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A Theoretical Evaluation of a Youth Mental Health Court Program Model

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Abstract

Mental health courts are a promising new approach to addressing the overrepresentation of mental health needs amongst offender populations, yet little is known about how they facilitate change, particularly for youth. The current study reports on a process evaluation of a youth mental health court in Toronto, Canada. Drawing upon observations of the court and interviews with key informants, we developed a program model of the court and explored its implementation within the context of empirical evidence for treating justice-involved youth. Findings revealed that the proposed mechanism of change, which focuses on reducing recidivism through the treatment of mental health needs, should also consider factors directly related to offending behavior. Findings further highlight several strengths of the program, including the program’s supportive environment and ability to engage and link youth and families with treatment. Areas for continued growth include the need for comprehensive protections of legal rights.

Keywords: mental health court, youth, rehabilitation, justice
1. Introduction

Research has consistently shown that young people with mental health needs are overrepresented in the criminal justice system (Gretton & Clift, 2011; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Ulzen & Hamilton, 1998; Wasserman, McReynolds, Schwalbe, Keating & Jones, 2010). Mental health courts, which are designed to divert defendants with mental illness into community treatment programs, represent one recent approach to addressing this problem (Schneider, Bloom, & Hereema, 2007). Although research on youth mental health courts is sparse, studies of adult mental health court defendants demonstrate an increase in treatment service usage (Boothroyd, Poythress, McGaha, & Petrila, 2003) and lower recidivism rates (Dirks-Linhorst & Linhorst, 2012; Frailing, 2010; Hiday, Wales, & Ray, 2013; McNiel & Binder, 2007; Moore & Hiday, 2006; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011) compared to defendants with mental health needs who are processed through traditional courts. While these findings are promising, further research is needed to better understand the mechanisms of change responsible for reducing recidivism and importantly, such research must also be conducted with youth.

1.1. The Relationship Between Mental Health Problems and Justice System Involvement

Researchers exploring the mechanisms of change in adult mental health courts have highlighted the importance of procedural justice and therapeutic jurisprudence (e.g., respect, autonomy, voluntariness) as important factors in reducing recidivism (Ray, Dollar, & Thames, 2010; Redlich & Han, 2014; Wales, Hiday, & Ray, 2010). The mechanisms of change in youth mental health courts, however, have yet to be researched. Such research is particularly important given the differences between mental health court programs for youth and adults (e.g., different governing legislation), as well as differences between the youth and adult mental health court
populations that have implications for the goals, focus, and operations of these courts. For example, youth are more vulnerable due to their lack of cognitive and social maturity (Cauffman & Steinberg, 2000) and adult mental health court populations have a relatively higher proportion of psychotic disorders (Steadman et al., 2011) than youth mental health court populations (see Davis, Peterson-Badali, Weagant & Skilling, 2014). As a result, change mechanisms that have been identified in adult programs may not generalize to youth programs.

Given the lack of knowledge regarding the mechanism through which youth mental health court involvement produces change, it is useful to look more broadly at the relationship between mental health and criminal behavior and how this relates to treatment programming. Many criminal justice programs for offenders with mental illness rest on the assumption that treating psychiatric symptoms will reduce criminal justice involvement (Abrantes, Hoffmann, & Anton, 2005; Dembo, Schmeidler, Cooper, & Williams, 1997). Evidence of a causal association between mental illness and criminal behavior, however, is sparse (Skeem, Manchak, & Peterson, 2011). For the majority of offenders, criminal behavior is not directly related to mental illness and treatment programs targeted at reducing mental illness amongst adult offenders have not been found to reduce recidivism (Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005; Chandler & Spicer, 2006). These findings suggest that treating mental illness may be important for improving mental health symptomatology, but may not be sufficient for reducing recidivism.

In contrast, rehabilitative models based on correctional psychology theory and research (e.g., the Risk-Need-Responsivity (RNR) framework; Andrews, Bonta & Hoge, 1990) focus on reducing recidivism by addressing factors that are strong predictors of criminal behavior and amenable to change (i.e., ‘criminogenic needs’; Andrews & Bonta, 2010). In youth, these include, for example, family functioning, delinquent peer groups, and antisocial attitudes, as well
as several variables related to mental health functioning (e.g., substance abuse, impulsivity; Hoge & Andrews, 2002). Other areas of mental health (e.g., mood concerns, trauma) are generally considered ‘specific responsivity’ factors: those that, while not strong direct predictors of offending, impact the effectiveness with which criminogenic needs can be addressed (Bonta, 1995). Although the RNR model helps to identify specific targets for intervention to reduce recidivism, there are fewer guidelines for how to treat areas of mental health not directly related to risk to reoffend.

Treatment of mental health or criminogenic needs in isolation may not be optimal for improving the well-being of justice-involved individuals with mental health needs. Results of a recent meta-analysis indicate that treatment addressing both the mental health and criminal needs of adult offenders had the largest effect on psychiatric functioning and recidivism compared to treatments that targeted mental health only (Morgan et al., 2012). Taken together, these findings are important to consider for mental health court treatment and programming.

1.1.2. Mental Health Courts, Rights, and Criminal Justice Principles

Mental health courts must not only consider how their programs achieve change, but how to do so while adhering to legislative and constitutional requirements, including individuals’ due process and privacy rights. Mental health courts typically operate as resolution courts and therefore require an admission of responsibility as a criterion for participation. Concerns have been raised in the literature regarding: the protection of defendants’ due process rights, whether mental health court programs are truly voluntary, whether defendants fully understand the court process, the potential for disproportionate time spent under the supervision of the court relative to offense severity, and the need for increased protections for privacy of treatment-related information (e.g., Redlich, 2005; Seltzer, 2005). These issues may be particularly concerning for
youth given the increased vulnerability that stems from their lack of cognitive and social maturity.

1.1.3. The Present Study

While there is plenty of research on the design, implementation, and functioning of mental health courts for adults (Frailing, 2011; McNiel & Binder, 2010; Petrila, Poythress, McGaha, & Boothroyd, 2001; Redlich, Steadman, Monahan, Petrila, & Griffin, 2005; Schneider, 2010; Slinger & Roesch, 2010), there has been a dearth of such research on mental health courts for youth. Evaluation research is needed to outline how such programs for youth achieve change (i.e., process) in order to better understand their impact (i.e., outcomes). Process evaluations can provide important information about program functioning and program components responsible for change (Steadman, 2005). Such evaluations typically include a review of the program model and program implementation (Rossi & Devaney, 1997) using data gathered from qualitative and quantitative methods (Centers for Disease Control [CDC], 1999).

In accordance with this approach, the first goal of this study was to identify and evaluate the program theory of a recently established mental health court for youth in Toronto, Canada¹. This included the development of a logic model, which provides a visual representation of the program’s functions and rationale for expected outcomes (Brouselle & Champagne, 2011). Articulation of a logic model allowed us to address the second objective of the study: an analysis of how the program theory fits with existing research – in this case, on what is known about best practice for treating justice-involved youth with mental health needs – as well as with criminal justice and privacy principles. To address these objectives, we reviewed the court’s published documentation, examined the knowledge, perceptions, and experiences of those involved in the court, and observed the court’s operations.² Although the study examined one particular court, it
represents an important contribution to the meagre evidence base for a practice that is gaining popularity (Dirks-Linhorst & Linhorst, 2012; Slinger & Roesch, 2010) throughout North America. In addition, while anecdotal evidence indicates that youth mental health courts vary in their models and operations, there are common – and critical – underlying assumptions to the mental health court model (e.g., the contribution of mental health factors to offending) that require study.

2. Method

2.1. Participants

Participants for the current study were comprised of two groups: service users (i.e., youth and parents who participated in the court) and key informants (i.e., prosecutors, defense counsel, duty counsel – government lawyers who provide limited legal services to those without legal representation – judges, youth mental health court worker, and treatment providers involved with the court).

Youth \( (N = 58) \) who completed their court requirements within the mental health court during the year of data collection (September 2012-August 2013) were invited for an interview. Of those, 34 adolescent service-users (23 males and 11 females) and 11 independent parents (i.e., not two parents of the same child; 4 males and 7 females) participated in the study. Pairwise comparisons revealed that the youth who participated did not differ from youth who did not participate in terms of gender, motivation level, previous number of diagnoses, and number of criminal charges (see Table 1 for an overview of youth characteristics). The average age of parents who participated was 51.82 \((SD = 8.39)\). In terms of education level, three parents were high school graduates, two had some university or college education, five were university or college graduates, and one had post-graduate education. Comparison data on parents who did not
agree to participate was not available.

A total of 42 key informants were invited for interviews, of these, 30 (13 males and 17 females) consented to be interviewed. Key informants were comprised of the core mental health court team (i.e., judges, duty counsel lawyers, and crown attorneys, and a single youth mental health court worker), as well as defense counsel and community treatment providers (the latter two groups work with the mental health court team on a case by case basis and are not consistent members of the core team). All members of the core mental health court team at the time of the study participated in the interviews. The majority of key informants had postgraduate training ($n = 26$); the remaining four had completed university or college. In terms of age, 13.3% ($n = 4$) were under 30, 26.7% ($n = 8$) were 30-39, 26.7% ($n = 8$) were 40-49, 26.7% ($n = 8$) were 50-59, and 6.7% ($n = 2$) were over 60.

Table 1 about here.

2.2. Materials

Interview protocols were developed for the current study following Steadman’s (2005) guide to mental health court evaluations, as well as past research (McNiel & Binder, 2010) and the particular needs identified by stakeholders of the mental health court under evaluation. The interview protocols were semi-structured and largely open-ended to allow participants to provide details regarding opinions and experiences that were not the explicit focus of questions. Service user interviews included questions exploring their decisions for entering the court and questions seeking feedback regarding the strengths and weaknesses of the court and suggestions for improvement. Key informant interviews included questions in several broad areas, including understanding of the court’s purpose and goals, success in reaching its target population, clients’
access to treatment, perceptions regarding how rehabilitation is achieved, and the court’s adherence to clients’ legal rights and freedoms.

2.3. Procedure

The program theory evaluation was conducted following Brouselle and Champagne’s (2011) logic analysis procedures. The first step involved building a visual representation of the program’s inputs and activities and how these activities were thought to bring about change. Data used to develop the logic model included documentation on the court program and processes (Ontario Court of Justice [OCJ], 2011), stakeholder interviews, and court observations (i.e., a research assistant attended all court dates for a period of one year to gather informal observational data regarding the key operations within the mental health court). Key stakeholders also reviewed the logic model and provided feedback on the court’s hypothesized mechanism of change. The next step involved reviewing research literature related to the underlying causal mechanisms and using this information to highlight the strengths and weaknesses of the program’s model.

Youth and parent interview participants were recruited by a research assistant who was present on each court date and approached potential candidates to briefly describe the study and solicit participation. Voluntary, informed consent was obtained before proceeding with interviews, which were conducted in a private space on court premises. Key informants were approached in person, by phone, or by email, to request participation. Those who agreed were interviewed at a time and place of their choice.

Interview responses were analyzed using thematic analysis (Braun & Clarke, 2006). Transcripts were initially reviewed several times to develop an understanding of the overall data. Data were then reviewed for codes representing noteworthy features and grouped into major
themes. All data were coded and organized using NVivo10 software (QSR International). Interrater reliability assessing the presence or absence of themes was established for a random subset of 10 parent and youth interviews and seven key informant interviews. Overall reliability with an independent coder was found to be adequate (Kappas ranged between .76 and .83).

3. Results and Discussion

3.1. Program Theory Evaluation

A logic model of the court (as it was functioning at the time of evaluation) – which represents its personnel, activities, and goals – is presented in Figure 1. Characteristics of the model, including the mechanism of change, strengths, and weaknesses, are discussed below in relation to relevant research literature.

3.1.1. Youth and family engagement.

One of the strengths of the model is the focus on the relationship between the youth mental health court worker and youth and their families. Research indicates a moderate to large relationship between the degree of collaboration and emotional bond between a therapist and client and positive treatment outcomes (Karver, Handelsman, Fields, & Bickman, 2005; Martin, Garske, & Davis, 2000). Although the youth mental health court worker did not provide direct treatment, a therapeutic alliance with the court’s clients may be important for engaging youth in the court process, developing collaborative treatment plans, and promoting treatment engagement.

Best practice guidelines for treating justice-involved youth also highlight the importance of involving families in the treatment process (Guerra, Kim, & Boxer, 2008). A significant association between family involvement in court proceedings and has been found to have
favorable outcomes in juvenile drug court treatment (Salvatore, Henderson, Hiller, White, & Samuelson, 2010). Furthermore, implementing evidence-based principles to improve family engagement has been found to result in better outcomes for youth drug court defendants than those in treatment as usual (Henggeler, McCart, Cunningham & Chapman, 2012). The mental health court under evaluation focuses on engaging youth and families in treatment at the court level, which is an important strength that could be further enhanced by having an established, evidence-based set of steps for engaging families both within the court and within treatment.

3.1.2. Collaboration.

Another important aspect of the logic model is the collaboration between members of the mental health court team, defense counsel, and treatment providers, as well as the interest of core members of the team (i.e., judges, crown attorneys, duty counsel, youth mental health court worker) in mental health and the expertise they bring to the court. One of the common themes amongst youth and parents who found the court helpful was the supportive environment and the court’s clear focus on helping youth. These findings are in keeping with Thompson, Osher, and Tomasini-Joshi’s (2007) essential elements for a successful mental health court program, which include a team that works collaboratively, is able to adapt to a non-traditional court environment, and has a special interest and/or special training in mental health issues. The collaborative nature of mental health courts provides a less adversarial environment that promotes a focus on treatment as opposed to punishment.

3.1.3. Screening and assessment.

Another strength of the model, that is in keeping with the literature, is the court’s use of a standardized, valid, and reliable screening measure to identify the mental health needs of youth (Borum, 2003; Hills, Shufelt, & Cocozza, 2009; Hoge, 2008). However, absent from the logic
model is widespread screening across the justice system to be able to identify potential candidates and policies for responding to these screening results (e.g., identifying clinical cut-offs for program acceptance and next steps for assessment and treatment). In addition, within the current model, screening for mental health concerns is completed, but no further assessments are done. Best-practice guidelines indicate that screening measures should not be used for treatment planning and indicate the need for comprehensive follow-up assessments to better understand each young person’s unique strengths and needs in order to target treatment (Grisso, 2008; Grisso & Underwood, 2004; Hills et al., 2009). For example, successful models in other jurisdictions have implemented empirically-supported assessment procedures conducted by either psychiatrists or psychologists to identify important areas of need for youth involved with the justice system (Kahn, O’Donnell, Wernsman, Bushell, & Kavanaugh, Clark, Masson, & Kahn, 2007). If comprehensive assessments were conducted as part of the court, a corollary to such in-depth gathering of personal information would be the need for clear and well-enforced privacy protocols to limit sharing of assessment information within the court.

3.1.4. Treatment and rehabilitation.

The causal mechanism assumed under the current mental health court model is that mental health treatment will improve well-being and reduce recidivism. This model (i.e., treating mental health needs to reduce recidivism) may be appropriate for a small proportion of youth whose mental health functioning is directly related to criminal behavior. However, of this court’s client population, only one in five youth had charges that were a direct result of mental health functioning; for most youth, mental health needs were prominent, but not considered the direct cause of criminal behavior (see Davis et al., 2014). Thus, for the majority of youth in this court the evidence suggests that it is also important to evaluate and address factors that are directly
linked to recidivism (i.e., criminogenic needs; Andrews et al., 1990), something that is not currently done within the court’s model or practices. While more research is needed, existing theory and research suggest that it is important to 1) assess the degree to which the young person’s crime is causally linked to his or her mental health issues and 2) treat both mental health and criminogenic needs.

With regards to the treatment services that youth receive through the court, there is currently no mechanism in place for selecting and evaluating programs. Guerra et al., (2008) have highlighted four key components of effective treatment that may be important for mental health court programs to consider when referring youth. First, treatment programs should be highly structured and target individual skills and beliefs. Less structured programs, such as group therapy and general counseling, vary widely in their activities and have been found to be less effective with this population. Second, treatment programs should involve a cognitive component that addresses areas such as anger management, problem solving, perspective taking, and empathy. Third, programs should engage families in treatment and seek to reduce family risk factors. Fourth, treatment programs should address a variety of risk factors across several contexts. To promote evidence-based practice amongst treatment providers, the mental health court will require clearly articulated treatment plans and a case manager to connect youth to treatment and ensure that treatment does in fact address their needs. Interventions that are informed by valid assessments and adhere to the four principles above are the most likely to be successful.
3.2. Program Model Implementation

3.2.1. Understanding of the court.

Key informants were asked to identify what they saw as the goals of the court. Their responses were generally in keeping with the program’s stated goals, particularly with regard to improving access to treatment, improving well-being, and reducing recidivism (OCJ, 2011). In addition, many participants focused on the positive legal outcomes for youth (i.e., having charges withdrawn), which is not a stated goal of the court but provides insight into possible reasons for referring youth.

3.2.2. Target population.

When asked about the court’s ability to reach its target population, key informants discussed the possibility of ‘missing’ youth in the regular court stream for legal reasons (e.g., clients may choose to contest their charges, an option not available in this resolution court). Participants also noted that youth might not participate due to the stigma surrounding mental health problems and that mental health needs were sometimes difficult to detect because it was primarily up to legal professionals to identify these issues. Best practice guidelines call for widespread screening across courthouses to systematically identify youth with mental health needs in order to provide them with proper services (Grisso & Underwood, 2004; Skowyra & Cocozza, 2007).

3.2.3. Access to treatment.

One of the key goals of the mental health court program is to improve access to community treatment services for youth with mental health needs. There was a consensus amongst key informants that access to treatment had been greatly improved in comparison to the traditional court system as a result of having a mental health specialist (i.e., youth mental health
court worker) whose role was dedicated to coordinating treatment services for youth. Youth and parents also reported being linked to services or being provided resources that they otherwise would not have received. At the same time, a common theme across interviews was the lack of mental health services available in the community. These findings are in keeping with Odgers, Burnette, Chauhan, Moretti, and Repucci’s (2002) call for policy-level changes focusing on the implementation of evidence-based treatment programs for justice-involved youth in the community. Best practice guidelines suggest that the most effective treatment model for justice-involved youth with mental health needs involves intervention within the community through collaboration with the juvenile justice system (Grisso, 2008).

3.2.4. Outcomes.

According to the court’s stated goals, the long-term outcomes of the program are to improve youth well-being, as well as reduce recidivism and improve community safety. Improvement in well-being was seen by key informants as stemming from positive legal outcomes, parents’ involvement in the process, the positive court experience (i.e., that youth felt treated differently or that the court cared about them), and the connection to treatment services. These responses were in keeping with those of youth and parents, who described the court as being superior to their experiences in traditional youth courts and discussed the importance of receiving a positive legal outcome. Youth and parents specifically highlighted that in comparison to typical courts, the mental health court was less intimidating, more focused on success, provided young people the opportunity to share their stories, and was more focused on parent involvement. Youth and parents also highlighted the importance of collaboration, noting their involvement in treatment planning and being updated on the youth’s progress. Others highlighted the collaboration between members of the mental health court team and the importance of
working together for youths’ best interests. These results are in keeping with the program’s logic model, which highlighted positive relationships and family engagement as important factors in engaging youth in the court process.

With respect to reduced recidivism and increased community safety, key informants stated that if the court was addressing the “underlying factors” that resulted in a young person’s arrest then there would be a reduction in future criminal behavior. However, in most cases respondents did not specify what these underlying factors were and whether they were being met in treatment. Some treatment providers did explicitly discuss the need to address criminogenic needs, a perspective that is consistent with current research (Skeem et al., 2011) on mental health and criminal justice involvement.

In addition to considering the needs targeted in treatment it is also important to consider treatment engagement, which has been found to be significantly correlated with treatment outcomes for youth (Karver et al., 2006). Key informants raised concerns regarding the lack of treatment engagement from youth, noting that some youth may not even have the appropriate supports necessary to ‘get them through the door’ (e.g., available parents, accessible transportation). Youth and parents of youth who attended treatment discussed factors that impacted their level of treatment engagement, including difficulties managing treatment expectations, the stress of managing multiple systems, being forced into programs, as well as the time investment required of families. Key informants suggested that youth should have more input into their treatment plan and to be given more incentives to complete treatment (i.e., verbal and physical rewards for completing certain steps of the program). More intensive case management may be required to assist youth in attending and engaging in treatment. This is in
keeping with the program theory evaluation findings (above), which suggested the need for more in-depth assessment and increased communication and follow up with treatment providers.

3.2.5. Adherence to rights and criminal justice principles.

A critical concern regarding treatment courts in general is that rights, principles, and protections that are foundational to the criminal justice process (e.g., right to legal counsel, proportionality), as well as broader freedoms (e.g., privacy and autonomy of consent) may be violated in the name of ‘helping’ individuals and protecting society. To protect against these violations, key informants noted that the youth mental health court has a dedicated ‘duty counsel’ lawyer assigned to assist youth who are not represented by their own lawyer. There was some concern voiced by key informants, however, that the presence of duty counsel has led to a reduction in the number of youth who retain their own lawyer and that duty counsel may not provide the in-depth legal representation necessary in a mental health court. By the nature of the duty counsel program, youth only meet with duty counsel on the day of their court proceedings which does not necessarily allow for the extra time that may be required for mental health court defendants. Similar concerns have been raised in the literature, which highlights the need for defense counsel to have adequate time to work with defendants in order to properly inform them of the risk of waiving their right to trial and to protect clients’ privacy and due process rights during court procedures (Seltzer, 2005).

Proportionality is another key concern, as participation in a treatment court should not result in lengthier or overly intrusive involvement with the justice system compared to standard court proceedings. For example, at the ‘entry’ phase of the youth mental health court process, it is important to ensure that the court is not engaging in ‘net widening’ whereby youth are formally processed for more minor offenses than young people seen in the regular youth court.
Clients in the court under evaluation were most commonly charged with administration of justice offenses, assault, and break and enter/theft/auto theft (see Davis et al., 2014), which is in keeping with the pattern of most common youth court charges across Canada in 2011/2012 (i.e., theft, common assault, break and enter, and failure to comply; Dauvergne, 2013).

In terms of case processing time, key informants reported that certain aspects of the court were faster than the typical youth court system and others were slower, resulting in comparable overall case processing time. Such perceptions are consistent with statistics indicating that case processing in the mental health court was similar to that in the regular system (Davis et al., 2014). Factors that facilitated case processing included expedited assignment of initial court dates, case management (i.e., linking youth with treatment, monitoring progress) and work done by team members between court dates (i.e., meetings to discuss next steps). In contrast, case processing was delayed largely due to treatment issues (e.g., waitlists, length of time for youth to stabilize or complete treatment).

With regards to the severity and intrusiveness of court outcomes compared to those in regular youth court, some key informants noted that the resolutions themselves tended to be more lenient, but that the requirements within the plans could be more intrusive (e.g., more intensive treatment programs). Other key informants noted that the nature of the outcomes was similar to that in the regular youth court, but that in the mental health court they were “front loaded” in that youth completed their requirements before, rather than after, the judge disposed of the case. In the current study over 90% of youth ultimately had their charges stayed, withdrawn, dismissed or discharged, compared to just over 40% of such resolutions in the traditional Canadian youth court system (Dauvergne, 2013).
Concerns around broader rights, including free and informed consent and protection of privacy, are also critical to explore in the context of a mental health court. Key informants noted that youth had the freedom to choose whether they participated in the mental health court and treatment services, and that youth had access to counsel who explained the process and advised them of their rights. Although mental health courts are generally considered voluntary, the degree to which defendants fully comprehend what is involved in participation has been questioned (Redlich, 2005). In the present study, parents generally articulated a greater understanding of the court than young people, whereas youth often appeared not to understand the purpose of the court. For instance, when asked about why they chose to go through the mental health court, 60% ($n = 27$) of interviewees recalled not having a choice and indicated that no one had explained the court, that they did not know it was different from a regular court, or described the court as an easier way to get their charges dropped. Interestingly, research shows that despite not reporting a choice in participating, many mental health court defendants do not find their court involvement to be coercive (O’Keefe, 2006; Poythress, Petrila, McGaha, & Boothroyd, 2002). Others have argued that having to make difficult choices about participation does not equate to coercion (Stefan & Winick, 2005) and that the mere option to participate in a mental health court is a benefit to defendants (Schneider et al., 2007). While it remains unclear the degree to which youth in the current study felt coerced into participation, further protections may be needed to ensure that youth understand the court process and their options through developmentally appropriate communication at every step.

With respect to privacy, there was a consensus amongst key informants that the court adheres to legislative requirements. Some informants also highlighted additional privacy measures (e.g., not discussing mental health problems in open court in order to reduce the
amount of information stated on public record) which are in keeping with other mental health court programs (Bernstein & Seltzer, 2003). Despite this, concerns have been raised in the literature regarding the use of treatment information within mental health courts (Seltzer, 2005). Indeed, participants in the current study indicated that youth were required to give up a certain amount of privacy due to the nature of the court and youth and parents expressed concerns over having to share at least some mental health information with all of the individuals present in the courtroom. To address these issues, key informants suggested having formal measures in place to protect mental health information and to reduce the number of unnecessary individuals in the court. This is in keeping with Seltzer’s (2005) call for rules that limit information spoken on record, the use of case conferencing to discuss sensitive information off record, and the use of defense counsel to protect privacy.

4. Summary

One of the main objectives of the current study was to understand the court’s proposed mechanism of change and how it relates to the theoretical and empirical evidence for treating justice-involved youth with mental health needs. The key outcomes targeted by the mental health court were to improve well being amongst youth, reduce recidivism, and increase community safety (OCJ, 2011). Through the creation of a logic model, we determined that the proposed mechanism for achieving these goals is mental health treatment. As noted above, the focus on treating mental health needs to reduce recidivism is common amongst justice programs, but has generally not been found to be effective. Research suggests that mental health treatment may be most effective in reducing risk to reoffend amongst those who’s criminal behaviors are directly linked to their mental health functioning. For the majority of offenders, findings indicate the need to address both mental health and criminogenic needs (Skeem et al., 2011). Within the
literature there is strong evidence that assessing for and treating areas of criminogenic need that have been empirically linked to delinquent behaviors can reduce recidivism (Andrews, et al., 1990; Hollin & Palmer, 2003; Schlager & Pacehco, 2011; Simourd, 2004; Vieira, Skilling, & Peterson-Badali, 2009).

The mental health court under evaluation does not currently assess or systematically address areas of criminogenic need. Our findings suggest the need for enhanced screening and comprehensive assessments. This includes quicker access to screening and/or universal screening of young people who appear in any youth court to ensure that youth with mental health needs are identified. Screening should be followed up by comprehensive assessments of mental health and criminogenic needs to help inform evidence-based treatment plans. Importantly, treatment needs must be balanced with the need to protect due process and privacy rights for youth. Comprehensive legal representation and formal privacy guidelines are two ways in which mental health courts can help to promote these protections.

5. Limitations and Future Research

There are several important limitations of the current research that should be considered when interpreting results. First, only youth who completed their court requirements and parents present at court could be approached for interviews. Thus, findings do not include the perspectives of those who did not complete the court and may not be generalizable to parents who were less involved with their child’s court proceedings. The small number of parent respondents, in particular, reflects the overall lack of parental involvement in court proceedings. Approximately one third of youth seen in the court had no parental support in dealing with their criminal matters and even fewer parents actually attended court appearances (Davis et al., 2014). Because parents are not required to be involved in their child’s court matters, no parent data is
systematically collected by the courts. However, from our interview data we know that parents who chose to participate in the study had high levels of education, on the whole. It is possible that youth from these types of families are different than youth whose parents have lower educational attainment in ways that are relevant to the operation of the court (e.g., more likely to complete their court requirements).

Similar constraints arise with regard to key informant interviews; those who participated may have a vested interest in the court, particularly when it comes to defense counsel, who are not a part of the core mental health team and tend to vary by case. While a participation rate of 71% is quite respectable, it is possible that respondents’ views are not representative of the total population of key informants. Finally, the generalizability of the logic model results is also limited to the court under evaluation, as many jurisdictions operate through different mechanisms (e.g., different structures for mental health service involvement, availability of resources, frequency of hearings, etc.). Nevertheless, the results provide important information regarding lessons learned in the development and implementation of this court and may be useful for developing future mental health court models or adapting existing models.

In terms of future research, multisite evaluations are needed to compare mental health court processes and structures across programs in order to determine key differences amongst program models that may produce different outcomes. Research is also needed to better understand the various needs of youth mental health court defendants, particularly, understanding the level of risk and criminogenic needs that characterize this sample of youth. Standardized outcomes evaluations are also needed to begin to highlight the impact of youth mental health courts on both mental health functioning and recidivism. Research that uses
control groups or randomized control groups are ideal to be able to parse out the unique effects of the court.

6. Conclusion

Youth mental health courts are a relatively new development and there is limited research documenting their functioning and effectiveness. The current study highlights important areas of strength in one mental health court model, including the supportive and understanding environment for youth and their families. This environment reflects the collaboration between the court team members and promotes engagement of youth and families. Similarly, the focus on developing positive relationships with youth was found to be a strength of the logic model and was also acknowledged by youth and their parents. Results also revealed general success in linking youth with treatment services – something that youth reported was one of the more helpful aspects of the court. In addition to these strengths, several areas for improvement also emerged. In both the program theory evaluation and interviews, there was a common theme calling for more formalized and comprehensive treatment to address multiple areas of need (i.e., mental health and criminogenic needs) experienced by youth. Incorporating aspects of evidence-based practice, including widespread standardized screening as well as comprehensive assessment and treatment should lead to better overall outcomes for youth (i.e., higher rates of desistance from crime). Continued research will be important for ongoing evaluation of the program and to ensure that the program is meeting the needs of justice-involved youth with mental health needs.
References


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Table 1.

Summary of characteristics of youth interviewees and youth not interviewed for the study

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Youth Interviewees</th>
<th>Youth Not Interviewed</th>
<th>Comparison Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Years)</td>
<td>16.49 (0.94)</td>
<td>15.56 (1.27)</td>
<td>$U(58) = 227.50, Z = -3.07, p = .002$</td>
</tr>
<tr>
<td>Motivation rating</td>
<td>6.03 (1.77)</td>
<td>5.72 (1.84)</td>
<td>$U(58) = 313.00, Z = -1.24, p = .214$</td>
</tr>
<tr>
<td>Number of diagnoses</td>
<td>1.24 (1.06)</td>
<td>1.83 (1.50)</td>
<td>$U(58) = 255.50, Z = -1.51, p = .132$</td>
</tr>
<tr>
<td>Number of Charges</td>
<td>4.49 (3.52)</td>
<td>2.92 (2.33)</td>
<td>$t(50) = 1.65, p = .105$</td>
</tr>
<tr>
<td>Female</td>
<td>66.67</td>
<td>72.00</td>
<td>$\chi^2(1, N = 58) = 0.19, p = .664$</td>
</tr>
<tr>
<td>Male</td>
<td>33.33</td>
<td>28.00</td>
<td></td>
</tr>
</tbody>
</table>
Figure 1. Logic model of the youth mental health court program under evaluation.
Author Notes

1 The court sees young people charged with an offense who present with a major mental health or substance use problem and wish to resolve their charges. Its goals are to improve access to community treatment services, reduce case processing time, improve general well-being, reduce recidivism, and increase community safety. Following referral to the mental health court by court personnel (e.g., the young person’s lawyer, the prosecutor, or a judge), a youth undergoes mental health screening to determine eligibility for the court. Members of the mental health court team, which consists of a dedicated prosecutor and youth mental health (social) worker as well as the young person’s lawyer, collaborate to develop a treatment plan for the youth within the community, which is approved by the judge who oversees the court. Once the youth has made significant progress in treatment the prosecutor recommends an appropriate disposition (e.g., withdrawal of charge, stayed charge, sentence).

2 This study was part of a larger process evaluation that described how the court operates and examined predictors of successful court completion as well as how the court addresses the mental health and criminogenic needs of clients (Davis et al., 2014).