CITA demonstrates, in order for a proposed mental health element to be introduced into current juvenile drug courts, much more attention must be paid to who is selected into the court program to ensure that the program is being utilized to its fullest potential.<sup>183</sup> CITA represents a workable guide as to how juvenile drug courts can implement diagnostic and selection procedures for mental health care treatment and implementation.

CITA and other mental health courts represent the future on how mentally ill offenders should be dealt with.<sup>184</sup> It will be nearly impossible to decrease the recidivism rates of mentally ill offenders without first addressing the mental illnesses that caused them to be delinquent in the first place.<sup>185</sup> This Note's proposal is simply another tool for courts to use in order to detect and treat mentally ill offenders who have co-occurring substance or alcohol abuse issues that otherwise may have slipped through a traditional court system's cracks.

#### IV. CO-OCCURRENCE OF MENTAL HEALTH ISSUES AMONG JUVENILE DRUG/ALCOHOL OFFENDERS

In order to understand why a juvenile's mental health issues should be considered in the therapeutic justice system, especially in the juvenile drug court model, the current state of juvenile mental health and juvenile substance abuse must be studied jointly.<sup>186</sup> In order to do so, one must first determine whether or not there exists enough prevalence of juvenile drug or alcohol abuse to even warrant drug or other therapeutic courts.<sup>187</sup> It is also important to examine how much more likely, if any, a juvenile criminal offender is prone to use drugs or alcohol.<sup>188</sup> Lastly, in order to

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<sup>181</sup>Miller Interview, *supra* note 47.

<sup>182</sup>Arredondo et al., *supra* note 9, at 17. In addition to biologically based mental illnesses, juveniles with developmental disabilities or those who have suffered severe head injury or trauma may also be eligible for CITA.

<sup>183</sup>*Id.* at 11.

<sup>184</sup>*Id.* at 1.

<sup>185</sup>Judge Lohn Interview, *supra* note 20.

<sup>186</sup>*See* Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. 108-414, 118 Stat. 2327 (2004). The Act cites an occurrence of high levels of mental health disorders among juvenile offenders.

<sup>187</sup>Susan M. Gordon, *Teen Drug Abuse: Underlying Psychological Disorders and Parental Attitudes Have a Big Effect on Teens Addictive Behaviors*, 23 BEHAV. HEALTH MGMT. 25, 25-30 (Sept. 1, 2003).

<sup>188</sup>Substance Abuse And Mental Health Services Administration, Office of Applied Studies, *The National Survey on Drug Use and Health, Substance Use, Abuse, and Dependence Among Youths Who Have Been in a Jail or Detention Center* (2004), available at

determine the utility of a mental health component in juvenile drug courts, a link must be established between juvenile mental health illnesses and subsequent co-occurring drug or alcohol use.<sup>189</sup>

*A. Alcohol and Drug Abuse Among Juveniles*

The rate at which this nation's juveniles are using alcohol and drugs is alarming and represents an area that needs improvement with the help of our juvenile justice system.<sup>190</sup> For example, young people from the ages of 15 to 19 represent the largest group of new alcohol drinkers in the United States.<sup>191</sup> Approximately 50% of adolescents who reported using marijuana stated that they did so for the first time when they were 13 years old or younger.<sup>192</sup> One major contributing factor to juvenile drug and alcohol use is the availability of drugs and alcohol.<sup>193</sup> A survey of high school students revealed that 70% of students said it was "easy" to obtain drugs, while another 25% reported that they could obtain cocaine within twenty-four hours.<sup>194</sup> Another contributing factor to the high level of juvenile drug and alcohol use is that juveniles often use drugs and alcohol to self-medicate themselves or to help themselves cope with difficult times in their lives.<sup>195</sup> Many other reasons exist as to why juveniles frequently use alcohol and drugs, but it is plain to see that America's juveniles are using and abusing drugs and alcohol at a rate substantial enough to induce the use of therapeutic courts as one of many tools to help stop this epidemic.

*B. Juvenile Drug and Alcohol Use Among Juveniles in Detention Centers*

As the following data will demonstrate, juvenile drug use is found to be even more of a problem among juveniles that have been or are currently placed in juvenile detention centers or jails, compared to the general juvenile population.<sup>196</sup> On February 24, 2004, SAMHSA released the National Survey On Drug Use and Health (formerly known as the National Household Survey on Drug Abuse).<sup>197</sup> The survey

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<http://www.DrugAbuseStatistics.samhsa.gov> (last visited Feb. 21, 2006) [hereinafter "National Survey"].

<sup>189</sup>See Judge Lohn Interview, *supra* note 20 (stating that a mental health element is only necessary to the drug court participants who have a co-occurring mental health disorder along with a substance abuse problem).

<sup>190</sup>Boone et al., *supra* note 17. The aim of therapeutic courts, such as juvenile drug courts, is to decrease recidivism by treating the sources that cause juveniles to re-offend.

<sup>191</sup>Gordon, *supra* note 187.

<sup>192</sup>*Id.*

<sup>193</sup>*Id.*

<sup>194</sup>*Id.* (stating that possible reasons for such easy access to serious drugs, such as cocaine, are the increased expendable income that teenagers have, their increased access to transportation, and the fact they do not have to travel far to find a dealer).

<sup>195</sup>*Id.* at 26. Other reasons for teen drug and alcohol use include peer and family influence that cause a teen not to understand the severity of dangers involved in such activity.

<sup>196</sup>*National Survey*, *supra* note 188.

<sup>197</sup>*Id.*

asked youths, ages 12 and above, to report their use of illicit drugs, alcohol, and tobacco during the year prior to the interview.<sup>198</sup> Within this survey, “illicit drugs” included marijuana/hashish, cocaine, crack, inhalants, hallucinogens, heroin, or prescription type drugs used for non-medical purposes.<sup>199</sup> The survey also inquired whether or not the juvenile interviewee had ever been in jail or a detention center before.<sup>200</sup>

The results of this survey demonstrate that drug and alcohol is even more of a problem among the 1.5 million juveniles (6%) who have been in a detention center or jail at some point in their lives compared to juveniles who have not been in contact with the juvenile justice system.<sup>201</sup> For instance, past-year marijuana use for juveniles who had been detained in jail or a detention center was 44%, compared to 15% for juveniles who had not been jailed or in a detention center.<sup>202</sup> Past-year alcohol use for detained youths was at 50%, versus 34% of other youths. Detained juveniles were twice as likely to use illicit drugs as the rest of America’s youth population.<sup>203</sup> Approximately 42.4% of all youths who had been detained in the juvenile justice system reported using illicit drugs in the past year.<sup>204</sup> This demonstrates that while juvenile drug use is a serious problem among this nation’s youth, it is far more prevalent among juveniles who have been involved in the juvenile justice system.<sup>205</sup> This data further reinforces the need for therapeutic courts to address the growing problems and needs of this country’s youths who are involved in the juvenile justice system.

### C. *Overlap Between Juvenile Substance/Alcohol Offenders and Mental Illness*

Finally, to better understand why mental health concerns need to be considered in therapeutic courts, a link between juvenile drug use and mental illnesses must be shown. As the following data indicates, a large correlation between juvenile drug use and co-occurring mental illness does exist. SAMHSA has reported that, according to President Bush’s New Freedom Commission on Mental Health, over 75% of girls and 66% of boys detained in the juvenile justice system have at least

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<sup>198</sup>*Id.*

<sup>199</sup>*Id.* (defining “abuse” of and “dependence” upon alcohol or drugs using the criteria set forth in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders).

<sup>200</sup>*Id.* All responses to the survey of children ages 12 and above were analyzed by gender and race/ethnicity for comparative purposes.

<sup>201</sup>*National Survey, supra* note 188, at 2 (finding that 7.7% of males versus 4.2% of females reported being in a jail or detention center at some point of their lives; also finding that 5% of white, 8% of black and 7.9 % of Hispanic survey participants reported being in jail or detention center at some point of their lives).

<sup>202</sup>*Id.*

<sup>203</sup>*Id.*

<sup>204</sup>*Id.* (reporting that 44% of females versus 42% of male juvenile offenders surveyed stated they had used illicit drugs in the past year).

<sup>205</sup>*Id.*



one mental health disorder.<sup>206</sup> Additionally, over half of these children have a substance abuse disorder.<sup>207</sup> Specific data is not available as to the percentage of detained children having both a mental illness and a substance abuse disorder. However, based on the above data, one could infer that a child suffering from a substance abuse disorder could also have a substantial chance of suffering from at least one mental illness. The following studies support this conclusion.

#### 1. Caron Foundation Survey

A study done at the Caron Foundation, a leading addiction treatment center in the United States, concluded that substance and alcohol abuse is often linked to mental illnesses among juveniles.<sup>208</sup> The Caron Foundation discovered this link because its treatment program involves not only stopping a youth from partaking in illegal substances, but also finding out why the youth began using illegal substances in the first place.<sup>209</sup> Based on its experiences, the Foundation stated that a majority of teens referred for drug or alcohol treatment also have significant co-occurring psychiatric problems.<sup>210</sup>

The Caron Foundation pointed out that in the general juvenile population, approximately 3 to 5% suffer from ADHD.<sup>211</sup> However, among its own patients, it found that rate to be as high as 30 to 50%.<sup>212</sup> Also, the foundation reported that, among their female patients, almost 50% reported having an eating disorder.<sup>213</sup> Many of these same females used cocaine or heroin as a vehicle to support their eating disorders because of the drugs' well-known tendency to be an appetite suppressant.<sup>214</sup> The Foundation also stated that many other psychiatric disorders exist among their patients, including depression, anxiety, and conduct disorder.<sup>215</sup>

#### 2. Phoenix House Survey

The Phoenix House, another substance abuse treatment center located in California, reported the same link between drug use and significant psychological

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<sup>206</sup>Substance Abuse and Mental Health Services Administration, *SAMHSA Action Plan, Criminal and Juvenile Justice FY 04 and FY 05*, [http://www.samhsa.gov/Martrix/SAP\\_criminal.aspx](http://www.samhsa.gov/Martrix/SAP_criminal.aspx) (last visited Feb. 21, 2006) [hereinafter "*Action Plan*"] (stating that, of the 100,000 released from detention facilities each year, 63% of them re-offend).

<sup>207</sup>*Id.*

<sup>208</sup>Gordon, *supra* note 187, at 26.

<sup>209</sup>*Id.*

<sup>210</sup>*Id.*

<sup>211</sup>*Id.*

<sup>212</sup>*Id.*

<sup>213</sup>*Id.*

<sup>214</sup>*Id.* Many children abuse prescription drugs because parents are ignorant of the highly addictive nature of such drugs and are unaware of other dangers associated with them.

<sup>215</sup>*Id.*

problems among its patients.<sup>216</sup> Phoenix House formed this conclusion based on research it had performed on its patients for one year after their release from the center.<sup>217</sup> Researchers from the RAND Corporation concluded that not only did Phoenix House participants report less drug use and criminal behavior after their release, but they also reported receiving substantial mental benefits from the substance abuse program that was administered.<sup>218</sup> Participants reported that the substance abuse treatment also caused reductions in depression, anxiety, and other forms of psychological distress.<sup>219</sup> The study indicates that the treatment given to help youths cope with substance abuse problems also gave them the ability to help cope with their own psychological problems.<sup>220</sup>

The Phoenix House study demonstrates not only that mental health issues and drug use are related to some extent, but also that, by helping a youth succeed in abstaining from illegal substances, centers can help the youth cope internally with psychological problems that may have caused the drug use in the first place. This is not to say that every juvenile drug offender should also be classified as a drug abuser, such as the patients at the Caron Foundation and Phoenix House, but these two studies demonstrates how the introduction of a mental health element can supplement a drug court's rehabilitation programs for those who show signs of mental illnesses.<sup>221</sup> The introduction of a mental health element is not a silver bullet to stopping juvenile drug use, but it can help prevent a juvenile who occasionally uses drugs and alcohol from becoming a juvenile who abuses them constantly.<sup>222</sup>

### 3. South Carolina Department of Justice Study

The co-occurrence of drug and alcohol use and significant psychological problems can also be found in wide-scale surveys not involving individual treatment centers. A study performed on 118 juveniles recruited from the South Carolina Department of Justice reported similar conclusions.<sup>223</sup> In this study, all participants

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<sup>216</sup>Phoenix House Study Documents, *Benefits of Adolescent Substance Abuse Treatment*, LAW & HEALTH WEEKLY, Oct. 2, 2004, at 13-14 [hereinafter "Phoenix House:"].

<sup>217</sup>*Id.* The study tracked 175 youths, ages 13 to 17, who were treated at the Phoenix House, and compared that group to 274 juvenile probationers with similar problems in drug use and other criminal activity.

<sup>218</sup>*Id.* The Phoenix House treatment gave its patients coping strategies and developed other internal resources that youths could successfully draw upon, even after they returned to the same environments in which they were faced with situations that caused the stress.

<sup>219</sup>*Id.*

<sup>220</sup>*Id.* The RAND study demonstrated that the Phoenix House patients received mental health benefits from their drug and alcohol treatment including reductions in symptoms of depression, anxiety and other forms of psychological distress while also showing decreasing levels in crime related outcomes such as re-arrest.

<sup>221</sup>*See id.*; see also Gordon, *supra* note 187.

<sup>222</sup>Phoenix House, *supra* note 216.

<sup>223</sup>Micheal Brondino, Scott W. Hennggeler, Susan G. Pickrel, & Jeff Randall, *Psychiatric Comorbidity and the 16-Month Trajectory of Substance-Abusing and Substance-Dependent Juvenile Offenders*, 38 J. AM. ACAD. OF CHILD AND ADOLESCENT PSYCHIATRY 1118, 1118 (Sept. 1999).

met the criteria for the state's requirement of substance abuse or dependence.<sup>224</sup> This study generally revealed that substance-abusing youths also have a high rate of co-morbid psychological problems, such as depression or conduct disorder.<sup>225</sup> The study showed that 44% of the participants had a substance dependence problem, while the remaining 56% had a substance abuse problem.<sup>226</sup>

However, the statistic that best supports this Note's proposal of addition of a mental health element into juvenile drug courts is that, among the entire sample, 72% of the participants met the criteria for one or more psychological problems.<sup>227</sup> The study concluded that a co-occurrence of substance abuse and mental disorders could increase an already high likelihood of teen deviant behavior, such as violence or dropping out of school.<sup>228</sup> To put this evidence in its proper perspective, juvenile drug courts deal with juveniles who have both substance dependence and substance abuse problems, with it being difficult to decipher what percentage of each drug courts deal with most.<sup>229</sup> However, a 72% correlation between substance-abusing and substance-dependent juveniles and mental health disorders is a strong indication that mental health issues play a prevalent role in a youth's decision to indulge in illegal substances such as drugs and alcohol.<sup>230</sup>

#### 4. Massachusetts Youth Screening Instrument Screen

An even larger scale study reveals very similar results regarding substance abuse and co-occurring mental health disorders. Between May 2000 and October 2002, over 18,000 juveniles from the ages of 10 to 19 participated in a computerized version of the Massachusetts Youth Screening Instrument (MAYSI-2).<sup>231</sup> This screen is used to help understand mental health problems among delinquent juvenile populations, while at the same time helping to eliminate biases in the allocation of

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<sup>224</sup>*Id.* The study used a multi-source measurement test to assess drug use, criminal activity, family relations, peer relations, school functioning, and out-of-home placements of the participant.

<sup>225</sup>*Id.* (explaining that substance-abusing juvenile delinquents are at an especially high risk of co-occurring mental health disorders).

<sup>226</sup>*Id.* at 1122 (juveniles with co-morbid externalizing factors, such as conduct disorder, were predicted to have high levels of school dropout).

<sup>227</sup>*Id.* at 1123. "Psychological problems" include conduct disorder, oppositional defiant disorder, ADHD, major depression, dysthymia, overanxious disorder, agoraphobia, social phobia, simple phobia, separation anxiety, panic disorder, obsessive compulsive disorder, avoidant disorder, mania, generalized anxiety disorder, anorexia, bulimia, vocal or motor tics, transient tic disorder, Tourette's disorder, diurnal enuresis, nocturnal enuresis, and encopresis.

<sup>228</sup>*Id.* at 1118. The teens in this survey are already at a high risk of high anti-social behavior which is magnified by external and internal co-morbid disorders.

<sup>229</sup>*Id.*

<sup>230</sup>*Id.* at 1123.

<sup>231</sup>Elizabeth Cauffman, *A Statewide Screening of Mental Health Symptoms Among Juvenile Offenders in Detention*, 43 J. AM. ACAD. OF CHILD AND ADOLESCENT PSYCHIATRY, 430, 430 (Apr. 2004). In this study, participants were given a MAYSI-2 computerized test, from 24 to 48 hours after they were placed in juvenile detention center.

mental health treatment resources.<sup>232</sup> The MAYSI-2 screening showed that 70% of males and 81% of females showed one or more of the following: alcohol or drug abuse, anger or irritability, depression or anxiety, somatic complaints, and suicidal tendencies.<sup>233</sup> The study further revealed that rates of mental disorders among juveniles in contact with the justice system are much higher than those of the general juvenile population.<sup>234</sup> The screening showed that 66% of juvenile criminal offenders, versus 20% juvenile non-offenders, have a mental disorder.<sup>235</sup>

In order to draw any concrete conclusions based on this data, one must know what percentage of juveniles in the justice system have drug related offenses. In 1997, Ohio reported that nearly 60% of its juvenile offenders were in the justice system because of drug related offenses.<sup>236</sup> For purely illustrative purposes, consider that 66% of the juvenile criminal offenders participating in the MAYSI-2 experiment were found to have a mental disorder, combined with the fact that 60% of Ohio's juveniles in the justice system had drug-related offenses.<sup>237</sup> One can discern that a juvenile drug court implementing a mental health element could help a significant number of juveniles with drug offenses to deal not only with their drug use but also with any mental health issues that may accompany it.

The research referenced above shows a strong correlation between substance and alcohol abuse, and mental disorders. Based on his experiences in dealing with the children that pass through his drug court, Judge Lohn of the Medina County Juvenile Drug Court gave a conservative estimate that at least 40% of the participants in his program suffer from co-occurring substance abuse and mental health problems.<sup>238</sup> However, the aforementioned studies and others like it are not alone in their concern with mental health issues in the justice system. Recent legislation, both pending and passed, concentrates on the growing need of mental health care for more Americans, especially those involved in the justice system.

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<sup>232</sup>*Id.* at 433-34. Females were more likely to show internalizing and externalizing problems. Also, mental health problems were more prevalent among white juveniles and least prevalent among young African-American children.

<sup>233</sup>*Id.* at 445-46.

<sup>234</sup>*Id.* at 431. Minority youths are referred less often to community mental health treatment centers and are characterized as "disorderly," while white juveniles are referred more often to treatment centers and are considered "mentally disturbed."

<sup>235</sup>*Id.* A significant number of youths in the juvenile justice system do not receive adequate or any treatment for their mental health disorders, and sometimes, given the disparity between those needing treatment and those actually receiving it, a systematic approach to identifying those needing treatment is necessary.

<sup>236</sup>David Mendell, *Juvenile Drug Court Sought*, DAYTON DAILY NEWS, Apr. 13, 1997, at D3 (explaining that the aim of juvenile drug courts is more quickly to detect and treat delinquent children involved in illegal drugs by mandating intensive drug treatment rather than sentencing the child to detention facilities; also citing national studies to have shown that 65% of drug court graduates stop using drugs).

<sup>237</sup>*Id.*; see also Cauffman, *supra* note 231.

<sup>238</sup>Judge Lohn Interview, *supra* note 20 (stating that the percentage of mentally ill participants in the Medina County Juvenile Drug Court could be as high as 60%).

## V. FEDERAL LEGISLATION

In recent years the mental health of Americans, especially those involved in the criminal justice system, has caught the attention of many lawmakers. More specifically, in 2002 President Bush created the President's New Freedom Commission on Mental Health.<sup>239</sup> In 2004, the Mentally Ill Offender Treatment and Criminal Reduction Act was signed into law.<sup>240</sup> Along the same lines, Congress is also currently considering legislation that takes into account a citizen's, both criminal and non-criminal, mental health needs.<sup>241</sup> While none of this legislation directly mandates mental health components into juvenile drug courts, they do make the impression that mentally ill criminals are a prime concern for this government and our society.

*A. President Bush's New Freedom Commission on Mental Health*

On April 29, 2002, the President's New Freedom Commission on Mental Health was launched.<sup>242</sup> On that day, President Bush identified three obstacles preventing Americans with mental illnesses from getting the care that they deserve.<sup>243</sup> These obstacles are (1) the stigma that surrounds mental illnesses, (2) the unfair treatment and financial requirements placed on mental health benefits in private health insurance, and (3) the fragmented mental health delivery system.<sup>244</sup> The Commission was charged with giving recommendations for how to detect mental illnesses early, how to create mental health care systems that are treatment and cure oriented, and how to accomplish these tasks while also creating a mental health care system that is accessible to anyone who needs it.<sup>245</sup> The Commission aims to create a system in

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<sup>239</sup>*President's New Freedom Commission on Mental Health*, available at <http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport.htm> (last visited Feb. 21, 2006) [hereinafter "*New Freedom Commission*"]. Executive Order 13263 details the exact instruction to the New Freedom Commission on Mental Health.

<sup>240</sup>APA News Release, *Mentally Ill Offender Act Signed*, [http://crime.about.com/od/inmates/a/treatment\\_act.htm](http://crime.about.com/od/inmates/a/treatment_act.htm) (last visited Feb. 21, 2006) [hereinafter "AP Release"]. The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 was signed into law by President Bush on October 30, 2004, and is designed to improve access to mental health services for adult and juvenile non-violent offenders.

<sup>241</sup>S. 285, 108th Cong. § 101 (2003), Native American Alcohol and Substance Abuse Program Consolidation Act of 2003, <http://thomas.loc.gov/cgi-bin/query/D?c108:1:./temp/~c108nbQtC6::> (last visited Feb. 21, 2006) (referred to House Committee after being received from Senate) [hereinafter "Native American bill"].

<sup>242</sup>*New Freedom Commission*, *supra* note 239. The New Freedom Initiative was created to promote increased access to educational and employment opportunities for juveniles and adults who have mental disabilities.

<sup>243</sup>*Id.*

<sup>244</sup>*Id.* at 2. President George W. Bush stated, "Americans must understand and send this message: mental disability is not a scandal, it is an illness. And like physical illness, it is treatable, especially when the treatment comes early."

<sup>245</sup>*Id.* Often the stigma of mental health illnesses, unfair treatment limitations and financial requirements, and a fragmented delivery system surrounding the current mental

which people with mental disabilities can live, work, learn and participate fully in the communities they live in.<sup>246</sup> However, in doing so, the Commission was to make innovative recommendations that not only fit President Bush's criteria, but could also be widely replicated in varied and broad settings.<sup>247</sup>

This presidential initiative, aiming to help people with disabilities, is the largest of its kind since the Americans with Disabilities Act of 1990.<sup>248</sup> President Bush decided that such action had to be taken for several key reasons. First, in any given year, 5 to 7% of adults have serious mental illnesses, while 5 to 9% of children have serious mental disturbances.<sup>249</sup> In the Commission's final report, "serious emotional disturbance" was defined as any mental, behavioral, or emotional disorder that meets the criteria for the Diagnostic and Statistical Manual For Mental Disorders that results in a "functional impairment," thus substantially interfering or limiting one or more major life activities.<sup>250</sup> Examples of functional impairments include those that adversely affect a child's educational performance, those that affect a child's inability to build or maintain satisfactory interpersonal relationships, or those that cause a generally pervasive mood of depression.<sup>251</sup>

Furthermore, the Commission was brought to action because mental illnesses rank first among illnesses that cause disability in the United States, Canada, and Western Europe.<sup>252</sup> Similarly, the World Health Organization reported that suicide worldwide, in recent years, accounted for more deaths than homicide or war.<sup>253</sup> In addition to the tragedies that can occur because of mental illnesses, the financial costs associated with mental illnesses are staggering. In the United States alone, it is

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health system are key components that need to be addressed in order to prevent Americans with mental illnesses from falling through the current mental health delivery system's cracks.

<sup>246</sup>*Id.*

<sup>247</sup>*Id.* The recommendations that the New Freedom Commission on Mental Health makes must provide concrete and immediate improvements that the federal, state and local government agencies can make.

<sup>248</sup>*Id.*; *see also* Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1999). This act aims to eliminate discrimination against individuals with disabilities in: public accommodations, services provided by the federal, state and municipal governments, public and private transportation, telecommunications and employment.

<sup>249</sup>*New Freedom Commission, supra* note 239, at 2.

<sup>250</sup>*Id.* "Serious emotional disturbance" is defined as mental, behavioral, or emotional disorder sufficient to meet diagnostic criteria specified in DSM-III that results in functional impairment that substantially interferes with or limits one or more major life activities for people up to 18 years of age. Examples include an inability to learn that cannot be explained by intellectual, sensory, or health factors; or any other inappropriate types of behavior.

<sup>251</sup>*Id.* at 3.

<sup>252</sup>*Id.* The fact that mental illnesses are under-recognized in society poses a major public health challenge.

<sup>253</sup>*Id.* Suicide is a most distressing and preventable consequence of undiagnosed, untreated, or under-treated mental illnesses.

estimated that the direct and indirect cost of mental illnesses approaches \$79 billion per year.<sup>254</sup>

Based on the importance of providing increased assistance to the mentally ill, the Commission recommended a new mental health system that embodies six general goals.<sup>255</sup> First, a new mental health system should help Americans understand that mental health is essential to overall health.<sup>256</sup> Second, mental health care should be consumer- and family-driven, and third, it should aim to eliminate the disparities that exist in the current mental health delivery system.<sup>257</sup> Fourth, early mental health screening, assessment, and referral services should become common practices.<sup>258</sup> Fifth, mental health research should be accelerated, and, finally, current technology must be used to provide better access to the mental health care system for the people who need it the most.<sup>259</sup>

The proposed integration of a mental health element into juvenile drug courts embodies the commission's fourth goal - requiring the early screening, assessment, and referral of children with mental illnesses.<sup>260</sup> The early detection of mental illnesses not only will prevent mental health problems from worsening, but will also prevent the potential onset of co-occurring substance abuse that can lead to school failure or other serious problems.<sup>261</sup> With the addition of a mental health element into juvenile drug courts, participants whom are already known to be using or even abusing drugs or alcohol can also be screened very early for any co-occurring mental health issues that might be related to the child's alcohol and drug use or any other delinquent activities that the child is involved in. If the child is found to have a co-occurring mental illness, that child can be treated within the therapeutic court itself via mental health clinicians or can be referred to an outside mental health care

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<sup>254</sup>*Id.* Of the \$79 billion lost each year to mental illnesses, \$63 billion reflects a loss of productivity due to the mental illness itself, \$12 billion reflects indirect costs of mortality, and almost \$4 billion reflects productivity losses for incarcerated individuals.

<sup>255</sup>*Id.* at 6. The achievement of these six goals will aid in transforming the mental health care delivery system in the United States.

<sup>256</sup>*Id.* Following this goal, Americans should seek mental health care when they need it with the same confidence that they seek "physical" health care. Mental health education programs should specifically target rural Americans with little exposure to mental health delivery systems, racial and ethnic groups who may hesitate to seek treatment in the current system, and people whose primary language is not English.

<sup>257</sup>*Id.* A reformed system should give any American with a mental disturbance an array of services that is personalized, highly individualized, and leading towards a treatment-oriented system for the consumer.

<sup>258</sup>*Id.* at 9. The President hopes for an outcome that will allow all Americans to share equally in the best available services and outcomes regardless of race, gender, or geographic location.

<sup>259</sup>*Id.* at 10.

<sup>260</sup>*See id.*

<sup>261</sup>*Id.* at 11-12. Asking for the consistent use of evidence-based, state-of-the-art medications and psychotherapies will standardize practice throughout the mental health delivery system. Advanced communication and information technology will empower consumers and families and will be tools for providers to provide the best care.

provider if needed.<sup>262</sup> An early mental health assessment of a substance or alcohol abusing juvenile, provided by a juvenile drug court, can be an important step in implementing the mental health provider plan, recommended by President Bush's New Freedom Commission's.<sup>263</sup>

*B. Mentally Ill Offender Treatment and Crime Reduction Act*

The Mentally Ill Offender Treatment Act ("the Act"), signed into law by President Bush on October 30, 2004, further represents the federal government's mission to help mentally ill criminal offenders overcome mental illnesses.<sup>264</sup> This Act was passed based on the findings, according to the Office of Juvenile Justice and Delinquency Prevention, that approximately 20% of youths in the juvenile justice system have a serious mental health problem.<sup>265</sup> That Office further found that over 150,000 of the juveniles who come into contact with juvenile justice system each year meet the diagnostic criteria for at least one or more mental or emotional disorders.<sup>266</sup> The Mentally Ill Offender Act was also enacted based on the finding that programs that encourage the collaboration between mental health, substance abuse, and juvenile justice systems can reduce the number of mentally ill offenders that recycle back into the justice system while also improving public safety.<sup>267</sup> It should be noted that this Act is consistent with President Bush's New Freedom Commission on Mental Health, which encourages jail diversion and community re-entry programs for non-violent, mentally ill offenders.<sup>268</sup>

The purpose of this Act is to ensure that mentally ill, non-violent offenders are identified properly and are given the necessary treatment so that they are not simply recycled back into the justice system.<sup>269</sup> Specifically, the Act seeks to minimize the re-arrests rates of mentally ill offenders by providing new and existing mental health courts with proper mental health and substance abuse treatment options, instead of only having the option of distributing jail sentences.<sup>270</sup> It seeks to do this by promoting adequate training concerning mental health issues for criminal justice

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<sup>262</sup>*Id.* Early assessment and screening of juvenile participants of drug courts satisfies the commission's fourth goal of the proposed mental health system.

<sup>263</sup>*See id.*

<sup>264</sup>AP Release, *supra* note 240. This law will improve collaboration among criminal justice, juvenile justice, mental health, and substance abuse treatment centers, while at the same time ensuring that mentally ill offenders are properly identified and treated.

<sup>265</sup>Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. 108-414, 118 Stat. 2327 (2004). The research leading up to this Act found that up to 40% of adults with a mental illness will come into contact with the criminal justice system at some point in their lives.

<sup>266</sup>*Id.* A significant proportion of adults with a serious mental illness who are involved with the criminal justice system are homeless or at imminent risk of homelessness, and many of these individuals are arrested and jailed for minor, non-violent offenses.

<sup>267</sup>*Id.* at § 2(7).

<sup>268</sup>AP Release, *supra* note 240.

<sup>269</sup>*Id.*

<sup>270</sup>*Action Plan, supra* note 206.



personnel, while also promoting adequate training for mental health workers about criminal offenders with mental health issues.<sup>271</sup> The Act further seeks to encourage communication and cooperation between criminal or juvenile justice personnel, mental health treatment personnel, and the mentally ill offender.<sup>272</sup> By training drug court personnel to deal with co-occurring mental health issues while concurrently treating mentally ill drug offenders, this Note's proposal is in accordance with the goals of the Mentally Ill Offender Act.

As a bill co-sponsored by Senator Mike DeWine of Ohio and Representative Ted Strickland of Ohio, it authorized a \$50 million federal grant program to communities to establish mental health courts, programs that offer specialized training to justice system personnel about identifying mental health problems among its offenders, and programs that support the collaboration of criminal and juvenile justice systems with mental health and substance abuse treatment services.<sup>273</sup> The Act is aimed at helping newly formed, collaborative programs continue to grow and strengthen, while encouraging new programs to commence.<sup>274</sup> These collaborative programs will help prisons and detention centers cease to be *de facto* mental health hospitals. Dr. Reginald Wilkinson, Director of the Department of Rehabilitation and Correction of Ohio, in his Congressional testimony for this Act stated, "Our principal job is to incapacitate people who are dangerous to the community, not to hospitalize sick people."<sup>275</sup> The Mentally Ill Offender Act demonstrates that mental health issues are and should be at the forefront of the juvenile and criminal justice system.<sup>276</sup>

### C. Native American Alcohol and Substance Abuse Consolidation Act of 2003

Pending legislation, such as the Native American Alcohol and Substance Abuse Program Consolidation Act of 2003, also identifies the need to address mental health and substance abuse problems in treatment programs.<sup>277</sup> The purpose of this proposed Act is to provide more efficient and effective services to American Indians afflicted with mental health, alcohol, or other substance abuse problems.<sup>278</sup> If passed, it would allow Indian tribes to consolidate and integrate alcohol and other

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<sup>271</sup>*Id.*

<sup>272</sup>*Id.*

<sup>273</sup>AP Release, *supra* note 240.

<sup>274</sup>*Id.*

<sup>275</sup>Oral Testimony of Dr. Reginald Wilkinson, Director of the Department of Rehabilitation and Correction of Ohio, Before the Senate Judiciary Committee, July 30, 2003, <http://www.drc.state.oh.us/web/Articles/article77.htm> (last visited Feb. 21, 2006) (stating that that prison administrators are becoming *de facto* mental health administrators of the 1.3 million people incarcerated in the United States at this time; also stating that suicide is a special problem in prisons, with Ohio's inmate suicide rate at 77 per 100,000 inmates – a rate seven times higher than that of the general population of Ohio).

<sup>276</sup>*See id.*

<sup>277</sup>Native American bill, *supra* note 241.

<sup>278</sup>*Id.* In order to effectuate this purpose a tribe must identify the program to be integrated, be consistent with the proposed Act, describe a comprehensive strategy, and describe the manner in which services are to be integrated.

substance abuse prevention and treatment programs with mental health programs.<sup>279</sup> The proposed Act seeks to assist Native Americans to maximize the use of public, tribal, human, and financial resources to provide the most effective delivery and treatment results from the Indian behavioral health care programs.<sup>280</sup>

In conclusion, this proposed Act for Native Americans, the Mentally Ill Offender and Crime Reduction Act, and President Bush's New Freedom Commission on Mental Health all demonstrate alternative solutions to mentally ill offenders that emphasize the collaboration between the criminal and juvenile justice system, mental health and substance abuse centers, and other local community programs.<sup>281</sup> None of this aforementioned legislation specifically mandates a mental health element into current juvenile drug courts, but they all point to the proposition that early screening and treatment of mental health issues for juvenile offenders should be addressed by collaborative efforts between the juvenile justice system and mental health treatment communities.<sup>282</sup> These same ideals lead to the conclusion that juvenile drug court participants would be better served by the therapeutic community if they were screened for mental health illnesses and given proper treatment when necessary.

#### VI. PROPOSED INTEGRATION OF MENTAL HEALTH ELEMENT INTO JUVENILE DRUG COURT SYSTEM

This Note has thus far shown that the juvenile justice system is evolving in terms of the manner in which it handles many of the juveniles that come into contact with it. The emergence of therapeutic courts demonstrates that juvenile courts must assume the role of a problem-solver rather than simply a distributor of punishment.<sup>283</sup> By doing so, the juvenile justice system is trying to decrease recidivism rates by addressing the core problems that cause juveniles to become juvenile offenders in the first place.<sup>284</sup> While juvenile drug and mental health courts have enjoyed much early success, they need not be considered in a mutually exclusive manner.<sup>285</sup> Accordingly, the juvenile drug court system should integrate a mental health assessment and referral program into its current procedures. The support for this

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<sup>279</sup>*Id.* at 2. An automated clinical information system should be utilized. This system is an automated computer system that can be used to manage clinical, financial, and reporting information for the Indian behavioral health care programs.

<sup>280</sup>*Id.* The proposed act defines "Indian Behavioral Program" as health care programs that are federally funded for the benefit of Indians to prevent, diagnose, treat, or enhance the ability to treat mental health programs or alcohol or substance abuse problems.

<sup>281</sup>See *New Freedom Commission*, *supra* note 239; see also Native American bill, *supra* note 241; see also Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. 108-414, 118 Stat. 2327 (2004).

<sup>282</sup>*Id.*

<sup>283</sup>Griffin & Jenuwine, *supra* note 16 (discussing an experiment involving the criminal cases of ten and eleven year boys who dropped a five year old from a high rise building in Chicago and the impact of the judicially-mandated experiment that ordered state officials to provide the defendants with intensive mental treatment in combination with incarceration).

<sup>284</sup>Boone et al., *supra* note 17.

<sup>285</sup>*Id.* Problem-solving courts are spreading quickly because they reduce recidivism amongst juvenile offenders more effectively than traditional, non-therapeutic courts.

comes from federal legislation and executive orders, scientific research showing an overlap of substance-abusing juveniles and mental issues, the success of current juvenile mental health courts, and, most importantly, the flexibility of the current procedures of juvenile drug courts.<sup>286</sup>

*A. Placement of Mental Health Element Within Current Procedural Framework*

The first step of this Note's proposal is to show how and where a mental health element can be employed into the current juvenile drug court system. The procedures referred to below are based the Medina County Juvenile Drug Court and Judge Lohn's participant procedures manual.<sup>287</sup> As previously mentioned, once a juvenile is deemed eligible and voluntarily agrees to enter the drug court program they are immediately sent to an initial drug screening.<sup>288</sup> Before the juvenile's first drug court appearance, this time is a perfect opportunity for a participating child to be pre-screened for any mental health issues by a specially trained drug court clinician or outside service provider.<sup>289</sup> Screening for a mental health illness at this point will help the drug court better to determine the most efficient and effective course of treatment for the individual applicant.<sup>290</sup> If no mental health issue is detected, then the juvenile should continue the drug court path as it currently stands and should then be placed in either the intensive or non-intensive element of the program.<sup>291</sup> However, if a mental health issue is detected at this point, further mental health treatment and evaluation can then become an integral part of the juvenile's completion of the drug court program.<sup>292</sup>

*B. Implanting Mental Health Assessment and Treatment*

The question then exists of whether mental health treatment can coincide with the substance abuse treatment that the juvenile drug court model currently provides.<sup>293</sup> This Note opines that mental health treatment not only coincides with, but also complements a juvenile drug court's current procedures. Depending on whether the juvenile is in the intensive or non-intensive phase, the child may spend up to nine hours per week meeting with the court's substance abuse clinicians.<sup>294</sup> There is no

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<sup>286</sup>See *Handbook*, *supra* note 9; see also Boone et al., *supra* note 17; Cauffman, *supra* note 231.

<sup>287</sup>Judge Lohn Interview, *supra* note 20.

<sup>288</sup>Miller Interview, *supra* note 47 (stating that, in order to subject participants to random and immediate drug testing, waivers must be signed by the participants and their parents).

<sup>289</sup>See Arredondo et al., *supra* note 9, at 8. The initial screening by a mental health coordinator is described as one of the first steps in CITA's procedures.

<sup>290</sup>*Action Plan*, *supra* note 206 (emphasizing that quick and individualized dispositions of juvenile drug court cases is a key to the program).

<sup>291</sup>Miller Interview, *supra* note 47 (stating that one of the first decisions a drug court must make is which component is necessary for full treatment of the individual participant).

<sup>292</sup>See Arredondo et al., *supra* note 9 (mental health therapy and treatment as a prime objective of CITA).

<sup>293</sup>*Handbook*, *supra* note 9.

<sup>294</sup>Miller Interview, *supra* note 47.

problem diverting some of this time to specialized mental health clinician meetings involving a mental health expert for children with co-occurring mental health issues. Furthermore, the weekly mandatory meetings in which juvenile's parents participate can be also separated into two groups.<sup>295</sup> One could be comprised of the newly formed group, consisting of parents with substance-abusing children with co-occurring mental health issues, and the other being the parents of children without mental health issues. This segregation could help parents better to understand their children and why they act in certain ways at certain times.<sup>296</sup>

A second opportunity for a child to be referred to the special co-occurring mental health component of the drug court is during the weekly clinician meeting.<sup>297</sup> It is quite possible that, for some reason, a participant's mental health issue was not detected during the initial screening. Therefore, this added element would allow a child to be referred to the mental health element at any time. The clinician often spends up to nine hours per week with a juvenile in a group setting, and thus the clinician can impart personal judgment as to whether the child suffers from a mental illness or has mental issues that are prohibiting proper substance abuse treatment.<sup>298</sup> If the substance abuse clinician suspects a mental health issue, then the child can be re-assessed, or, if the clinician is certain enough, the child can be directly referred to mental health co-treatment with the court's mental health clinician. Obviously, if a mental health clinician believes the mental health problem is too advanced for the level of individual expertise, the child can then be referred to a clinic or other advanced-care mental health service.<sup>299</sup>

### C. Critique of Mental Health Element: Over-Inclusiveness

Opponents of integrating a mental health assessment and subsequent treatment plans to current drug court procedures may state that these procedures are over-inclusive, in that not every juvenile in the drug court system has a co-occurring mental illness. Even though research and interviews with court personnel show a high co-occurrence level of mental health issues and substance abuse issues ranging from 40 to 70%, not all participants have a co-occurring mental illness.<sup>300</sup>

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<sup>295</sup>*Id.*

<sup>296</sup>Judge Lohn Interview, *supra* note 20 (stating that an important step in fostering treatment for a juvenile is incorporating parental support so that lessons learned during treatment are reinforced in the home setting).

<sup>297</sup>*Handbook*, *supra* note 9.

<sup>298</sup>Miller Interview, *supra* note 47.

<sup>299</sup>*See* Arredondo et al., *supra* note 9, at 15. The CITA mental health court in Santa Clara uses a full range of mental health services as deemed medically appropriate, including individual supportive therapy, specialized psychotherapy, family therapy, group therapy, emergency services/crisis intervention, medication evaluation and support, wraparound services, and other individualized services.

<sup>300</sup>Judge Lohn Interview, *supra* note 20 (noting the difficulty in determining a proper course of treatment for substance abuse issues when a hidden mental health disorder co-occurs with the substance abuse problem that initially placed the juvenile in the juvenile drug court program).

However, the proposed system can live in harmony with these critics. A child will only be referred to the mental health clinician if a mental health issue is detected. Otherwise, the child will not be exposed to any extra mental health attention unless it is warranted by the initial mental assessment or by a clinician referral. The drug court's current procedures are not impeded in any way, since only those with mental health issues will be required to meet with a mental health clinician in order to fulfill the requirements of the drug court program.<sup>301</sup> For this proposal to be feasible, a mental health clinician will also need to be added as a member of the drug court team and report to the judge and probation officers in the same way that the current substance abuse clinicians do.<sup>302</sup>

#### D. Cost Concerns

The proposed integration of a mental health element into the juvenile drug court system faces other issues. A significant concern could be the additional cost that a mental health element may add to the current juvenile drug court system. Earlier in this Note, it was mentioned that states that have already incorporated juvenile drug courts were saving millions of dollars.<sup>303</sup> Savings to taxpayers came in the form of decreased recidivism rates, which in turn avoided expensive prison and prosecutorial costs for repeat offenders.<sup>304</sup> Taxpayer savings also came from money that potential victims saved because previously jailed mentally ill criminals did not victimize them.<sup>305</sup>

The integration of a mental health element into current juvenile drug courts is an example of a project with a minimal initial expenditure in proportion to the benefits yielded in the long run. Additionally, recent legislation, such as the Mentally Ill Offender and Crime Reduction Act of 2004, has authorized millions of dollars in federal grants to communities that integrate mental health treatment and detection into its justice system.<sup>306</sup> Communities seeking to implement a mental health element into their current drug court system or ones that are looking to start from scratch should look into receiving federal grants to off-set the costs of implementing a therapeutic justice system dealing with mental health issues.<sup>307</sup> While some additional cost may be incurred in the implementation of an integrated juvenile

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<sup>301</sup>See *Handbook*, *supra* note 9.

<sup>302</sup>Miller Interview, *supra* note 47 (emphasizing that the proposed addition of clinicians would not impede and would in fact help the juvenile drug court process better to serve its clients in helping them properly address the child's substance abuse problem).

<sup>303</sup>Boone et al., *supra* note 17, at 3 (claiming that drug court savings came in the form of court costs avoided, jail time avoided, and the costs avoided by potential victims of crimes).

<sup>304</sup>*Id.*

<sup>305</sup>*Id.*

<sup>306</sup>Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. 108-414, 118 Stat. 2327 (2004) (designating \$50 million in federal grant money to establish more mental health courts, to provide for additional pre-trial jail diversion programs, and to fund cross-training for law enforcement officials and mental health personnel dealing with juvenile offenders with mental health disorders).

<sup>307</sup>*Id.*

mental health and substance abuse court, the long-term benefits to society and taxpayers would abundantly compensate the initial costs of its implementation.

*E. Issues Facing Court Personnel Training*

Another issue facing an integrated system is the feasibility that current juvenile drug court personnel could also be trained to handle mental health issues of its participants. Some critics claim that the therapeutic system demands too much of judges because they have to consider mental health and behavioral issues while also playing the role of a judge.<sup>308</sup> However, studies have shown that extensive training has little to do with achieving effective therapeutic outcomes.<sup>309</sup> These studies conclude that effective “therapy” depends less on a particular therapeutic approach and more on an actor’s ability to promote certain factors common to all therapy.<sup>310</sup> These common factors include employing the participant as the fundamental engine of change; taking into account each participant’s personality, skills, and circumstances; establishing a trusting relationship with the participant; and instilling hope and positive expectations in the participant that the therapy they are receiving will bring positive outcomes.<sup>311</sup>

This is not to be construed to mean that unlicensed professionals can treat serious biologically based mental disorders, which would require a referral to an outside care provider, but rather is meant to demonstrate that current personnel could adapt to mental health training without extreme difficulty or expense. While others may disagree with these findings, the therapeutic systems are currently succeeding due to their very nature, in that they already treat the participant with respect, compassion, and in accordance with the participant’s particular traits.

Finally, a specially trained mental health clinician would have to be employed in the integrated system and act as another team member.<sup>312</sup> The mental health team member would report to the probation officers and judges, just like any other clinician currently does.<sup>313</sup> Essentially, the other team members would only have to be initially trained in simple mental illness detection so that they could refer the participant to the mental health clinician for further evaluation. In conclusion, the additional personnel training needed for this system would be minimal because the majority of the mental health evaluations would be done by the mental health coordinator who would be added to the newly proposed drug court team.

The issues and problems facing this proposed integration of a mental health element into juvenile drug courts are not limited to the ones just discussed.

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<sup>308</sup>Scott, *supra* note 7, at 5. One could argue that judges may lose their impartiality by becoming more closely involved in the defendant’s progress and that there is a possibility that courts are crossing the line into the powers reserved for the executive branch of the government when they actively manage the defendant’s behavior in the court process.

<sup>309</sup>*Id.* at 5. (citing a study showing that experienced therapists were no more helpful than untrained college professors and novice graduate students and were more effective than trained professionals at couple’s therapy).

<sup>310</sup>*Id.*

<sup>311</sup>*Id.*

<sup>312</sup>Miller Interview, *supra* note 47.

<sup>313</sup>*Id.*

Confidentiality issues may also exist. However to overcome this, the juvenile justice system and partner agencies must agree to share confidential information and agree to use that information solely for diagnosis, medication and the implementation of a treatment plan.<sup>314</sup> Furthermore, much can be borrowed and learned from the newly formed mental health courts in regards to this problem.<sup>315</sup> When asked about this problem Judge Lohn of the Medina County Juvenile Drug Court suggested that waiver forms signed by the participants could eliminate a significant number of confidentiality problems.<sup>316</sup>

#### VII. CONCLUSION

The therapeutic justice system has seen many successes since its inception less than fifteen years ago. However, in order for it to survive and thrive, it must be flexible enough to evolve with needs of its future participants, while also addressing the needs of the communities it serves. Recent legislation and executive orders have established that the mental health of our society, especially that of its criminal offenders, must be brought to the forefront of society's attention. Therapeutic courts, especially juvenile drug courts, are advised to adopt a mental health element into their procedures. Significant links have been established between the criminal offender and subsequent mental health issues.<sup>317</sup> In order for therapeutic courts to continue to treat the core problems that plague criminal offenders, mental health assessments must be implemented to identify and treat any possible mental ailments in order to keep recidivism rates low. The criminal justice system is evolving, and therapeutic courts that specialize in individualized treatment are in the front line of this evolution.

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<sup>314</sup>Arredondo et al., *supra* note 9, at 8.

<sup>315</sup>*Id.*

<sup>316</sup>Judge Lohn Interview, *supra* note 20 (explaining that participants are not inclined to decline signing waivers because they are often very anxious to participate in this innovative program).

<sup>317</sup>*See* Phoenix House, *supra* note 216.