

# Public Interest Law Reporter

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Volume 15  
Issue 3 Summer 2010 Symposium Issue

Article 2

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2010

## Preface

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### Recommended Citation

Diane Geraghty, *Preface*, 15 Pub. Interest L. Rptr. 159 (2010).

Available at: <http://lawcommons.luc.edu/pilr/vol15/iss3/2>

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# PREFACE

*by* **DIANE GERAGHTY**<sup>1</sup>

A recent story in the New York Times included a surprising statistic. Although a majority of the 800 youth in New York's juvenile prisons have some form of mental disorder, the state does not have a single full-time psychiatrist on staff to serve these youth.<sup>2</sup> The problem is not unique to New York. What is unusual about the New York Times article is that the topic of mental health and juvenile justice has now become a subject of national media focus. Traditionally, scant attention was paid to the challenges faced by children, families and juvenile justice stakeholders when mentally-disordered young offenders entered the justice system. Prior to the mid-1990s, relatively little was known about the prevalence of mental disorders among this category of youth.<sup>3</sup> No reliable mechanisms existed for identifying the broad range of mental health issues among the juvenile justice population.<sup>4</sup> Similarly, there was little research on successful strategies for intervention or prevention. In the

past two decades, however, scientists, juvenile justice practitioners, policy makers, and advocates increasingly have turned their attention to these issues.<sup>5</sup> The *Public Interest Law Reporter* Symposium Issue, “Delinquency or Illness? The Intersection of Mental Health and Juvenile Justice,” builds on their efforts in a series of articles that review existing knowledge, discuss promising practices and identify areas of ongoing need. The authors are social scientists and practitioners who study and observe how the mental health, education and juvenile justice systems respond to the needs of youth with mental disorders. The goal of this preface is to set the stage for that discussion by identifying areas of progress and issues of concern when exploring the intersection of delinquency, adolescent development, and disease.

#### MENTAL HEALTH AND TRAUMA DISORDERS AMONG JUSTICE-INVOLVED YOUTH

In the 1990s, concerns about a rise in youth violence and a corresponding increase in “get tough” responses led researchers to explore a broad range of issues related to juvenile crime.<sup>6</sup> An important aspect of this effort involved the use of new technologies to better understand how the brain develops and changes during adolescence. The outcome of this research was to provide empirical validation for the centuries-old observation that children, including teenagers, are fundamentally different than adults.<sup>7</sup> These developmental differences help explain why adolescents are at special risk for behaviors that may lead to their involvement in the juvenile justice system.

Although normal adolescent development places all youth at risk for behaviors that pose potential harm to themselves or others, these risks are compounded when adolescents have mental health problems.<sup>8</sup> A recent study found that the median age of onset for all types of mental disorders is age 14.<sup>9</sup> According to the study, anxiety disorders can begin as early as late childhood, while mood disorders typically develop in later adolescence and substance abuse issues in one’s early 20s.<sup>10</sup> The overall prevalence rate for youth with some form of behavioral health disorder is estimated at somewhere between 15 percent and 25 percent.<sup>11</sup>

It is now well-established, however, that youth in the juvenile justice system have higher rates of mental disorders than those in the general public. Prevalence studies have consistently found that up to 70 percent of justice-involved

youth suffer from some form of mental health disorder.<sup>12</sup> In at least a quarter of cases the disorder is so severe that a youth's ability to function is seriously impaired.<sup>13</sup>

To further complicate matters, some young offenders have undergone traumatic experiences which exacerbate the challenges they already face in coping simultaneously with normal adolescence and mental health needs. Such traumatic events may include experiencing or witnessing family or community violence, physical or sexual abuse, loss of a loved one or unintentional injury. Although trauma is a comparatively new area of research, preliminary data suggests that youth in the juvenile justice system have been exposed to higher levels of trauma than youth in general.<sup>14</sup> Some studies have found that the rate of victimization among youth in the justice system is as high as 75 percent.<sup>15</sup> Girls appear more likely to exhibit trauma-related symptoms than boys.<sup>16</sup> The higher levels of trauma-affected youth in the justice system is attributed in part to the way some youth respond to their traumatic experiences, including heightened levels of aggression and oppositional behavior.<sup>17</sup>

#### AREAS OF PROGRESS

Prevalence studies on mental health and the impact of trauma have contributed to an increased awareness of the need for better early identification and intervention strategies for youth with mental health and related needs. This heightened awareness has prompted new areas of research as well as changes in law, policy and practice. Four recent positive developments include better screening and assessment mechanisms, new strategies for diverting youth from the formal justice system, increased use of evidence-based practices and experimentation with specialized juvenile mental health courts.

#### SCREENING AND ASSESSMENT

One of the most significant developments in the last decade has been the increased availability of scientifically-validated tools designed to screen and assess youth for mental health disorders. Although justice-involved youth are at higher risk than others for mental health problems, the absence of tools to assess this risk long served as a barrier to the timely and accurate identification of a youth's mental health status and needs.<sup>18</sup> Juvenile detention and correc-

tions personnel were at a particular disadvantage in not knowing what effect a youth's unidentified mental disorder might have on institutional safety and discipline. Today there are a number of scientifically sound tools for screening and assessing the mental health needs of youth in the justice system. One of the most widely used instruments is the MAYSI-2, a self-report tool administered on youth entering detention or corrections facilities.<sup>19</sup> Now in use in the majority of states, MAYSI-2 is intended to be a fast, easily administered method for determining whether further clinical assessment is required.<sup>20</sup> Other scientifically sound screening tools are also available for use in determining if a youth requires more extensive evaluation.<sup>21</sup>

As useful as screening and assessment tools are in evaluating a youth's mental health needs, researchers caution that their reliability depends on a clear understanding of their purpose and limits and as well as training in their administration.<sup>22</sup> There is still some confusion in the field, for example, about the difference between screening and assessment – screening is a preliminary determination of whether additional follow-up is indicated, whereas assessment is a more in-depth examination of a youth's mental health status.<sup>23</sup> Untrained juvenile justice practitioners also continue to confuse mental health screening and assessment tools with instruments designed for other purposes, such as a youth's risk of violence or repeat offending.<sup>24</sup>

## DIVERSION

A significant percentage of youth who enter the juvenile justice system, including those with mental health disorders, are charged with lower-level offenses.<sup>25</sup> There is now abundant evidence that many of these youth can be successfully diverted from the formal justice system into less expensive and more effective community-based and family-focused programs.<sup>26</sup> Among the services offered by these programs are individual and family counseling, substance abuse treatment and medication prescription and management.<sup>27</sup> Several model diversion programs have emerged in recent years.<sup>28</sup> For example, the Texas Front-End Diversion Initiative is an early intervention and diversion effort.<sup>29</sup> This program uses Specialized Juvenile Probation Officers who have received training in such areas as motivational interviewing, crisis intervention, family engagement and case management. Specialized Juvenile Probation Officers work with youth and families for up to six months, linking them with community-based ser-

vices and helping them develop aftercare plans to ensure that treatment continues after formal system involvement has ended.

Diverting youth with mental disorders from secure detention is the goal of the Illinois Mental Health Juvenile Justice program.<sup>30</sup> Begun as a pilot program in 2000 and later expanded to include all counties with detention centers, the program uses master's level mental health professionals to serve as liaisons linking detention centers, juvenile courts and community-based mental health and substance abuse treatment programs. Upon entry into a detention center, each youth is screened for a serious mental illness. When such an illness is identified, the liaison prepares a treatment plan as an alternative to secure confinement. Consistent with the plan, youth and their families are referred to community-based providers for services which may include substance abuse treatment, individual and family therapy, educational advocacy and job training. The re-arrest rate for the over 4,500 youth who have received community services is slightly over 20 percent, as compared to a re-arrest rate of over 70 percent for youth detained prior to trial.<sup>31</sup>

A youth's mental health needs are also relevant at the time of adjudication and sentencing. The Cook County Juvenile Court Clinic has drawn national attention for its success in achieving better informed decision-making on behalf of youth with mental health disorders.<sup>32</sup> Established in 1999, the Cook County Juvenile Court Clinic provides a comprehensive set of services aimed at helping judges understand the competency, culpability and treatment implications when a youth suffers from some sort of mental impairment. Each juvenile courtroom has a clinical coordinator who responds to requests from any party to provide relevant behavioral health information and, where appropriate, arranges for a clinical evaluation. The clinic's interdisciplinary staff conducts the evaluation and files a report with the judge. The report may include a treatment recommendation, but the Juvenile Court Clinic does not itself provide clinical services. The Clinic instead provides the court with information about community-based services appropriate to a youth's needs. The Juvenile Court judge, in turn, may use this information either to divert cases from the formal system or as part of a dispositional order after adjudication.

## EVIDENCE-BASED PRACTICES

Another area of progress in responding to the mental health needs of justice-involved youth has been the development of treatment interventions that produce empirically-verifiable positive outcomes. The body of intervention and treatment approaches with proven records of success is collectively known as evidence-based practices or EBPs. Rather than relying on anecdotal experiences or traditional practices, EBPs are the product of rigorous scientific testing.<sup>33</sup> Increasingly public and private service providers are being advised, and in some cases required, to use EBPs to treat youth with behavioral health disorders.<sup>34</sup> In Oregon, for example, the use of EBPs is required for service-providers receiving state funds.<sup>35</sup> Among the EBPs that have shown promise in reducing recidivism among juvenile-involved youth are Aggression Replacement Training (ART), Functional Family Therapy (FFT), Multi-Systemic Therapy (MST) and Multidimensional Treatment Foster Care (MTFC).<sup>36</sup>

Although EBPs have been proven to reduce delinquency, similar to mental health screening and assessment tools, they must be understood and used as intended or they will not produce the results for which they are designed. Unfortunately, some of the most effective EBPs are very expensive (although proponents argue that costs are recouped in lower rates of system involvement).<sup>37</sup> In addition, not every community has access to evidence-based practices. Stakeholders in small rural communities, for example, argue that it would be unfair to withhold state funding from a local service provider who lacked the training and resources to provide a range of evidence-based interventions for the relatively small number of youth entering the justice system in their communities.

## JUVENILE MENTAL HEALTH COURTS

Some jurisdictions have begun to explore the feasibility of establishing juvenile mental health courts which specialize in responding to justice-involved youth with mental health disorders. The first of these courts was established in Santa Clara County, California in 2001.<sup>38</sup> Modeled on similar courts developed in the adult criminal justice system, these courts are intended to respond to the mental health needs of youth charged with crimes, while at the same time protecting the community from future crimes attributable in part to youths'

unaddressed behavioral health problems. The criteria for deciding which youth are eligible for referral to the mental health court and the timing of referral vary by program.<sup>39</sup> Some programs specialize in youth with a particular diagnosis, such as a dual diagnosis of mental health and substance abuse. Others serve youth with severe biologically based disorders, such as bipolar and post-traumatic stress disorder. Additional selection criteria may include a youth's age and the seriousness of the charge.<sup>40</sup> Although some juvenile mental health courts operate at the front end of the process, the majority intervene after adjudication and prior to entry of a dispositional order.<sup>41</sup>

Those who support the idea of courts focused on the mental health status and needs of youthful offenders cite the benefits of using a multi-disciplinary approach to decision-making, the potential for greater compliance with judicially-imposed treatment orders and an increased understanding of the role of mental health in the justice system that comes with having a court docket expressly devoted to that issue.<sup>42</sup> Despite their increasing popularity, however, juvenile mental health courts have not been met with universal enthusiasm. Those expressing concern about such courts note that under this model mental health services only become available after a youth has entered the formal justice system, giving rise to fears that such courts will have a "net-widening" effect if the courts are relied on as the source for access to mental health services.<sup>43</sup> In addition, given lingering attitudes about mental illness in the larger society, many youth and families worry about the stigma of being sent to a specialized mental health court.<sup>44</sup> They also note that the *quid pro quo* for receiving behavioral health services is that youth in these specialized courts may be subject to longer and more active system oversight than those charged with similar crimes.<sup>45</sup> While acknowledging the importance of identifying and responding to a young offender's mental health problems, these critics suggest that a jurisdiction's resources are better spent on community-based mental health programs tailored to meet the needs of youth in conflict with the law.<sup>46</sup>

#### SYMPOSIUM ARTICLES

The articles in this symposium issue elaborate on many of the above themes, but also introduce new issues such as the role of education in responding to a youth's mental health needs.

In her article, “Illinois’ Fitness Statute: Is It a Good Fit for Juvenile Court?,” Rachel Tait, Juvenile Justice Clinical Director of the Cook County Juvenile Court Clinic, tackles the question of how the law should be framed when considering whether a youth is competent (or “fit”) to stand trial. Although the Illinois Juvenile Court Act does not have an express provision relating to fitness to stand trial, the adult standard is applied when issues of competence to stand trial are raised in delinquency proceedings. As a consequence, youth, like adults, are presumed fit to stand trial.<sup>47</sup> Tait faults Illinois’ current approach to youth competency on three grounds. First, she observes that the adult fitness standard is flawed, at least when applied to minors, because it does not specify what aspects of the trial a juvenile is expected to understand or ways in which he or she must be able to participate in the defense. She also questions the practice of holding unfit youth in a secure setting while efforts are made to restore them to competency. Finally, Tait joins the national debate over whether juvenile fitness standards should take into account developmental immaturity in addition to mental illness or retardation.<sup>48</sup>

In their article, “Cost-Effective Crime Prevention: Economic Analysis of the Chicago Child-Parent Centers’ Early Education Program,” University of Minnesota’s Judy Temple, Associate Professor at the Humphrey Institute of Public Affairs, Barry White, Research Fellow of the Institute of Child Development and Arthur Reynolds a Professor at the Institute of Child Development, explore the relationship between early education programs directed at vulnerable children and crime reduction. In particular, they use a cost-benefit analysis to assess the effectiveness of the Chicago Child-Parent Center in reducing juvenile and adult crime. Because the Chicago-Parent Center has operated in low-income neighborhoods for nearly 50 years, the authors were able to conduct a longitudinal study tracing the trajectory of approximately 1,500 children up to the age of 26. This study, combined with earlier cost-benefit analyses, provides strong evidence for the proposition that early education programs, such as the type provided by the Chicago Child-Parent Centers can be effective in preventing and reducing juvenile crime.

In “The School-to-Prison Pipeline: How Schools Are Failing to Properly Identify and Service Their Special Education Students and How One Probation Department Has Responded to the Crisis,” Kristina Menzel, Assistant Public Defender at the Law Office of the Cook County Public Defender, Juvenile Justice Division, observes that one of the many benefits of compulsory education is that schools become a catchment area for early identification of youth

with special education and mental health needs. Recently, however, she suggests too many schools have become part of the problem rather than part of the solution. She notes that although federal law imposes on schools which receive federal funds an obligation to identify and provide appropriate services to children with mental health needs, their failure to do so results in an overrepresentation of these youth in the juvenile justice system. The link between unmet special education needs and justice system involvement is exacerbated by the increasing trend on the part of school districts to rely on the law enforcement and judicial system to punish in-school behaviors, including those that traditionally were dealt with as a school disciplinary matter. Although Menzel argues for strategies designed to keep youth with mental health needs out of the juvenile justice system, she also addresses the need for justice system stakeholders to engage with school districts on behalf of their young clients.

In “Service for All: Mental Health Services for At-Risk Children,” Miquel Lewis, Disproportionate Minority Contact Project Administrator, Cook County Juvenile Probation Department; Michael Fletcher, Assistant Director, FACE-IT Residential Program; and Randell Strickland, State DMC Coordinator, MacArthur Foundation’s Illinois Models for Change Juvenile Justice Reform Initiative, explore the negative environmental determinants that impact adolescent behavior and elevate their risk for involvement in the juvenile justice system. In particular, they point to children’s exposure to violence as a form of “social toxicity,” which threatens the upward trajectory of their lives, and too often, the lives of their victims. The authors also catalogue a list of promising service delivery strategies as well as programs and initiatives being used in the Cook County schools and court system to respond to youth in the justice system with mental and substance abuse needs. The article concludes with the common-sense observation echoed by other authors that mental health intervention before a youth becomes involved in the justice system is a less-costly and more effective response to the behavioral health needs of youth.

One of the persistent problems in the juvenile justice system is the overrepresentation of youth of color at all stages of the process.<sup>49</sup> In their article, “Encouraging the Use of Community Involvement and Restorative Practices as Treatment for Trauma with Black Juvenile Offenders,” Uduakobong Ikpe and Kendell Coker explore the issue of racial disparity in the juvenile justice system and consequences for Black youth. They advocate for the use of restorative justice practices as one approach for meeting the needs of African-American youth in conflict with the law. Restorative justice offers a new paradigm for

responding to youth crime, one which rejects an approach focused primarily on rehabilitation and substitutes a model which seeks to repair harm to victims and communities while at the same time helping the young offender to develop external and internal competencies.<sup>50</sup> Restorative justice practices can take different forms, including victim-offender mediation, peer juries, community panels for youth and peacemaking circles. The model advocated for by Ikpe and Coker is group conferencing because it involves the community in addressing the youth's offending and invests its members in helping the youth to succeed.

Linda Uttal, Chief of the Juvenile Justice Division, Law Office of the Cook County Public Defender and David Uttal, Professor of Psychology and of Education at Northwestern University, co-authored the final article in the symposium issue, entitled "Children Are Not Little Adults: Developmental Differences and the Juvenile Justice System." The article advocates for the use of a developmental perspective when adopting policies and practices affecting youth at risk of entering or already involved in the justice system. Using this approach, they argue that the goal should be to stop youth from entering the system whenever possible. The authors suggest that principles of adolescent development should also inform law and practice surrounding custodial confinement and clinical evaluations. Finally, the article urges jurisdictions such as Illinois to raise the age of juvenile court jurisdiction to at least 18, consistent with recent brain development research suggesting that adult-level maturity is not achieved until an individual's early 20s.

#### GOING FORWARD

The prospects for achieving better outcomes for justice-system involved youth with mental health needs appear to be improving, supported by emerging research and new empirically-tested intervention and treatment approaches. There is now widespread acceptance of the idea that appropriate intervention and treatment can reduce re-offending and promote positive youth behaviors even among young offenders charged with serious crimes.<sup>51</sup> For some, this optimism is tempered by a fear that much of the progress that has been made over the last decade may be at risk in light of the financial crisis that is crippling many states. Cash-strapped states such as Illinois have already slashed their human services' budgets and many service providers are barely surviving. In the grim economic climate, some wonder how long states and local jurisdic-

tions will be able to maintain proven, but more expensive, evidence-based and community-based intervention and treatment programs.

Will a decline in community-based care lead to higher rates of confinement as an alternative to more expensive therapeutic options? Is there the potential for the overuse of medication as a cheaper form of behavioral control?<sup>52</sup> In the short term, these concerns are real. In the longer term, however, there are good policy arguments, grounded in well-designed research, for continuing to invest in evidence-based prevention efforts and community-based treatment alternatives for justice-involved youth with mental health needs. As an attendee at the *Public Interest Law Reporter* Symposium expressed it, “we’re on the right side of the hope curve.”

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## NOTES

1 Diane Geraghty is the A. Kathleen Beazley Chair in Children’s Law at Loyola University Chicago School of Law, where she directs the Civitas ChildLaw Center.

2 Julie Bosman, *For State’s Detained Youth, No One to Oversee Mental Health Treatment*, N.Y. TIMES, Feb. 11, 2010 at A24.

3 Joseph J. Cocozza & Kathleen R. Skowrya, *Youth with Mental Health Disorders: Issues and Emerging Responses*, 7 Juv. Just. 3, 4-5 (2000), available at <http://www.ncmhjj.com>.

4 KATHLEEN R. SKOWRYA & JOSEPH J. COCOZZA, *Introduction*, in MENTAL HEALTH SCREENING WITHIN JUVENILE JUSTICE: THE NEXT FRONTIER 1 (2009), available at [http://www.ncmhjj.com/pdfs/MH\\_Screening.pdf](http://www.ncmhjj.com/pdfs/MH_Screening.pdf).

5 Thomas Grisso, *Progress and Perils in the Juvenile Justice and Mental Health Movement*, 35 J. AM. ACAD. PSYCHIATRY L. 158, 158-59 (2007). Grisso attributes the current focus on justice-involved youth with mental health disorders to the decline in juvenile crime over the last fifteen years and a corresponding willingness to examine the wisdom of “get-tough” policies that began two decades earlier.

6 Roy J. O’Shaughnessy & Holly T. Andrade, *Forensic Psychiatry and Violent Adolescents*, 8 BRIEF TREATMENT AND CRISIS INTERVENTION 27 (2008).

7 Elizabeth S. Scott & Laurence Steinberg, *Adolescent Development and the Regulation of Youth Crime*, 18 THE FUTURE OF CHILDREN 15, 19 (2008).

8 A mental disorder is defined as a mental disability that is sufficiently severe to meet the formal criteria under the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, DSM-IV* (American Psychiatric Association, 1994). See Cocozza & Skowrya, *supra* note 3, at 7.

9 RC Kessler et al., *Mental Illness Exacts Toll, Beginning in Youth*, 20 CURR OPIN PSYCHIATRY 359 (2007), cited in Press Release, National Institute of Mental Health, *Mental Illness Exacts Toll, Beginning in Youth* (June 6, 2005), available at <http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml>.

10 *Id.*

11 Thomas Grisso, *Adolescent Offenders with Mental Disorders*, 18 THE FUTURE OF CHILDREN 143, 150 (2008).

- 12 Kathleen Skowrya & Joseph J. Cocozza, *A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System*, Research and Program Brief 1 (2006), available at <http://www.ncmhjj.com>.
- 13 *Id.*
- 14 See Julian D. Ford et al., *Trauma among Youth in the Juvenile Justice System: Critical Issues and New Directions*, Research and Program Brief (2007), available at <http://www.ncmhjj.com>.
- 15 *Id.* at 3.
- 16 *Id.* at 2.
- 17 *Id.* at 3.
- 18 Gail A. Wasserman, Susan J. Ko & Larkin S. McReynolds, *Assessing the Mental Health Status of Youth in Juvenile Justice Settings*, OJJDP Juvenile Justice Bulletin 1 (2004), available at <http://www.ojp.usdoj.gov/ojjdp>.
- 19 Grisso, *supra* note 5, at 161.
- 20 *Id.*
- 21 SKOWYRA & COCOZZA, *supra* note 4, at 2-3.
- 22 *Id.* at 3.
- 23 VALERIE WILLIAMS, *Procedures and Policies: Good Practice and Appropriate Uses of Screening Results* 5, in MENTAL HEALTH SCREENING WITHIN JUVENILE JUSTICE: THE NEXT FRONTIER (2009), available at [http://www.ncmhjj.com/pdfs/MH\\_Screening.pdf](http://www.ncmhjj.com/pdfs/MH_Screening.pdf).
- 24 See generally O'Shaughnessy & Andrade, *supra* note 6, at 35-39.
- 25 Kathleen Skowrya & Susan Davidson Powell, *Juvenile Diversion: Programs for Justice-Involved Youth with Mental Health Disorders*, Research and Program Brief 1 (2006), available at <http://www.ncmhjj.com>.
- 26 *Id.* at 2 (summarizing findings that the most successful models for responding to mental health issues and reducing repeat offending are community and family-based).
- 27 *Id.* at 4.
- 28 *Id.* 4-5.
- 29 See *Advances and Innovations Emerging from the Mental Health/Juvenile Justice Action Network: 2009 Update*, National Center for Mental Health and Juvenile Justice (2009), available at <http://www.ncmhjj.com/pdfs/publications/ActionNetworkBrochure.pdf>.
- 30 A detailed description of the program is available at <http://www.modelsforchange.net/reform-progress/45>.
- 31 *Id.*
- 32 See *The Second Century: Juvenile Justice Reform in Illinois* 28-33, available at <http://www.modelsforchange.net>.
- 33 Holly Hills, Jennie L. Shufelt & Joseph J. Cocozza, *Evidence-Based Practice Recommendations for Juvenile Drug Courts* 23 (2009), available at <http://www.modelsforchange.net/publications/235>.
- 34 *Id.*
- 35 Information on Oregon's statutory requirement that state-funded programs to use treatment practices which have been shown to reduce recidivism and/or mental health commitments is available at [http://www.oregon.gov/OYA/rpts\\_pubs.shtml](http://www.oregon.gov/OYA/rpts_pubs.shtml).
- 36 Peter Greenwood, *Prevention and Intervention Programs for Juvenile Offenders*, 18 THE FUTURE OF CHILDREN 185, 193-94 (2008).
- 37 Greenwood, *supra* note 36, at 201 (noting that initial licensing fees may cost more than \$100,000 annually, with initial training fees running between \$20,000 and \$50,000).
- 38 Ellen Harris et al., *The Role of Specialty Mental Health Courts in Meeting the Needs of Juvenile Offenders*, The Bazelon Center for Mental Health 1, 2, fn. 6 (2004), <http://>

www.baselon.org/issues/criminalization/publications/mentalhealthcourts/juvenilemh (last visited Apr. 23, 2010).

39 See generally *Juvenile Mental Health Courts Program Descriptions: Processes and Procedures*, National Center for Mental Health and Juvenile Justice, Aug. 2005.

40 *Id.*

41 Joseph J. Coccozza & Jennie L. Shufelt, *Juvenile Mental Health Courts: An Emerging Strategy* 3, Research and Program Brief (June 2006), available at <http://www.ncmhjj.com>.

42 *Id.* at 4-5.

43 *Id.* at 5.

44 Harris et al., *supra* note 38, at 5.

45 *Id.*

46 *Id.*

47 725 ILL. COMP. STAT 5/104-10 (West 2008).

48 See Dana Royce Baerger et al., *Competence to Stand Trial in Preadjudicated and Petitioned Juvenile Defendants*, 31 J. AM. ACAD. PSYCHIATRY L. 314, 318 (2003) (reviewing studies on the link between developmental immaturity and competency to stand trial and finding that Illinois youth are most likely to be found incompetent under the state's adult fitness statute if they are younger than age 12, have a history of special education needs, and have received some form of mental health treatment).

49 American youth of color comprise approximately 38 percent of the population but nearly 70 percent of youth in confinement as a result of higher rates of arrest and incarceration than nonminority youth charged with similar crimes. See The W. Haywood Burns Institute for Juvenile Justice Fairness and Equality Fact Sheet, available at <http://www.burnsinstitute.org>.

*Id.*

50 Peter Freivalds, *Balanced and Restorative Justice Project*, Office of Juvenile Justice and Delinquency Prevention (1996).

51 O'Shaughnessy & Andrade, *supra* note 6, at 33.

52 *Id.*