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How Adoptees Continue to Struggle with Emotional, Behavioral, and Educational Issues Post-Adoption

Keeley Minzenmayer[*]

I. Introduction

Although adoption has been used for centuries, the practice of adoption is constantly evolving and changing, and many of the adoption policies seen today were created so long ago that they are no longer appropriate when used in today's world.[1] New research has brought to light some of the effects that an adoption can have on a child and a family, and adoption practices are evolving to help remedy these issues.[2] This paper examines the practices of adoption and how they have changed throughout history to accommodate the culture, attitude, and needs of the time period, and how these practices have impacted the lives of the children who are voluntarily or involuntarily placed into this system.

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[*] Keeley Minzenmayer wrote this article in Spring 2016 while attending Arizona Summit Law School.

[1] Deborah H. Siegel, *Adoption Trends Today*, Soc. Work Today, http://www.socialworktoday.com/archive/111715p18.shtml (last visited May 6, 2016).

[2] *Id*.

II. ADOPTION IN GENERAL

The practice of adoption attempts to permanently place a child with a non-biological parent or parents.[3] The adoptive family permanently takes on the legal rights and responsibilities of the child's biological family, and this can have an effect on the psychological and social tendencies of the people involved.[4] The placement of a child into a new family has a major effect on the child, often changing his or her geographical location or culture in the process.[5]

There are many reasons that a family may want or need to give a child up for adoption, and these circumstances can be involuntary or voluntary depending on the family's situation.[6] Involuntary termination of a parent's rights involves the court system deciding to permanently take a parent's rights away.[7] There are many reasons that a court could ultimately decide to terminate a parent's rights, including neglect, alcohol or drug abuse, abandonment, or abuse.[8]

Conversely, a child's birth parents may decide to terminate their parental rights at their own will and place their child for adoption—this is considered to be a voluntary termination of parental rights.[9] A parent may voluntarily decide to terminate his or her parental rights for many reasons, including having an unplanned pregnancy that could interfere with life plans,

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[3] *Adoption*, NEW WORLD ENCYCL., http://www.newworldencyclopedia.org/entry/Adoption (last visited Apr. 18, 2016).
[4] *Id*.
[5] *Id*.
[6] *Termination of Parental Rights*, ADOPTION.COM (Apr. 15, 2014), https://adoption.com/termination-of-parental-rights.
[7] *Id.*
[8] *Id.*
[9] *Id.*

career, or education.[10] A birth mother may also recognize that she is unable to give her child the best life possible, and will place the child in an adoption in order to provide the child with a safe and stable home.[11] Many times, these decisions are made out of the birth mother's loving desire to give the child the best opportunities in life, knowing that these may be found while living with another family.[12]

A study has shown that the differences between voluntary and involuntary termination have an effect on the child.[13] If the biological parents fought to keep the children in the family, but their rights were severed by the court, some children felt they were being unfaithful to their biological parents when they accepted a foster care or adoption placement.[14] On the other hand, in situations where a parent's rights were voluntarily severed, children had an easier time entering into an adoption relationship.[15] Kristin Chenoweth, a Hollywood and stage actress who was adopted just after birth, has stated, "I knew that my birth mother loved me so much that she wanted to give me a better life."[16] Placing a child up for adoption is a serious de-

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[10] *Advantages of Adoption for Pregnant Women*, AM. ADOPTIONS, http://www.americanadoptions.com/pregnant/article_view/article_id/4390?cId=150 (last visited Apr. 18, 2016).

[11] Annaleece Merrill, *4 Things Birth Moms Wish You Knew*, ADOPTION.COM (Feb. 12, 2016), https://adoption.com/4-things-birth-mothers-wish-you-knew.

[12] *Id*.

[13] Rebecca L. Scharf, *Separated at Adoption: Addressing the Challenges of Maintaining Sibling-of-Origin Bonds in Post-Adoption Families*, 19 U. C. DAVIS J. JUV. L. & POL'Y 84, 118 (2015).

[14] *Id*.

[15] *Id*.

[16] Kristen Chenoweth, *Kristen Chenoweth: Why Adoption is the Biggest Blessing of Them All*, PEOPLE MAG. (Nov. 20, 2015, 12:00 PM), http://www.people.com/article/kristin-chenoweth-national-adoption-day-essay?xid=facebook-todayshow.

cision, but it often leads to a better life and opportunities for both the child and the birth mother.[17]

In her article, Kristin Chenoweth also stated that the act of adopting a child is a "full-circle blessing," and a child placed for adoption is a beautiful gift to the adopting family.[18] There are numerous reasons in today's world that adoptive parents may want or need to adopt a child rather than have a biological child of their own.[19] An adoptive couple may struggle with several different issues that limit their ability to bear their own children, including infertility or difficulty conceiving, medical or genetic illnesses that make it dangerous to have a child, or health issues that may lead to a high risk pregnancy.[20] Other reasons a parent could choose to bring an adopted child into the family could also include the dream to grow a family, to bring in a child of a certain gender, to help save a child from growing up without a family, or to create a family when one has not yet met the right partner. [21]

III. HISTORY AND EVOLUTION OF ADOPTION LAW

In today's Western world, adoption is a standard practice that can be seen as a response to several common problems, including parental infertility, the need for humanitarianism, or the desire to create a new or larger family.[22] However, the act of moving children from parents who could not or even would not care for them, to the care of adults or parents who

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[17] *Id*.
[18] *Id*.
[19] Kathryn Patricelli, *Choosing to Adopt*, MENTALHEALTH.NET (Jan. 22, 2007), https://www.mentalhelp.net/articles/choosing-to-adopt/.
[20] *Id*.
[21] *Id*.
[22] Professor Ellen Herman, *Adoption History in Brief*, THE SOC. WELFARE HIST. PROJECT, http://www.socialwelfarehistory.com/programs/child-welfarechild-labor/adoption/.

wanted to care for them has been found throughout history in all cultures.[23] In ancient cultures, adoption was usually used to benefit the needs and rights of the adopting parents or adults, rather than being concerned with providing for the best interests of the child involved in the adoption.[24]

Adoption has been found in ancient documents such as the Code of Hammurabi, which was a statement of laws created by Hammurabi while he reigned over Babylon around 1780 B.C.[25] These writings contain information about the purposes that adoption served in these times, such as providing care for elderly individuals who may have never had children of their own, or whose children had all married and left the family home.[26] Additionally, in these times, children could be adopted to take on the role of an apprentice and learn from an individual who practiced a certain skill, trade, or craft.[27] Similarly, the theory of adoption and its practice has been found in the Codex Justinanus from ancient Rome, where the aristocratic culture used adoption principles to preserve power and wealth.[28]

Moving into the Middle Ages, the popularity of adoptions slowed due to the traditions and ideals of the noble class found in Europe as these cultures placed a high importance on maintaining a family's lineage through biological children.[29] The stigmas placed on adoption during this time period were shown in how the law progressed—by placing strict restrictions on who could adopt children or by making it clear that the

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[23] *Id*.
[24] NEW WORLD ENCYCL., *supra* note 3.
[25] *Code of Hammurabi*, NEW WORLD ENCYCL., http://www.newworldencyclopedia.org/entry/Code_of_Hammurabi#Adoption (last visited Apr. 18, 2016).
[26] *Id*.
[27] *Id*.
[28] NEW WORLD ENCYCL., *supra* note 3.
[29] *Id*.

practice of adoption would not fit into the current system used to determine inheritance.[30] Due to the decline in adoption rates, different methods were used to care for abandoned or orphaned children.[31] These methods included giving children to the church at a monastery or a convent, which made it so that the birth family no longer had to care for the child.[32] "Foundling homes" also began to emerge in this time, giving needy children a place to stay—however, children were not often adopted from these places.[33]

Adoption law began to change into what we know today when society began to place more importance on making sure that children were well cared for, and, as such, there was a social shift to view adoption as a way to promote the best interests of the child rather than the best interests of the adopting adults.[34] Massachusetts is widely seen as creating the first modern adoption laws in 1851, which laid out the rules and obligations for all parties involved in the adoption and the processes required to complete the adoption.[35] Additionally, the laws set out the role of the courts, which allowed judges to make determinations on whether a potential adoptive family would be the best fit for the child in question.[36] Although Massachusetts is known to be the first legal community to provide modern adoption law and practices, many countries have followed and used the Massachusetts adoption laws as a guide to create their own.[37]

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[30] *Id*.
[31] U.N. DEP'T OF ECON. & SOC. AFFAIRS, *Child Adoption Trends and Policies*, at 10, U.N. Doc. ST/ESA/SER.A/292, U.N. Sales No. E.10.XIII.4 (2009), http://www.un.org/esa/population/publications/adoption2010/child_adoption.pdf.
[32] *Id*.
[33] *Id*.
[34] *Id*. at 12-13.
[35] *Id*. at 13.
[36] *Id*.
[37] *Id*. at 14.

Adoption law and practices have changed greatly throughout history in order to accommodate the changing attitudes of cultures, and currently, adoption law and practices are continuing to grow and evolve with the priorities and practices of today's modern world.[38] There are many organizations today that are attempting to bring even more awareness to the need for adoption, including National Adoption Day, which works to advocate for more than 100,000 children currently in the foster care system.[39] The Dave Thomas Foundation for Adoption also attempts to raise awareness of the growing need for adoptive families in America, and is devoted to helping foster children find permanent placement with adoptive families.[40]

Globally, the United Nations estimates that there were 260,000 children adopted annually around the year 2005, and at more than 127,000 adoptions, almost half of these global adoptions were completed by adoptive parents living in the United States.[41] The practice of international adoption in the United States and throughout the world is beginning to change.[42] This change is occurring for several reasons, including a higher importance being placed on domestic adoptions throughout the world, and foreign countries placing more restrictions upon international families that want to adopt a child from the country.[43] Similarly, here in the United States, a survey has shown that the public's view of adoption from the foster care system is now more desirable than adoption from an-

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[38] *Id*. at 21.
[39] *About National Adoption Day*, NAT'L ADOPTION DAY, http://www.nationaladoptionday.org/about/ (last visited Apr. 18, 2016).
[40] DAVE THOMAS FOUND. FOR ADOPTION, https://davethomasfoundation.org/learn/get-informed/ (last visited Apr. 18, 2016).
[41] U.N. DEP'T OF ECON. & SOC., *supra* note 31, at 66.
[42] Richard Gibson, *Trends in International Adoption*, RESOLVE THE NAT'L INFERTILITY ASS'N, http://www.resolve.org/family-building-options/adoption/trends-in-international-adoption.html (last visited May 6, 2016).
[43] *Id*.

other country or from a private infant adoption.[44] However, although the act of adoption from foster care is known to be important, some are still concerned with the potential issues involving the costs and process of foster care adoption, as well as the issues facing the children that have spent time in the foster care system.[45]

IV. EMOTIONAL ISSUES SURROUNDING ADOPTION

Adopted children struggle with many different emotional issues due to the unique circumstances of their past, and it is unlikely that others will be able to relate to their personal emotional struggles.[46] Many of the emotional issues that adoptees face can be traced back to the secretive nature that used to surround the process of adopting a child, which likely caused children to wonder why the circumstances of their past and their life needed to be kept hidden from the community.[47] Additionally, almost all adoptees are forced to cope with some form of loss prior to the adoption that brought them to their new families.[48] This could be loss through the death of their biological parents or through a court-ordered decision that severed their parents' rights to raise them. Many adoptees are also forced to suffer the loss of their biological siblings who they

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[44] *Dave Thomas Foundation for Adoption Survey Finds Shifting Trends in Adoption*, DAVE THOMAS FOUND. FOR ADOPTION, https://davethomasfoundation.org/news_story/dave-thomas-foundation-for-adoption-survey-finds-shifting-trends-in-adoption/ (last visited May 6, 2016).

[45] *Id*.

[46] *Impact of Adoption on Adopted Persons,* CHILD WELFARE INFO. GATEWAY, at 2 (Aug. 2013), https://www.childwelfare.gov/pubPDFs/f_adimpact.pdf.

[47] Joanne Wolf Small, *Adopted in America: A Study of Stigma*, at 6-7 (June 17, 2013), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2280517.

[48] Deborah N. Silverstein & Sharon Kaplan, *Lifelong Issues in Adoption*, FAMILIES ADOPTING IN RESPONSE, http://www.fairfamilies.org/2012/1999/99LifelongIssues.htm (last visited Apr. 18, 2016).

may have grown to develop an incredibly strong relationship with.[49] All of these factors have contributed to the emotional issues that many children living with an adoptive family have dealt with throughout their childhood and often into adulthood as well.

A. Adoption Stigma

Research has shown that an adopted child may face stigma involving his or her adoption stemming from being labeled as "adopted." Often, others presume an adopted person to be "flawed, defective, deficient, and deviant."[50] This is likely due to the fact that, starting in the early 1900s, adoption tended to be a secretive event.[51] Commonly-held social ideals at the time made being a single mother or having an "illegitimate child" a shameful situation, and, as a result adoptions were kept secret from the community.[52] Members of the community, including doctors, ministers, or even the young mother's parents, believed that adopting the child to a married family would keep the child and young mother from feeling the shame of the unplanned pregnancy.[53]

This, however, has caused many adopted individuals to face a world that labels them as different from people who were raised by their biological parents.[54] It is hard for some adoptive parents to have a discussion with their child about their adoption into the family, and they find it difficult to disclose that information to other family members or their community.[55] However, it is important for parents to engage the

[49] Scharf, *supra* note 13, at 112.
[50] Wolf Small, *supra* note 47, at 4.
[51] *Id*. at 6.
[52] *Id*. at 7.
[53] *Id*. at 9.
[54] *Id*. at 12.
[55] *Id*. at 3.

adoptive child in conversations about his or her birth family and to be ready to answer questions the child has about his or her past.[56]

Although modern times have made it easier to have conversations and discussions about adoption, there is evidence that adopted individuals remain unwilling to disclose their adopted status for fear of feeling shame.[57] Similarly, despite the fact that we have seen an increase in attention to celebrities that adopt children, there is no evidence that this has helped to take away the stigma many adopted individuals feel regarding their "deviant" upbringing.[58] In looking at the way society still views adoption, H. David Kirk noted that, although outward opinions of adoption seem to portray a complete societal approval, there remain other internally held beliefs regarding the differences in a biological family and a family that adopts.[59]

B. Identity and Self Esteem

Development of a person's sense of identity is very important to the journey into adulthood. Individuals begin to realize their identity from an early age, and this process tends to continue into their teenage years.[60] For adoptees, their adoption is an important part of developing a sense of self and it may cause additional issues involving their identity even as they become adults.[61] Adoptees likely have a more difficult time finding their identity because they are confronted with the unique problem of being "born into one family, a family prob-

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[56] Rhonda Jarema, *Talking to Adopted Children About Birth Parents and Families of Origin: How to Answer the "Hard Questions"*, NAT'L COUNCIL FOR ADOPTION (Sep. 01, 2015), https://www.adoptioncouncil.org/publications/2015/09/adoption-advocate-no-87.
[57] Wolf Small, *supra* note 47, at 21.
[58] *Id*. at 24.
[59] *Id*. at 8-9.
[60] *Impact of Adoption on Adopted Persons, supra* note 46, at 2-3.
[61] *Id*.

ably nameless to them now, lose an identity and then borrow one from the adopting family."[62]

The reasons that adoptees have a more difficult time developing their self-identity vary, but it is likely that one of the main reasons is that many do not have access to information regarding their biological families.[63] This often leaves the adopted child with many unanswered questions about the circumstances of their birth or adoption, why the birth family decided to choose adoption, and why the specific adoptive parents were chosen.[64] The lack of information and identity can also sometimes cause adoptees to look for ways to develop their sense of self or act out by running away or rejecting their adoptive families.[65]

Many adoptees will try to search for their birth families.[66] An adoptee's decision to search for family members may happen for many reasons, such as the desire to gain valuable family medical history, to know more about any shared family resemblance, or to understand the reasons that he or she was placed with the adoptive family in the first place.[67] Searching for biological family members has become increasingly easier with the social media options that are available today, and this has led some adopted children to search for their biological families, with or without their adopted families' permission or knowledge.[68]

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[62] Silverstein & Kaplan, *supra* note 48.
[63] *Id*.
[64] *Id*.
[65] *Id*.
[66] *Searching for Birth Relatives*, CHILD WELFARE INFO. GATEWAY, at 2 (Dec. 2011), https://www.childwelfare.gov/pubPDFs/f_search.pdf.
[67] *Id*.
[68] Siegel, *supra* note 1.

C. Loss & Grief

The process of adoption is inherently associated with some amount of loss on the adopted child, the birth parents, or the prospective adoptive parents.[69] In their article, *Lifelong Issues in Adoption,* Deborah N. Silverstein and Sharon Kaplan stated, "Adoption is created through loss; without loss there would be no adoption."[70] Adopted children lose connections to their birth parents, siblings, and extended family, birth parents lose the rights and companionship of their biological child, and adoptive parents have possibly lost a child of their own or their ability to have a child.[71] These losses tend to be found only in these similar situations, and it may be difficult for adopted individuals to find someone to whom they can truly relate and who understands what they are going through.[72] The effects of the loss, although likely to have occurred early in the adopted child's life, may have an impact on the individual throughout his or her life, and could cause feelings of loss, grief, anger, or fear—especially at important life events.[73]

In addition to feelings of loss, an adopted child will likely have to grieve the loss of his or her biological family, which can be difficult because the outside world tends to view adoption as an event that should be filled with happiness and love.[74] Adopted children, although they often know about the situations that brought about their feelings of loss and grief, may not fully understand the details of their circumstances until later in life, which could lead to other problems, including alcohol or drug abuse, depression, or behavioral issues.[75]

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[69] Silverstein & Kaplan, *supra* note 48.
[70] *Id*.
[71] *Id*.
[72] *Impact of Adoption on Adopted Persons*, *supra* note 46, at 2.
[73] *Id*.
[74] Silverstein & Kaplan, *supra* note 48.
[75] *Id*.

In some instances, adoptive parents or other close family members may attempt to make an adopted child feel better by trying to soften the situations that the child has gone through.[76] However, this can cause the adopted child to believe that he needs to keep his feelings of loss and grief to himself, and that he must deal with his emotions internally.[77] This is not an ideal way for the child to cope with these feelings. The child should have access to information regarding grief and an environment where he can show his feelings without judgment from others.[78]

D. Separation from Siblings

Another change in adoption that has been made over the last several decades is that there are now more open practices of adoption.[79] There was a time when adoptions were made in secret in order to avoid the shame from the circumstances that led the parties to enter into adoption in the first place.[80] This could be observed from the embarrassment of the adoptive parents' inability to have children of their own, the birth mother having a child out-of-wedlock, or the adopted child being abandoned by his or her biological family.[81] However, many factors have changed, and society is moving toward a less secretive and more open process of child adoption.[82]

In today's world, there is more information regarding the downfalls of secret adoptions, better access to various birth

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[76] Nancy Randall & Kim Shepardson Watson, *Post-Adoption Services: Acknowledging and Dealing with Loss*, NAT'L COUNCIL FOR ADOPTION (Mar. 01, 2016), https://www.adoptioncouncil.org/publications/2016/03/adoption-advocate-no-93).
[77] *Id*.
[78] *Id*.
[79] Scharf, *supra* note 13, at 103-04.
[80] *Id*. at 103.
[81] *Id*.
[82] *Id*. at 104.

control methods, and less shame surrounding single mothers and having children outside of marriage.[83] All of these factors have combined to lead to a situation where there are far fewer infants placed into adoptions voluntarily by their birth parents, and more children being adopted out of the foster care system at much older ages than previously seen.[84] However, because some of these children are older when adopted, many more are entering into new families while already having a history and a connection with their biological siblings.[85]

The loss of a biological sibling can be very challenging for an adopted child due to the closeness and memories that he or she likely shares with that sibling.[86] A sibling relationship is unique because they have often experienced many of the same situations and challenges, and they alone understand what it was like to be raised in and grow up in their family home.[87] This is true whether the siblings come from a healthy and happy home that was broken due to the death of a parent, or whether they come from an abusive and neglectful home that was broken involuntarily by the placement of the children in foster care. In fact, those children who faced parents that were absent or neglectful are more likely to have a stronger emotional relationship with their siblings.[88]

Although the court system usually sees the value of placing biological siblings in the same foster care home, the same rights are not always afforded to children that are adopted into families without their siblings.[89] The United States Supreme Court case *Troxel v. Granville* confirmed a parent's con-

[83] Scharf, *supra* note 13, at 104.
[84] *Id*. at 107.
[85] *Id*.
[86] *Id*.
[87] *Id*.
[88] *Id*. at 108.
[89] *Id.* at 85-86.

stitutional right to decide and to have control over the way that they will raise their children, and this ruling also applies to parents who adopt.[90] Due to this case, when children are adopted in single-child situations and are severed from their biological families, they could lose the power or right to contact their biological siblings until they reach the age of adulthood.[91]

Due to the fact that a child from an abusive or neglectful home will likely have a very strong emotional and physical attachment to his or her siblings, separating those siblings could have a profoundly damaging effect on the child's development and attitude.[92] Even if a child is placed into a loving and accommodating adoptive family, separation from siblings could lead to the child having incredible difficulty overcoming the sense of loss that he or she has endured.[93] In fact, many studies have shown that allowing a child to preserve his relationship with his biological siblings could lead to many benefits for the child regarding his social and psychological outlook.[94]

When biological siblings are adopted into the same adoptive family, there is a higher probability that there will be a successful adoption and less of a chance the adoption will disrupt before it is finalized.[95] Additionally, allowing biological siblings to be adopted into the same household can have many positive effects on the child's psychology, including reducing his or her feelings of fault, failure, or unworthiness.[96] Although there are many benefits to placing biological siblings together, it is not always easy to do so.[97] There are many fac-

[90] Scharf, *supra* note 13, at 92.
[91] *Id*. at 85.
[92] *Id*. at 112.
[93] *Id.* at 111.
[94] *Id*. at 112.
[95] *Id*. at 114.
[96] *Id*. at 115.
[97] *Id*. at 116.

tors that decide whether siblings are able to be placed together, including the number of siblings in the family, whether any of the children have special needs, and the number of available families.[98]

V. BEHAVIORAL ISSUES SURROUNDING ADOPTION

Thousands of children are adopted each year, and most of these adoptees grow into successful and happy individuals.[99] However, a University of Minnesota study has found that about fourteen percent of adoptees have a behavior disorder diagnosis or see a mental health professional at some point during childhood, which is about twice the rate of non-adopted adolescents.[100] For some time, this increase was thought to be a direct result of the adoptive parents having more wealth and education and the fact that these parents would have better access to medical or behavioral services for their adopted children.[101] However, new evidence shows that these issues may be due to factors such as how the child was cared for during and just after the pregnancy, the biological parents' genetics, or another event that occurred before the adoption.[102]

A. Reactive Attachment Disorder

Reactive attachment disorder is a condition that is known to affect children who are adopted from orphanages[103]—institutions in which children are raised by very few

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[98] *Id*.
[99] Kathleen Kingsbury, *Adoptees More Likely to be Troubled,* TIME MAG. (May 05, 2008), http://content.time.com/time/health/article/0,8599,1737667,00.html.
[100] *Id*.
[101] *Id*.
[102] *Id*.
[103] Jessica Gerard, *Reactive Attachment Disorder in Adoptees*, RAINBOW KIDS ADOPTION & CHILD WELFARE ADVOC. (Jan. 01, 2006), http://www.

caretakers who are usually unable to care for the large amount of children that they are responsible for.[104] In these situations, it is not uncommon for children to be left uncared for or alone in their cribs for extended periods of time.[105] The children are often left without proper diaper changes, baths, food, or physical and emotional connection.[106] When these children are not adequately cared for or when they learn that their cries for help will not bring them the aid that they need to thrive, they may never trust that their needs will be provided for.[107] Eventually, they may stop trying to get their physical and emotional needs met, and may be left with feelings of "rage, helplessness, fear, and shame."[108]

These situations experienced by children adopted from institutionalized care can cause many behavior issues in adopted children throughout their lives.[109] Some of the most common behavioral issues seen in children with the disorder are the inability to connect with their adoptive parents, never crying—even when they are uncomfortable, or crying all the time.[110] Additionally, these children may throw tantrums or be disobedient, may have intense separation issues, or may have trouble sleeping at night.[111] The problems seen with this disorder often go unnoticed until the child is older or has started school, and the disorder is often misdiagnosed and mistreated as other disorders like autism or Attention Deficit Hyperactivity Disor-

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rainbowkids.com/adoption-stories/reactive-attachment-disorder-in-adoptees-513.

[104] *Id*.
[105] *Id*.
[106] *Id*.
[107] *Id*.
[108] Gerard, *supra* note 103.
[109] *Id*.
[110] *Id*.
[111] *Id*.

der.[112] The errors in diagnosis cause many children to receive treatments that are inappropriate or ineffective in helping the child and parents cope with the effects of the disorder.[113]

B. Adoption Disruption

Adoption is supposed to be a permanent placement for children who need a family and a home, and an option for parents who want to start growing their family.[114] In the past, permanent adoption was usually the rule, and estimates suspect that fewer than two percent of adoptions did not work out.[115] Today, it is very difficult to track the number of adoptions that do not work out because there are no government organizations keeping track of unsuccessful adoptions and there is no legal remedy that can help an adoptive family if they are not able to take care of their adopted child.[116] The suspected number of unsuccessful adoptions varies, but the lowest estimate is seven percent, while the highest estimate is fifty percent.[117] Some states have tried to track this information, and have returned adoption disruption statistics as high as twenty percent.[118]

There are several reasons that the number of unsuccessful adoptions has increased dramatically in recent years, including an increase in adoptees that are older children or children with special needs, children from foreign countries, and children that have spent a lot of time in the foster care system.[119] Recently, there is a call to help get older children adopted in order to give homes to the children that need them

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[112] *Id*.
[113] *Id*.
[114] Andrea B. Carroll, *Breaking Forever Families*, 76 OHIO ST. L. J. 259, 259-60 (2015).
[115] *Id*. at 261.
[116] *Id*.
[117] *Id*. at 262.
[118] *Id*.
[119] *Id*. at 262-63.

the most, but this causes problems because older children tend to have a more difficult time adjusting to life with their new families.[120] Another major influence on the higher rates of adoption disruptions is the prevalence of international adoptions.[121] It is estimated that most of the unsuccessful adoptions are those that include an international child, and it is estimated that seventy percent of disruptions involve an internationally-adopted child.[122]

Research has attempted to uncover the reasons international adoptions are so unsuccessful, and, although the reasons are not fully understood, it is possible that Reactive Attachment Disorder has a major impact on the families of international adoptees.[123] This disorder results from neglect or trauma during the child's early life, which changes the brain and eventually causes children to be unable to form attachments to their families.[124] The disorder lasts throughout their entire lives, and although treatment may help the severity of the disorder, there is no known cure.[125] The reason that many foreign adoptees seem to suffer from this disorder is likely the notable differences between the United States' foster care system and the orphanages of some foreign countries that supply little contact to the infants and children in their care.[126] These problems have led to many unsuccessful adoptions, and, as the legal community has left adoptive parents struggling and confused about their options in these situations, many adoptive parents have looked for other ways to cope.[127]

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[120] *Id*.
[121] Carroll, *supra* note 114, at 262-63.
[122] *Id*. at 263.
[123] *Id*.
[124] *Id*.
[125] *Id*.
[126] *Id*. at 264.
[127] *Id*. at 267.

Because of the problems seen in these unsuccessful adoptions, some adoptive parents that are unable to adequately care for their adopted child have used private rehoming as a solution.[128] This process involved the adoptive parents looking for other families that would be willing to take the child into their home, which was sometimes completed through various Internet Exchange websites.[129] This caused more problems because it was unclear whether the people that were taking the adoptive child were dangerous or untrustworthy, and because the process required no notice to any state-run child welfare organization or child welfare case worker.[130] This is in direct contrast with the method used to adopt children legally, which requires a "comprehensive and invasive process" in order to ensure that the child will be safe in his or her adoptive home.[131]

VI. LEARNING AND EDUCATION ISSUES SURROUNDING ADOPTION

Parents and families who adopt children provide an amazing service to the children, to the birth parents, and to society by providing a safe and nurturing home for the children who need it most.[132] They open their homes and hearts in order to provide the best possible life and opportunity to the children in their care. These children are sometimes subject to tremendous trauma or neglect prior to being placed into an adoptive home.[133] Despite the fact that adoptive parents provide a stable home life, and that numerous adoptees perform quite well in their school environments, some adopted children

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[128] *Id*.
[129] Carroll, *supra* note 114, at 268.
[130] *Id*. at 268-69.
[131] *Id*. at 269-70.
[132] Nicholas Zill, *The Paradox of Adoption*, FAMILY STUD. BLOG (Oct. 07, 2016), http://family-studies.org/the-paradox-of-adoption/.
[133] *Id*.

perform and behave worse than children raised in a household with both biological parents.[134]

Many adoptions are by families that have higher income and education levels than many biological parents, and adoptive parents often make more of an effort to raise and care for their children.[135] This is due to the fact that adoption tends to attract these types of adoptive parents and because adoptive parents are often subjected to serious background evaluations before they are able to follow through with adoption.[136] However, despite the resources and attention available to adoptees, some do not perform as well as expected throughout their schooling.[137]

These issues are shown in many aspects of the adopted child's academic and classroom life.[138] A study comparing kindergarten and first grade children living with adoptive parents to those living with birth parents or other types of families showed the adopted children performed at lower levels than children living with their biological parents or with another type of family.[139] The study showed that children from adopted families became angry or argumentative more easily than children from families with biological children.[140] Additionally, adopted children scored lower on reading and math assignments than children from families with both birth parents.[141]

Although the reasons for this difference in classroom performance are not known for certain, there are several possible reasons for the differences, including attachment issues be-

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[134] *Id*.
[135] *Id*.
[136] Zill, *surpra* note 132.
[137] *Id*.
[138] *Id*.
[139] *Id*.
[140] *Id*.
[141] *Id*.

ginning early in life, the after effects of trauma or abuse, and the genetics passed down from parents.[142] Attachment disorder begins in a child's earliest years but it can affect the social and emotional bonds that the child has with others, and being unable to adapt to a variety of social situations could explain why there is a difference between the different groups of children.[143] Additionally, some adoptees experience trauma or abuse prior to adoption, which may affect their performance in school, and genetic factors or disabilities could likely have an affect on how well children perform.[144]

VII. CONCLUSION

The practice of adoption has evolved for centuries in order to fit the needs and views of the culture and time period, and today it works to help provide families and homes for children who need them.[145] The process of adoption, however, has a profound impact on the adopted child that can lead to emotional feelings of loss or grief and difficulties for the child in developing his or her sense of self.[146] Additionally, children who are adopted have a greater chance of being diagnosed with a mental health disorder or having contact with a mental health professional during adolescence than children that are not adopted.[147] Lastly, some adoptees, although they have access to plenty of resources and help, do not perform as well academically as children who were not adopted.[148] These emotional, behavioral, and educational issues that some adoptees face will hopefully offer guidance on how to provide more help and re-

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[142] *Id*.
[143] *Id*.
[144] *Id*.
[145] NEW WORLD ENCYCL., *supra* note 3.
[146] *Impact of Adoption on Adopted Persons, supra* note 46, at 2.
[147] Kingsbury, *supra* note 99.
[148] Zill, *supra* note 132.

sources to adopted children and their families before, during, and after their adoption into the family.

THE TALE OF A YOUTH GUILTY PLEA COURT & A YOUTH MENTAL HEALTH COURT IN ONTARIO: HOW DIFFERENT ARE THEY IN PRACTICE?

Voula Marinos Ph.D[*]
Devon Gregory M.A.

Abstract

The current case study examines the application of Therapeutic Jurisprudence (TJ) principles compared to adversarial principles in two youth courts in Ontario. In a single courtroom, a plea court for the youth runs in the morning, followed by a youth mental health court in the afternoon. The purpose of the study was to assess the extent to which the mental health court adheres to key characteristics of the TJ process model, relative to an adversarial model. Observational data and field notes resulted in some dominant themes within the youth mental health court, including a culture of collaboration between justice professionals and the accused, offender-focused responses, and the active voice of the young person in an interdependent decision-making process. The "tale" of these two youth courts is focused on the extent to which they are qualitatively different in practice. The implications were analyzed within the context of literature on youth justice, court models, and therapeutic jurisprudence.

Keywords**:** *youth mental health court; therapeutic jurisprudence; adversarial process*

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[*] Voula Marinos: PhD (Criminology), Associate Professor, Department of Child & Youth Studies; Brock University, St. Catharines, Ontario, Canada.
Devon Gregory: M.A. (Criminology & Public Policy); Guelph University, Guelph, Ontario, Canada.

"Different programs have different names and intervene at different or multiple junctures but their aims are to ease the plight of the mentally disordered accused through the application of therapeutic jurisprudential principles."
(Bloom, Heerema & Schneider, 2006, p.110).

I. INTRODUCTION: YOUTH MENTAL HEALTH COURTS & THERAPEUTIC JURISPRUDENCE

Under the *Canadian Criminal Code*, "mental disorder" is defined as a "disease of the mind" (Part XX.1, s. 2) that renders an individual unfit to stand trial (s. 2) or if found guilty and sentenced by the court, not criminally responsible (s. 16(1)). Research demonstrates that youth with mental health needs are disproportionately involved in crime and the justice system (Colins, Vermeiren, Vahl, Markus, Broekaert, & Doreleijers, 2011; Dixon, Howie, & Starling, 2004; Odgers, Burnette, Chauhan, Moretti, & Reppucci, 2005; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). A young person who is justice-involved can have his or her underlying mental health needs addressed through the courts in a variety of ways.

The *Youth Criminal Justice Act ("YCJA")* emphasizes the principles of both accountability and rehabilitation with the purpose that youths are made accountable for their actions without overlooking their underlying needs. According to the *YCJA*, youth are viewed as being responsible for their actions, but since they are in a process of development and still maturing, they have time and opportunity to change their behaviour (Doob & Cesaroni, 2004). The unique needs of some youths, such as those with mental health concerns, have received specialized attention through both the *YCJA* (s. 3.(1)(c)(iii)) and the development of mental health courts ("MHC"). In addition to a young person's needs being addressed in "regular" youth courts, various provinces including Ontario, have developed specialized youth MHC's.

MHC's, just one among many types of problem-solving courts, were developed in response to the view that the traditional, adversarial courts do not effectively address the needs of youths and adults with mental health issues (Winick & Wexler, 2003). MHC's have proliferated internationally through the paradigm of therapeutic jurisprudence ("TJ") (Wexler, 2008). TJ is premised on the assumption that the law functions as a therapeutic "agent" and the criminal justice system should reflect its principles in both process and outcome (Bloom & Schneider, 2007; Petrucci, Winick, & Wexler, 2003). In fact, the traditional adversarial model has been criticized for criminalizing mental illness. Research shows that when an offender's mental health is not addressed effectively, the justice system becomes a revolving-door for further and deeper involvement in crime and custody (Kessler, 2007; Vincent, Grisso, & Terry, 2007). In addition, research shows that MHC's have had some success with decreasing recidivism (Hiday, Wales, & Ray, 2013; Lim & Day, 2014).

MHC's are focused on differential processes and goals compared to the traditional adversarial system. The "regular" youth court is based on an adversarial model and is characterized, for the most part, by formality, due process, efficiency, the opposition of Crown prosecutor and defense (although also characterized by agreements/negotiations primarily for plea bargaining, *Cf.* MacFarlane, 2008), structure in the courtroom and relationships, relative silence of the accused, and accountability (Ontario Ministry of the Attorney General, 1999). Since TJ is premised on the notion that the law should and can be applied in ways that are therapeutic, within the MHC there is attention given to the atmosphere, language used, relationships among decision-makers and vis-à-vis the accused, sentencing and treatment, and participation of key stakeholders within the very process and goals of justice (Fritzler, 2003). MHC's are expected to be qualitatively different than the adversarial process—emphasizing diversion, a team-approach by professionals, facilitating an active voice of the young person, and the

positive and therapeutic possibilities of the legal structure (Fritzler, 2003; Winick, 1997).

Individuals with mental health issues often require more intensive rehabilitative plans and services as well as more specialized attention over time as opposed to other accused individuals. Individuals with mental health issues can be diverted to MHC's, often but not necessarily after a charge has been laid, where the adjudication process is premised on a therapeutic, rehabilitative approach. The mental health needs of the individual are both assessed and addressed. The court (and/or an agency involved in the process) is responsible for monitoring the individual's progress and ensuring compliance with court conditions and/or sentence (Kessler, 2007; Winick & Wexler, 2003).

Within a relatively moderate-sized city in the province of Ontario, some justice professionals were committed to creating a youth MHC.[1] Broadly speaking, the objectives of the MHC are to divert youth from the formal judicial process, to address the mental health needs of youth, and to support plans and recommendations developed by the youth and their families. One judge and Crown attorney, both highly experienced, and in concert with a local organization and other justice and community players (the "court team"), run a MHC for youth. One day per week, there is a dedicated Crown and judge to run a Guilty Plea Court (GPC) from 9:00am to 11:00am per week.

[1] Most recently, the Mental Health Commission of Canada (established in 2007) produced its final report *Toward Recovery & Well-Being: A Framework for a Mental Health Strategy in Canada* (2009) denoting that Canada is one of the few remaining countries, until now, to have a national strategy to address mental health. One of many key recommendations for action within the justice system was to, "[i]ncrease the availability of programs to divert people living with mental health and illnesses from the corrections system, including mental health courts and other services and supports for youth and adults" (*Changing Directions, Changing Lives*: Priority 2.4, 2.4.1, p. 38).

Presumably to establish a MHC in an efficient and cost-effective way, the court operates in the afternoon the same day starting at 11:30am. The rationale is that with a half-hour break between the two courts, a clear distinction is made between the two. The MHC is characterized by voluntary participation on the part of the young person, but responsibility for the offence(s) has been taken. The youth is managed for up to one year after which the charge(s) is stayed. The MHC must operate within the parameters of the *YCJA*.

A local organization involved in the youth MHC helps children and families in the criminal justice system, and has expertise, in assessing individuals who come into conflict with the law, assisting them with services within the community, establishing treatment plans, and providing reports for the court. The MHC is premised on understanding every young person as a whole (*Cf.* Braithwaite, 2002) – addressing legal, social, psychological, academic, family and community dimensions. In this specific MHC, the "team" expanded to include another local community-based organization that could supervise services, as well as a probation officer, and a representative of the local school board.

More broadly, the theoretical context of the current study relates to literature on theories or models of justice and implementation gaps (Packer, 1964; Roach, 1999). While the adversarial model is presumed to be about the trial, much has been written about guilty pleas as a hallmark characteristic (Anleu & Mack, 2009; Baldwin & McConville, 1977; Ericson and Baranek, 1982). To our knowledge, there has been little empirical investigation of the application of TJ as a model in the context of youth court in Canada. A study by Davis, Peterson-Badali, Weagant and Skilling (2015), involved a process evaluation of Canada's youth MHC in Toronto, Ontario. They found that relative to the "traditional" (adversarial) court, the processing times within the MHC were relatively similar. But given the focus on addressing the mental health needs of youth,

they found that "approximately half of [the] youth did not receive treatment [that] matched . . . their mental health needs and another half of [the] youth did not have [treatment in the] areas of criminogenic need addressed through treatment" (p. 180). Among these important findings, the study pointed to the need for further research on the *operation* of MHC's. The current study echoes this suggestion, adds another dimension to understanding MHC processing for youth, but is distinct in its location, questions and methods.

It is insightful to examine the nuances of the operation of the MHC relative to a traditional court in practice, in this case a GPC, to see how and where they may diverge from their "models." As Roach aptly explains:

> It is, however, valuable to identify the areas where each model is dominant and to have a sense of the overall trends. It can be liberating to appreciate the different values found in the criminal process and the contingency of which model dominates in what particular area at what particular time. It can be constraining, however, if the models do not capture the full range of options or values in the criminal process. . . (Roach, 1999, p. 673).

In this quote, Kent Roach was discussing due process and crime control models in the context of Herbert Packer's seminal work *Two Models of the Criminal Process* written in 1964. The current case study broadly reinforces Roach's approach, but within a different context, appreciating any overlapping elements of the adversarial system and TJ in two youth courts.

Therefore, we asked the following questions:

1. To what extent do the Guilty Plea Court (GPC) and the Youth Mental Health Court (MHC) adhere to their intended qualities and characteristics?

2. How is the dual court system managed by the professionals, and what conditions appear to be necessary to accomplish this system effectively?

An examination of this particular MHC in Ontario provides an opportunity to compare the implementation of different models as one court shifts to another within the same courtroom and with many of the same professionals. The purpose of this study was not to evaluate the court responses or outcomes of youth going through these different courts, although this is clearly an important question (*Cf.* Moore, 2007). Nor was the purpose of this study to add to the increasing literature on the MHC model and its benefits for some offences and offenders (Behnken, Arrendondo, & Packman, 2009; Skowyra & Cocozza, 2006). Rather, the "tale" of these two youth courts was focused on the extent to which they are qualitatively different in operation and consistent with their respective characteristics. The implications of their similarities and differences were analyzed within the context of literature on youth justice and mental health, court models, and TJ.

II. METHODS

The following is a case study of a youth court within one large courthouse in Ontario that is organized as a GPC in the morning and a MHC in the afternoon, one day per week. It is likely that other courthouses have a relatively similar organization. The case study is a research strategy with two components of data collection, including observational data and field notes (*Cf.* Robson, 2011, p. 136).

The MHC ran every Monday starting at 11:30am with the same judge, although one week we saw another judge sit in as a substitute. One author attended court on Mondays in 2012 over a period of four months for six random weeks based upon her availability. On average four to six hours were spent observing cases per day/week, with the occasional breaks by the courts. To our knowledge, there is no known reason that the court processes in either the GPC or the MHC are systematically or organizationally related to any particular characteristics of youth or cases on the weeks that we chose.

A standardized recording form was developed to document observations and field notes including gender, offence(s), sentence(s) (if any), type of court (GPC or MHC), and evidence of six characteristics of the court processes. Six key components of a criminal MHC as identified by an American author (Judge Randal B. Fritzler (no date indicated), reprinted in (Winick & Wexler, 2003) were used to structure the researcher's observations and coding sheet within the study.[2] A description of each component is included in the Appendix. Out of the original ten components, six were adopted for this study because the remaining four could not be identified based solely on observations. The components include: therapeutic environment supported by a dedicated court team; stigmatizing labels; diversion,[3] stays or other deferred sentencing processes; least restrictive alternatives; interdependent decision-making; and enhancement of basic treatment.

[2] We adopted Judge Fritzler's key components of a criminal mental health court, reprinted by Winick and Wexler (2003), because it was a comprehensive list that specifically compares adversarial with therapeutic processes. We examined additional Canadian "expertise" on the adversarial system (Ontario Ministry of the Attorney General, 1999) and TJ/mental health courts (Bloom et al., 2006) for consistency in components.

[3] While it may appear obvious that a youth court dedicated to hearing guilty pleas would not be "diversion" and therefore irrelevant, it was important to see whether the court operated as such and whether it reflected any features of TJ, such as withdrawal of charges.

The researchers sat in rows with other members of the general public, family, and the accused while taking notes. We systematically recorded observations within court. If during our observations there was evidence of any of the components, a check mark was made along with the example(s) provided in the notes section for each component. Detailed descriptions were also recorded. Any action or spoken word that provided an example of any of these six components was recorded to the best of our ability. Finally, the data collection sheet included a general notes section to take down comments about the context and operation of the courts, the justice professionals, and the young accused persons. The detailed observations lend context and richness to our understanding of the presence and nuances of a key characteristic/component.

The same defence counsel often appeared within both the GPC and MHC; there was not a designated defence counsel or court-appointed counsel ("duty counsel") in the MHC. A single representative from the local district school board also appeared in both courts but acted in different roles. In the GPC he or she acted as a prosecutor for truancy offences under Ontario's *Education Act* and in the MHC he or she acted as a liaison between the school board and court providing information and reports to assist in the decision-making for the accused youth.

On the other hand, some professionals were seen exclusively within the MHC. A member from a local community-based organization conducts psychological assessments, while other workers from a local community-based organization supervise community service and restitution for victims. Based on the various community representatives involved in the MHC, it appears that the MHC is interdisciplinary in its approach to youth in conflict with the law (*Cf.* Winick 1997, p. 187).

Each youth case recording form was "quantified" and the corresponding examples were transcribed, including field notes. The frequencies for each case by characteristic and court type (GPC or MHC) were aggregated and presented in our results. The corresponding examples of those characteristics were coded as well as any revelatory phrases or comments made by professionals or the young person. For example, we saw a case in the GPC in which the judge asked the defence counsel "Does your client have anything to say?" at sentencing. Counsel answered "No." The question was directed towards counsel and not the young person. In this single instance, several things were recorded. First, the judge did not address the young person directly for input into sentencing but through counsel, and therefore this was recorded as an example of the component "decision-making within the adversarial system," and described as "youth more likely to be a spectator of the proceedings." Next, the judge used an impersonal label of "client" when she, the young person, was addressed. Therefore, in this single observation, a "count" would be provided for both "decision-making" and "label" consistent with the adversarial system. The communications heard were recorded by hand, word for word, as accurately as possible, and were added to a description of any examples of any of the components check marked. Additional field notes were also taken while observing the court processes. In the example provided here, we noticed the judge in the GPC was making considerable eye contact with the defence counsel (rather than the young person) in addressing the youth and her case. This behaviour was also recorded.

We employed open and axial coding to analyze the data.[4] First, we grouped main chunks or categories of infor-

[4] While open and axial coding are typically used as part of a grounded theory research design, qualitative research is increasingly using this method (e.g. Goodwin-DeFaria & Marinos, 2012; Clarke & Griffin, 2008; Matheson & McCollum, 2008).

mation within each characteristic for each case. We distinguished between concepts and categories. For example, for interdependent decision-making, we found that there was interaction between the justice professionals as less or more depending upon the type of court. As subcategories, youth were more passive or "tuned out" in body language and speech depending upon the court, the language of the court professionals was more or less formal, inclusive, and so on. Next, we examined each concept and category to code for theme. Here, we thought about how these concepts and categories were related by using examples of components for each court, as well as analyzing the total package of information within the context of the literature on court processing. In the example provided, we coded the observed interactions related to "interdependent decision-making" and "therapeutic environments supported by a dedicated court team" and developed the theme of "cooperation versus collaboration," as well as, in part, the theme of the "active voice of the young person." While the purpose was to collect primarily qualitative data, the (quantitative) frequencies that we observed about particular characteristics within each court are presented within the results added meaning and context to the depth of the observations. The purpose was not to make any statistical conclusions about the cases but merely to provide a quantitative perspective to the data.

The total number of participants in this study was thirty-seven accused young people between the ages of twelve to seventeen. There were fifteen participants observed within the GPC and twenty-two within the MHC. Comparisons were made between the two courts. The majority of youth participants within the study were male. We did not make any comparisons by gender within our analyses, although this would be an interesting question to explore in the future. The two dedicated criminal justice professionals were a judge and Crown prosecutor.

III. FINDINGS

A. How Adversarial is the Guilty Plea Court?

The fifteen cases from the GPC resulted in forty-five different observations of the six characteristics we were focused on. Of the forty-five observations within the GPC, the majority (82.2%, n= 37) were consistent with the adversarial model, while less than 20% (17.8%, n= 8) reflected the therapeutic model. The GPC was particularly "adversarial" with respect to non-diversion or alternative sentences outside the formal court (as expected), stigmatizing labels, and an emphasis on positions in court, rather than a team-oriented approach. There was some inclusion of the use of non-stigmatizing labels, the active role of the young person, and addressing the underlying needs of the young person in the court's response – consistent with the therapeutic model.

For example, youth Case thirty-four provided an example of a lack of a coordinated team with the GPC. The youth in this case had not been in school for four months and none of the court professionals knew why. Both the defence and Crown could not provide an explanation to the court. If a team approach had been implemented, there would likely be more in-depth information about the young person, and presumably, someone from the school board would have been in court to address these issues. In this case, the Crown had to page someone related to the case into the courtroom to try and answer the question around school attendance.

Looking at how the accused was addressed and whether formal labels were used within the GPC, for example, the youth were regularly referred to as the "accused" rather than the young person's name or a more personal label (or initials for privacy reasons under the *YCJA*), was reflective of the adversarial model. Language about "the accused" was used when going over the details of the case, but also in distinguishing dif-

ferent youth within the same case. An example of this label was ever-present in Case nine in which the young person was referred to as the "accused" on a number of occasions. When going over the details of the case, the Crown stated that the police found something belonging to "the accused." As there were a few youths involved in the case, the judge asked for clarification by saying, "What accused?" to which the Crown replied, "This accused," pointing to the defendant. The same youth was then referred to as "the accused" again when describing the case in which the police spoke to "this accused's father."

B. How Therapeutic is the Youth Mental Health Court?

In the MHC, there were a total of twenty-two cases observed, resulting in eighty-one different characteristics of the six components of the adversarial and therapeutic justice processes. We were interested in understanding the extent to which adversarial and therapeutic components made up the MHC. Within the MHC, almost all (96%, n= 78) of the characteristics were consistent with key components of a TJ model, while only 4% (n=3) reflected the adversarial model. The therapeutic model was portrayed through the court players working together collaboratively and additional professionals outside of the court environment were, at times, brought in to address the needs of the youth. The MHC professionals were observed working together with counselors, teachers from the youths' school, hospital workers, a cultural community support worker, workers from the Children's Aid Society (CAS), and workers at a local family resource organization.

We also observed an effort made around language within the court in four instances. Apart from the small number of observations relating to the explicit use of language, we observed how the professionals within the court worked collaboratively. The team environment was observed as the Crown prosecutor and defence counsel would often speak to one an-

other before presenting to the judge, as well as in front of the judge in open court; these conversations were essential as they provided time to go over new details of the case as they evolved or any other information for which one party was not aware. This reveals that the goal for everyone in the court is to be included in the case and informed about the process, even as proceedings are running in "real time." Clearly this resembles people working together as a team, rather than as individual parties with their own interests.

There were numerous examples of how all the court professionals were dedicated to producing a therapeutic environment—both emotionally and physically—for not only the accused persons but also their families. In Case thirty-seven, for example, a Section 19 YCJA "conference" was called. The court actors expressed an interest in supporting a youth's mother with some services to help her cope with the difficulties she was experiencing because of the nature of her child's charges and how they had affected the family. The judge asked the psychologists to recommend some viable services to the youth's mother after the conference was over. The inclusion of the youth and his family was also present in court as the defence counsel could be seen going over the Section 34 psychological assessment with the youth and his mother to make sure they were aware of what was said in the report and to understand how this information would guide the next steps in the court process. The dedication and inclusion of all team members was continuous in this case as the team displayed considerable concern about getting the father involved as a member of the team. In order to include the father, the team expressed the need to get the CAS involved to work with the family.

Finally, a therapeutic environment was observed through a much lighter tone of voice that resembled more of a conversation and an informal, inclusive atmosphere. We also noted that dedication was similarly present by members of the court, with consistent acknowledgment of both the parents' and

the youths' hard work during the process and when completing any conditions or treatment. The courtroom players consistently made statements such as "congratulations," "job well done," "[the youth's name] has done exceptionally well."

Therefore, the findings demonstrate that the GPC, reflective of traditional courts, typically adopted the adversarial model (in more than 80% of all cases in GPC, n= 37). However, the therapeutic model also played some minor role in the courtroom as more than 15% (n= 8) of the total observations in the GPC were consistent with this model. The operation of the MHC highly reflected the intended characteristics (96%, n= 78) (within the limits observed within this study), and operation of a specialized court consistent with the TJ model.

C. Thematic Findings

Our field notes were analyzed and resulted in three major themes that serve to highlight the relative differences in processes between the GPC and the MHC.

1. Culture of Cooperation versus Collaboration.

Overall, the professionals we observed within the GPC and MHC altered in the way they interacted with one another and with the youth. In several ways the GPC compared to the MHC according to the principles inherent within adversarial and therapeutic models. Within the MHC, we observed the presence of a dedicated court team (court environment) in all cases. This component was only present in one of the fifteen cases from the GPC, making the presence of a dedicated court team a characteristic that distinguishes the two models from one another. In the GPC, the defence counsel and the Crown prosecutor largely worked in formal opposition to one another, during the sentencing process rather than collaboratively as a team. Although we observed that there were most often joint submissions in speaking to sentence in the GPC, the relation-

ship is marked by cooperation and negotiation rather than collaboration (Macfarlane, 2008). The parties cooperated with one another in a respectful manner within a more formal and structured environment.

The language they used to communicate to each other, vis-à-vis the accused (in the prisoner's box for example) and the judge were formal. We documented that the defence and Crown prosecutor were directed to speak by the judge, and only spoke when it was their turn. If other parties were involved in the court process (such as the police or parents), then they too, were directed by the judge to speak and participate in the process, and they responded through a formal presentation of information.

In contrast, within the MHC, we observed that all parties worked together towards one common goal: to help provide the youth with the services he or she would need to address the young person's mental health issues. There was not one example, while observing the MHC, of a lack of collaboration. The Crown attorney, all defence counsel, the judge, a member from the local school board, a probation officer, a member from a local organization assisting families involved in the criminal justice system, and various members from a local community-based organization were all present for every case within this court. In some cases, teachers from the youth's school, hospital workers, an ethnic community support worker, staff from the CAS, and from a local organization would also attend the court, when relevant to the case, to support the youth they had been working with.

The collaborative relationship between these parties was most evident during "conferences" under s. 19 of the *YCJA*; five conferences were observed in the MHC (a conference was not expected in the GPC). In Case seven, for example, collaboration was present during a conference as the professionals outlined the other parties they will need to consult

with in order to best meet the young person's needs. The team outlined the need to contact an epilepsy support group and the doctors who have been taking care of the young person as they can provide important information about the needs of the youth and his progress over the span of the diversion program.

What emerged from the observations were two different cultures–one of cooperation in the GPC and one of collaboration in the MHC. The justice professionals appeared to be comfortable in working in both court models, clearly espousing the different values in each court, and the transition from one court to the other was relatively efficient and distinctive.

2. Offence versus Offender Focused

Another theme that emerged from the results was the tendency for the GPC to focus more on the offence rather than the offender, while the opposite result was found in the MHC. This theme was especially prevalent when the results of "stigmatizing labels" are compared between each of the two courts. In the GPC, there were seven examples (70%) observed in which criminal justice professionals referred to the young person in an impersonal way (by using labels). In these seven different instances, the professionals referred to the youth as the "accused," rather than on a first name basis. In addition, the discussion within GPC cases, even at sentencing, was predominately focused on the elements of the offence and deficits of the youth. In comparison, the details of the crime were rarely discussed in the MHC.

Under TJ, the law aims to help address the underlying circumstances of the behaviour, rather than focus on the offence that has been committed. For example, the youth were always referred to on a first name basis. Within the limits of this study, we did not see any evidence of language used to describe the young persons in impersonal ways. This is an important finding because research on the psychology of proce-

dural justice highlights that "people place a high value on how they are treated" by criminal justice authorities (Winick & Wexler, 2002, p. 108). Youth and adults alike want to be treated with respect and dignity in every facet of their lives, including the court process.

A second way in which the MHC avoided labeling the young person was by being sensitive to the personal struggles of youth, and how past challenges have shaped his or her current behaviour. The professionals spoke about the youths' past in a way that showed an understanding of their experiences of disadvantage, rather than stigmatizing or punishing youth for these experiences. In Case twenty-two, for example, the court mentioned the youth's membership in a First Nations Community, being a victim of physical abuse, moving from his father's home to live with his mother (where he resided in a marginalized neighborhood and became involved in a bad peer group), had trouble with anger and anxiety, a history of abuse and addiction in the family, and repeated suspensions from school. Case thirty-seven provides another example in which language was not used in a punitive manner. In this case, the professionals explained how domestic violence and parental separation had played a role in the youth's behaviour rather than blaming him for his actions without information about this important context.

Given that the young person checks in with MHC multiple times after entering the diversion/treatment plan, the court team also focused considerably on the progress the offender had made since the offence was committed. Focus was put on young people's mental health needs, school, work, future aspirations, and other responsibilities the individual had taken on. We witnessed counsel emphasize evidence of "progress" within the MHC. Clearly this is an advantage that may not always be possible within a GPC where pleas of guilt may occur on or shortly after the first appearance and communication ends at sentencing. Overall, we found that the MHC is more consistent

with a focus on the offender as part of the therapeutic process compared to the GPC.

3. The Passive/Active Voice of Youth

Each young person held his or her own role in both the GPC and the MHC; however, it was observed that it was up to the individual youth to choose to act on that role. In the GPC, youth were more likely to display an active voice only after they were addressed by the judge and given the formal opportunity to speak to the court. In five cases youth decided to speak to the judge in open court after being asked. This was not always the case; youth frequently expressed that they had no comment when asked by the judge if they wanted to share any additional information for the purposes of sentencing. Bala and Anand (2009) explain two possible reasons for the lack of youth input in court:

> Judges should ask the youth and parents if they have anything to say before sentence is imposed. Typically, the parents and youth feel intimidated by the court setting and are likely to say little or nothing. Further, defence counsel will sometimes advise the youth not to say anything for fear that the youth may make statements that could indicate a lack of remorse or an anti-social attitude…. There is some controversy about how actively the judges should attempt to engage the young person in the court process, especially at the sentencing stage (p. 506).

We found that the active voice of the youth in MHC was more frequent and intersected with the presence of "inter-dependent decision making." We observed eleven examples in the MHC, consistent with the therapeutic model. In fact, we witnessed some examples (Cases three, five, thirty, and twenty-nine) of the court team congratulating youth in open court for the decisions they have made throughout different stages of the process. In these cases, the judge and Crown prosecutor praised the youths in open court for all the hard work they have been doing. These cases revealed acknowledgement of the youths' own decisions to make positive changes. We also witnessed some cases in which youths would voice his or her opinion without being addressed. This was likely the result of the open, conversational, and accepting atmosphere of the court.

In addition, youths in the MHC were observed asking many questions to the judge. One youth asked, for example, whether he could continue his placement within certain services (Case thirty-two). Another youth asked if he could be kept in certain environments in order to feel more comfortable and refrain from future offending behaviour and asked for clarification on certain topics (Case thirty-seven). While it is likely that the young people were encouraged to speak by his or her lawyer, they felt comfortable, nevertheless, to do so. This suggests that a rapport had been gained with the (same) judge and the team supporting the youth.

On the other hand, within the GPC, youth were more likely to be observed making statements about their current behaviour, rather than asking questions. Youth would often express their remorse to the judge for their past criminal behaviour—consistent with the focus of the adversarial model—and the responsible decisions they had made since the incident to get their life back onto the right path. In addition, if a young person had a question or comment in GPC, they were more likely to do so through their lawyer, rather than directly to the

judge in open court.

There are many aspects distinguishing the two courts from one another. In summary, the GPC for youth was more offence-focused and fostered a cooperative environment with an individualistic approach. However, it was also less flexible in terms of sentencing, and was less open to youth asking questions and making statements during the sentencing process. In contrast, the MHC was more focused on the offender and his or her needs and strengths. It also implemented a collaborative approach among many professionals from several fields, provided a more holistic approach to meet the needs of the youth, and provided them with more of an opportunity to ask questions and be active members in an interdependent decision-making justice process.

IV. DISCUSSION AND CONCLUSIONS

The adversarial court system has been critiqued for its application of traditional techniques that are "ill-suited to address" the needs of offenders with "personal and psychological" dysfunction (Wiener, Winick, Georges, & Castro, 2010). The fundamental goal is to gain a conviction based on the offence, do so in an efficient manner so as not to waste precious resources (Ontario Ministry of the Attorney General, 1999), and to place more weight on the offender's offence compared to his or her personal circumstances. In essence, the adversarial process has been critiqued as being "anti-therapeutic" for particular populations of offenders; it fails to improve "…the psychological and emotional well-being of those affected by the legal process." (Wiener et al., 2010, p. 417).

In Ontario, the MHC developed as a separate entity even though the *YCJA* has a relatively strong rehabilitative focus balanced with accountability. Ontario was also relatively rich with community-based programs for youth, and psychological assessments can be ordered under the *YCJA* by any

"court" (S.34 *YCJA*). The development of a specialized MHC was, presumably, addressing a gap(s) in the traditional court. The MHC was meant to look and operate under a different set of principles. This case study illustrates that the two courts operate accordingly. Research on youth MHC's is relatively under-researched. Research by Davis et al. (2015) sheds light on the importance of examining processes within youth MHC's for value in and of itself. Additional research shows the importance of such research on processes. Greene, Sprott, Madon, and Jung (2010) provided evidence that youth who perceived the justice process to be professional and respectful were more likely to view the criminal justice system as being legitimate. By focusing on the offender in a humanizing way, their success was likely promoted as it fostered positive feelings of acceptance and respect.

The current case study offered an opportunity to analyze how the two courts operate in practice, whether the practices were consistent or not, and the extent to which the practices were consistent (or not) with their respective adversarial and therapeutic models. We also saw an opportunity to observe first-hand the nature and richness of characteristics of TJ in one jurisdiction. The purpose was not to evaluate the court responses or outcomes of youth going through these different courts, although this is clearly an important question (cf. Moore, 2007). The current study could act as a complement to an outcome evaluation (Robson, 2011; Davis et al., 2015).

The current study is limited in a number of ways. First, while our study was focused on a relatively small number of cases and over a relatively short period of visits, it would be valuable to observe a larger number of cases over a longer period of time, particularly if generalizability is an objective. Second, additional elements of TJ in the mental health context could be explored through interviews with the justice professionals working in these courts, and would offer insight into processes, complexities, strengths, challenges and areas in need

of improvement. Lastly, there is increasing attention on research that includes youth voice (Minaker & Hogeveen, 2009), and it would be valuable to interview the youth as they complete the GPC and MHC processes to understand how they experience these models from their own perspectives.

Our study showed minor evidence of the presence of characteristics of the therapeutic model within the traditional GPC system. We found some modest overlap of the two models. As Roach, (1999) explains, it is important to explore the ways in which models—as theories or paradigms—operate in practice. Additionally, it is valuable to provide a nuanced picture of which model is predominant and at what point in time (Roach, 1999). We found that the GPC reflected "therapeutic" characteristics in a relatively small percentage of observations in the use of non-stigmatizing labels, the active role of the young person, and addressing the underlying needs of the young person in the court's response. We characterize these observations as "therapeutic moments or values." As Bala and Anand (2009) note:

> Meaningful and empathetic engagement of the youth by the judge at the time of sentencing may have positive effects. Conversely, if a youth feels intimidated by the judge, is treated with a lack of respect, or feels humiliated by the judge, it will not make rehabilitation more likely (p. 507).

One could argue that our finding is a result of the emphasis on rehabilitation under the *YCJA* (Anand, 2003). Since one of the key purposes of the *YCJA* is to support young people in their rehabilitation and reintegration, a whole host of needs-based factors are to be considered when responding, as well as accountability, meaningful consequences, and proportionality. But the distinction between "TJ" or "rehabilitation" is key. As King (2008) argues, one should not misrepresent rehabilitation

as therapeutic as the latter is more holistic and involves process and outcome (p. 1116).

Moreover, the emphasis on an adversarial approach within the GPC combines principles of the model and prosecutorial policy to resolve cases early and efficiently (Ontario Ministry of the Attorney General, 2009). In Ontario, Crown attorneys screen charges to provide the accused person with an expectation of sentence. Crowns are encouraged to resolve cases through plea resolution discussions to allow the system to operate more smoothly and efficiently. The early resolution of a case requires cooperation among court players and some elements of a non-adversarial relationship. Similarly, cooperation and mutually beneficial interests are dominant values held by lawyers in traditional criminal courts. As Macfarlane (2008) explains, the current "new lawyer" has shifted from an adversarial role to one based on skillful negotiation, conflict resolution, and settlement (p. 166). Overall, on an adversarial-collaborative continuum, the GPC was consistent with adversarial values.

It appears that the MHC within this jurisdiction is functioning according to the TJ model and ethics articulated by its key proponents (Winick and Wexler, 2003). Our observations and field notes show that the court atmosphere, labels, diversion, decision-making, and treatment are not only part of the process of the court and its operation, but also were delivered in a relatively in-depth and consistent way. We witnessed ample evidence of court players working together in collaboration, solving complex problems relating to the young person and trying to provide solutions. One risk of the "team approach" is that the young person can feel coerced or "sold out" by his own lawyer (Winick & Wexler, 2003). This question would be interesting to examine in future research from the perspective of the young person.

The active voice of the young person was also apparent within the proceedings, including the opportunity to ask questions. The literature on TJ emphasizes the importance of procedural justice. As Winick and Wexler (2003) explain in a piece relating to drug treatment court, "[judges] need to understand the psychology of procedural justice, which teaches that people appearing in court experience greater satisfaction and comply more willingly with court orders when they are given a sense of voice and validation and treated with dignity and respect" (p. 108).

Finally, the focus on the individual young person with the MHC, in contrast to an emphasis on his or her behaviour, is consistent with literature on the importance of building strengths within individuals involved in problem-solving courts. "In a criminal justice framework," argues Maruna and LeBel, (2003), "strength approaches would ask not what needs to be done to a person in response to an offence, but rather what the person can accomplish to make amends for his or her actions…" (p. 268). Our study revealed that the courtroom team made consistent efforts to target young people's strengths to overcome mental health issues that were central to their offence. The focus was the youth's abilities within school and work, their passions and their future aspirations as ways, most likely, of ensuring accountability and therapeutic outcomes. The courtroom team was sensitive and respectful of each young person and made efforts to avoid divisive language.

The findings are consistent with literature on the TJ process and build on the theory of TJ and its operation within MHC's (Wexler, 2008). Within a Canadian context, the study of one jurisdiction's MHC reveals how the law, with strong needs-based provisions, and committed professionals within and beyond the courtroom serve to support and facilitate the process. This jurisdiction's local legal culture, the organization of the courts, and collaboration among a multidisciplinary team of professionals play a role in the operation of a problem-

solving court for youth consistent with the principles of TJ. They transitioned from a GPC to a MHC, ultimately being as efficient as a criminal justice process is meant to operate.

Differences Between Adversarial and Therapeutic Models[5]

	ADVERSARIAL MODEL	**THERAPEUTIC MODEL**
COMPONENT		
Court Environment	Prosecutor and defence working against one another each to achieve their objectives; Consent from the youth is not necessary to be involved in the court process; Decorum in speech; Law can be both anti-therapeutic and therapeutic at times. Less emphasis on a "team" of professionals for the youth, rather the youth is simply represented by a defence counsel. Other professionals within the court are relatively neutral to the young person's	***Therapeutic environment supported by a dedicated court team.*** Cooperative relationship between prosecutor and defence attorney; Youth must consent to undergo to the mental health court; Relaxed atmosphere. Informal and conversational tone; Team of professionals work together to help with issues and/or difficulties youth is experiencing in his/her life. Law is therapeutic and is being used to address needs of the young person.

[5] Adapted, in part, from, *Ten Key Components of the Criminal Mental Health Court Process* by Judge Randal B. Fritzler in Winick, B. J. & Wexler, D. B., Eds. 2003. *Judging in a Therapeutic Key*. (pp. 118-20). Durham, N.C.: Carolina Academic Press; Descriptions added as needed by author(s).

	situation.	
Labels	Referred to as the "accused" or some other impersonal label such as the "youth" or "young person."	***No stigmatizing labels.*** Addressed youth on a first name basis-conscious attempt made to humanize their experience.
Diversion	More emphasis on responses by the court, and sentencing and punishment that do not necessarily include diversion and stays of proceedings.	***Diversion, stays, and other deferred processes.*** Supportive programs and withdrawal of charges upon completion of program or requirement(s).
Alternative Response/Sentence	Sentencing is determined by the guidelines as outlined in the law. Least restrictive alternatives are not always sought out for the youth; punitive conditions may be preferred over therapeutic ones in their sentence.	***Least restrictive alternatives.*** Emphasis is on least restrictive alternatives as custody has shown to have a detrimental impact on youth with mental health issues. Get youth out of custody and into supportive programs as much as possible.
Decision-making	Youth is encouraged to play an active role in the court process but	***Interdependent decision-making.*** Youth is encouraged to play an

	do not always choose to does so. Youth more likely to be a spectator of the proceedings.	active role in the court process and has input into the decisions that are made. More likely to observe youth being consulted about decisions made about him/her.
Treatment	Focus is on sentencing the offender with more emphasis on the offence and record than on providing them with services to address their underlying needs.	***Enhancement of basic treatment***. Seeking expert advice on the best ways to address the young person's needs. A variety of methods to address mental health needs and other needs of young person.

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*MENTALLY ILL IN THE JUVENILE JUSTICE SYSTEM: THE SEQUENTIAL INTERCEPT MODEL APPROACH**

Melissa Cintrón Hernández[*]

Abstract

The alarming rate of youths with mental illnesses in the United States juvenile justice system has prompted recommendations and calls for reform for years. To apply these recommendations, Therapeutic Jurisprudence (TJ) and the Sequential Intercept Model (SIM) are handy mechanisms for identifying intercept points where it's possible to deviate from standard juvenile legal processes and reach a therapeutic alternative for young offenders who suffer from mental disorders. This work also identifies provisions that may represent SIM intercept points within the Puerto Rico law establishing the juvenile justice system (Ley de Menores), meanwhile evaluating whether they are in accordance with TJ principles.

Key words: *juvenile law, mental health, Sequential Intercept Model, Therapeutic Jurisprudence*

[*] JD Candidate 2016, University of Puerto Rico.
Email: melcintronhernandez@gmail.com

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I. INTRODUCTION

Two thirds of youths enter the juvenile justice system with some preexisting mental disorder.[1] This simple statistic alone is enough to make anyone question the efficacy of our juvenile legal system. These youths are not in need of punishment, but of treatment given outside the confines of a correctional facility or detention center. In order to redirect the efforts of a flawed system towards providing children and adolescents with the assistance they need, Therapeutic Jurisprudence ("TJ") offers a gateway to the true rehabilitative nature of the juvenile justice system. Due to its undeniable links to TJ, the Sequential Intercept Model ("SIM") was chosen as the main mechanism for proposing a better management of juveniles with mental illnesses within the juvenile justice system. SIM identifies five intercept points of possible deviation from standard legal norms. It is through these entry points that a series of recommendations, gathered from legal and mental health experts, are employed as a means of improving the juvenile justice system overall. To gain a practical perspective of the usefulness of SIM in the study of legal procedures, possible intercept points within the statute establishing the juvenile justice system in Puerto Rico are identified, analyzed, and critiqued based on TJ principles.

II. THERAPEUTIC JURISPRUDENCE

Therapeutic Jurisprudence ("TJ") is a different approach to law. It looks to humanize, to mold to people's well-being, and to analyze the impact of law on people's lives.[2] As the name suggests, TJ is the use of law as a "therapeutic

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[1] Mark R. Fondacaro, et al. *The Rebirth of Rehabilitation in Juvenile and Criminal Justice: New Wine in New Bottles,* 41 OHIO N.U. L. REV. 697, 705 (2015).

[2] David Wexler, *Therapeutic Jurisprudence and its Application to Criminal Justice Research and Development*, 7 IRISH PROB. J. 94, 95 (2010), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1628804.

agent."[3] Throughout TJ work, there are references to a concept known as the "wine and bottles" metaphor. The "bottle" is the law itself, while the "wine" or the "liquid" refers to the roles and practices of legal actors, such as judges and lawyers.[4] To determine the amount of TJ "wine" these bottles can receive, laws and provisions can be "TJ-friendly," "TJ-unfriendly," or "TJ-fair weather friends" for those in the middle ground.[5] TJ principles utilize insights from subjects outside the law, such as social work and psychology.[6] This makes TJ a perfect framework for analyzing and critiquing the American juvenile justice system alongside the law that regulates said system in Puerto Rico, herein after referred to as Ley de Menores.[7]

III. JUVENILE JUSTICE SYSTEM

An overview of the current state and challenges faced by the American juvenile justice system, in regards to the mentally ill population, is of vital importance to comprehend the recommendations that are to follow. Since its inception, the juvenile justice system has seen its fair share of transformation, from a system aimed at rehabilitation in its beginnings; to a shift toward cynicism and punishment as its main goal; to what it is now: a so-called "dumping ground" for adolescents who are deemed untreatable or uncontrollable, worsened by the loss of confidence in mental health institutions.[8] This lack of reli-

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[3] *Id.* at 95.

[4] David Wexler, *Moving Forward on Mainstreaming Therapeutic Jurisprudence: An Ongoing Process to Facilitate the Therapeutic Design and Application of the Law,* THER. JURIS. (2014), http://www.civiljustice.info/tj/6/papers.ssrn.com/sol3/papers.cfm?abstract_id=2564613.

[5] David Wexler, *New Wine in New Bottles: The Need to Sketch a Therapeutic Jurisprudence 'Code' of Proposed Criminal Processes and Practices*, 7 ARIZ. SUMMIT L. REV. 463, 464 (2012), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2065454.

[6] *Id.* at 463.

[7] Ley de Menores de Puerto Rico, Ley Núm. 88 de 9 de 1986, según enmendada 1987, 34 L.P.R.A. §§ 2201-2238 (1995).

[8] Fondacaro, *supra* note 1, at 699.

ance on mental health treatment institutions or hospitals may have been what convinced an Ohio judge to send a youth, suffering from bipolar disorder, to a juvenile correctional center rather than referring him to a treatment facility.[9] Said judge determined the youth would receive better care in the state correctional system than he would anywhere else in the country.[10] The boy, a sixteen year-old named Donald, was supposed to be serving a maximum of six months for breaking and entering, but his sentence had been repeatedly extended due to bouts of extreme violence against himself and others.[11]

It's estimated that two thirds of youths enter the juvenile justice system with some preexisting mental disorder, and at least half of them are in need of clinical care.[12] Juvenile detention began replacing psychiatric emergency rooms,[13] often because there were no other options while awaiting treatment.[14] When it comes to judges, they may not even know that the youth suffers from a mental disorder – and when they do know, they may not know what to do with them, as was the case of sixteen year-old Donald. The judges lack knowledge as to the alternatives they have in their power to divert the youth out of the justice system. In some instances, parents of mentally ill children or adolescents voluntarily hand over custody to the juvenile justice system in the hopes of obtaining mental health treatment unavailable to them elsewhere.[15] Many of the mental

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[9] Solomon Moore, *Mentally Ill Offenders Strain Juvenile System*, N.Y. TIMES, (August 9, 2009), http://www.nytimes.com/2009/08/10/us/10juvenile.html.

[10] *Id.*

[11] *Id.*

[12] Fondacaro, *supra* note 1, at 705.

[13] Thomas Grisso, *Double Jeopardy: Adolescent Offenders with Mental Disorders Executive Summary,* RES. NETWORK ON ADOLESCENT DEV. AND JUV. JUST., (Chi., IL: Chicago University Press) (2006), http://www.adjj.org/downloads/5314Double%20Jeopardy.pdf.

[14] Colleen Burns, *Access to Mental Health Services for Juvenile Detainees,* 18 ANNALS OF HEALTH L. ADVANCE DIRECTIVE 150, 151 (2009).

[15] Grisso, s*upra* note 13.

health problems in these youths remain undiagnosed and untreated,[16] due to aggressive behavior of their actions being perceived as threatening instead of as an indication of a possible mental issue in need of psychiatric clinic care.[17]

The conditions generated in detention centers and correctional facilities, such as overcrowding and the potential for violence and chaos, lead to an unhealthy environment.[18] Young people in confinement with existing mental health disorders simply become worse, not better.[19] These youths are particularly vulnerable psychologically during their time in detention. The general population of confined young offenders is at a higher risk of depression.[20] Over 33% of incarcerated youths report feelings of hopelessness, 10% report suicide ideation, and an additional 11% actually attempt to take their own lives.[21] Confinement further instills youths with lasting, maladaptive psychological tendencies, including limited impulse or aggression control and lessened abilities to make socially competent decisions.[22]

Another critical risk factor of detention is known as "peer deviancy training," which is a term used to define the outcome of treating youths together, indiscriminately of whether they committed a violent or non-violent offense.[23] Studies

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[16] Patrick Geary, *Juvenile Mental Health Courts and Therapeutic Jurisprudence: Facing the Challenges Posed by Youth with Mental Disabilities in the Juvenile Justice System*, 5 YALE J. OF HEALTH POL'Y, L., AND ETHICS 671, 676-677 (2005).

[17] Burns, s*upra* note 14, at 151.

[18] Barry Holman, et al., *The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities*, A JUST. POL'Y INST. REP., at 2 (2006), http://www.justicepolicy.org/images/upload/06-11_rep_dangersofdetention_jj.pdf.

[19] *Id.*

[20] Fondacaro, *supra* note 1, at 705.

[21] *Id.*

[22] *Id.*

[23] *Id*.

have found that treating youths in a group setting leads to a higher recidivism rate.[24] These youths are exposed to worse behaviors too, which they adapt easily due to an increased susceptibility to peer influence, a common trait among adolescents.[25] Adolescence, as a period of human development, is characterized by variability and change.[26] Contrary to theories of the past, the human brain does not reach anatomical maturity until well into adulthood.[27] The "developmental immaturity" attributed to developmental imbalances in the brain causes differences in behaviors distinguishable from adults such as: adolescents have less capacity than adults to exercise self-control of impulses; are less future-oriented than young adults; and are more susceptible to peer influence.[28] Thus, the failings of juvenile courts and the "inadequate and uneven delivery of mental health services to children and families in the juvenile justice system" are viewed by many as a national crisis in the United States.[29] Underfunding of juvenile mental health programs only worsens matters.[30]

The general consensus across studies is that the vast majority of incarcerated youth meet formal criteria for at least one mental disorder, with approximately 20% of youth meeting diagnostic criteria for a "serious mental health disorder."[31]

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[24] Holman, *supra* note 18, at 4.
[25] Fondacaro, *supra* note 1, at 706.
[26] Grisso, *supra* note 13.
[27] Fondacaro, *supra* note 1, at 716.
[28] *Id.*
[29] Geary, *supra* note 16, at 671 (quoting NAT'L COUNCIL OF JUV. & FAM. CT. JJ., Position Paper, *Enhancing the Mental Health and Well-Being of Infants, Children, and Youth in the Juvenile and Family Courts: A Judicial Challenge*, JUV. & FAM. CT. J., at 47 (Fall 2000)).
[30] Elizabeth Bonham et al., *Meeting the Mental Health Needs of Youth in Juvenile Justice*, 2008 INT'L SOC'Y OF PSYCHIATRIC-MENTAL HEALTH NURSES 2 (2008), http://www.ispn-psych.org/docs/JuvenileJustice.pdf.
[31] Candice L. Odgers, et al., *Misdiagnosing the Problem: Mental Health Profiles of Incarcerated Juveniles*, 14:1 CAN. CHILD & ADOLESCENT PSYCHIATRY REV. 26, 29 – 27 (2005). A "serious mental health disorder" is

Mental illness can refer to serious cognitive impairments, like schizophrenia or depression, or it can refer to anxiety disorders such as attention-deficit and disruptive behavior disorders. Other common disorders or conditions are autism, spectrum disorders, eating disorders, Post-Traumatic Stress Disorder, substance use disorders or Co-Morbidity.[32] Co-Morbidity –the simultaneous presence of two or more diseases or conditions – most commonly occurs in this young population in the form of a substance abuse disorder coupled with a mood disorder.[33]

Accordingly, the role of public agencies, as a custodian of these young offenders, focus on three main objectives: safety, rehabilitation, and reducing recidivism.[34] First, with respect to safety, they must address and reduce the risk of immediate harm to the youth, e.g., (be it suicide attempts or aggressive behavior), upon detainment and while they're in custody.[35] Next, with rehabilitation as the ultimate goal of the juvenile justice system,[36] mentally ill youths should receive a guaranteed spot in rehabilitative programs, unless their impairment is so severe they require intensive psychiatric care.[37] Finally, rehabilitation reduces the risk that a youth's mental disorder will recur and lead to further delinquency.[38]

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defined as a serious emotional disturbance resulting in functional impairment.

[32] *Id*. Co-morbidity is the simultaneous presence of two diseases or conditions. In this young population, the most common is a substance abuse disorder coupled with a mood disorder.

[33] *Id*.

[34] Grisso, *supra* note 13, at 2.

[35] *Id.*

[36] Burns, *supra* note 14, at 154.

[37] Grisso, *supra* note 13, at 2.

[38] *Id.*

IV. THE SEQUENTIAL INTERCEPT MODEL

The Sequential Intercept Model ("SIM") was developed by Mark Munetz and Patricia Griffin, in collaboration with Hank Steadman. Similar to TJ, SIM visualizes the law as a "therapeutic agent" through which services are provided to those who would benefit most. The greatest benefit comes not from incarceration, but from treatment for mental illness, drug abuse, or trauma.[39] Used in an investigation, SIM is a tool for identifying areas in current statutes or systems where TJ principles can be employed. I have not encountered any examples of SIM applied to anything other than the adult criminal justice system; therefore, I will make the appropriate tweaks throughout this article in order to transfer this model to a juvenile justice setting.

SIM identifies a series of intercept points or opportunities to prevent individuals with mental illnesses from being subjected to standard legal procedures or prosecution, by diverting them out of the system and into appropriate care or treatment.[40] As applied to the adult criminal justice system, the five intercept points are: 1) law enforcement and emergency services, 2) initial detention and initial hearings, 3) jails[41] and specialty courts, 4) reentry from jails or state prisons,[42] and 5) community corrections and community support services.[43] Each point serves as a "filter," which is an opportunity for diversion to decrease admissions to detention centers, engage

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[39] *Id.;* Kirk Heilbrum, *The Sequential Intercept Model (SIM) and Therapeutic Jurisprudence* (Aug. 9, 2015), https://mainstreamtj.wordpress.com/2015/08/09/the-sequential-intercept-model-sim-and-therapeutic-jurisprudence/.

[40] *Id.*

[41] Youths in the juvenile justice system are detained and sent to detention centers when detained prior to trial or adjudication hearings.

[42] In the juvenile justice system, youths are sent to correctional facilities.

[43] Mark R. Munetz, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCH. SERV. 544, 545-549 (2006).

youths in treatment as soon as possible, and reduce recidivism.[44]

V. APPLYING SIM TO THE JUVENILE JUSTICE SYSTEM

A. Intercept 1: Law Enforcement and Emergency Services

The initial interaction with law enforcement presents the first opportunity to provide mentally ill juveniles the treatment they need, making it a crucial—perhaps the most important—point of intervention. The police are often called first to handle crises involving people who suffer from mental illness.[45] Police officers possess the authority to solicit a psychiatric evaluation and treatment when they find probable cause to conclude that a person poses a risk to others or themselves.[46] Police are responsible for identifying when individuals are in need of mental health treatment, and subsequently connecting those individuals with the appropriate services.[47] Hence, the importance of properly training police officers to respond and defuse tense exchanges with people suffering from mental health issues, a situation made even more delicate when the subject is a vulnerable youth.

This sort of training is called Crisis Intervention Training ("CIT") or the Crisis Intervention Team Model, first developed in Memphis, Tennessee.[48] CIT provides crisis intervention training based on law enforcements procedures for assisting people with mental illnesses while improving the safety of

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[44] *Id.* at 544.
[45] H. Richard Lamb, et al., *The Police and Mental Health,* 53 PSYCH. Serv., 1266-1271 (2002).
[46] *Id.*
[47] *Id*. at 1266.
[48] *See generally* Randolph Dupont, et al., *Crisis Intervention Team Core Elements*, CIT CTR, UNIV. OF MEMPHIS (2007), http://www.cit.memphis.edu/information_files/CoreElements.pdf.

everyone involved, including the community at large.[49] CIT-trained officers are able to interact with crisis situations using "de-escalation techniques."[50] After de-escalation, the officers then transport the individual in need of special treatment to an appropriate facility, known in CIT literature as a Mental Health Receiving Facility.[51] In the CIT model, this facility should provide a source of emergency entry into the mental health system with minimal turnaround and acceptance of all referrals regardless of diagnosis or financial status.[52] Ideally, a pre-arrest diversion program would also be available to meet the mental health needs of juveniles.[53]

Collaboration between mental health facilities and law enforcement is essential, since neither can effectively serve the community separately without the assistance and expertise of the other. Additionally, the efficiency of this approach depends on the quality of the emergency services. If the emergency service provider is lacking or uncooperative, police officers may think twice before transporting the youth in need of help to a treatment facility rather than arresting them. If utilized correctly, the "Memphis Model" can eliminate these drawbacks. Compared to other diversion programs, the Memphis CIT program has "the lowest arrest rate, high utilization by patrol officers, rapid response time, and frequent referrals to treatment."[54]

Ley de Menores does not mention any such measures taken before the minor is arrested, but an amendment[55] made to

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[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] Munetz, *supra* note 43, at 545-46.
[54] *Id.* at 546.
[55] Para enmendar el Artículo 2.21 de la Ley Núm. 408 de 2000, a fin de ordenar a la Administración de Servicios de Salud Mental y Contra la Adicción (ASSMCA) a establecer un protocolo de intervención con pacientes de salud mental, Ley Núm. 88 de 17 de mayo de 2012.

Ley de Salud Mental de Puerto Rico[56] authorizes the Mental Health and Addiction Services Administration (Administración de Servicios de Salud Mental y Contra la Adicción, ASSMCA) to establish an intervention protocol for mental health patients in coordination with the Puerto Rico Police, mental health services providers, and hospital emergency rooms. Yet the current ASSMCA bylaw regulating the application of the Puerto Rico Mental Health Law[57] does not detail any protocol done in coordination with police in regards to receiving mentally ill adults under the custody of an officer, much less one for minors.

B. Intercept 2: Initial Detention and Initial Hearings

The youth's safety is a fundamental concern in this second stage of SIM. Reducing the risk of self-harm and harm to others should be the guiding principle in deciding whether to send the youth home or to a secure detention facility or hospital. If the youth is held in a detention facility due to security concerns or risk of aggression, treatment is imperative to reduce said risk when he or she is eventually released from custody.[58] Youths should be kept in secure detention facilities until the risk of aggression or harm is low enough that they can be treated in their community, as it is universally established among diverse studies on rehabilitation that young offenders benefit most from treatment in a family and community context.[59] Moreover, a detention center is not a place to receive mental health treatment. Detention centers are intended to temporarily house and supervise the most at-risk youth before their adjudicative hearing once it's been determined that con-

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[56] Ley de Salud Mental de Puerto Rico, Ley Núm. 408 de 2 de octubre de 2002, según enmendada 24 L.P.R.A. §§ 6152-6166.
[57] Reglamento para la implantación de la Ley de Salud Mental de Puerto Rico, Administración de Servicios de Salud Mental y Contra la Adicción del Estado Libre Asociado (2015).
[58] Grisso, *supra* note 13.
[59] *Id.*

finement is the best course of action.[60] Yet in the last years, detention has been steadily relied upon to handle youths from all over the spectrum, even those who do not pose a risk of re-offending before trial or were not involved in violent offenses.[61]

The first step to ensure youths are not wrongly sent to a detention facility when they are in need of treatment is to screen all incoming juveniles for mental illness. Screening is a "relatively brief process used to identify youth at an increased risk for mental disorders or in need of immediate attention and more complete review."[62] Screening requires reliable and standardized instruments, along with knowledge on how to best utilize them in order to distinguish a set of exceptionally troubled youth for whom special immediate response is necessary.[63] However, it should not be limited to just a testing instrument. The medical histories for both the youth and their family should be obtained for a more complete assessment.[64]

The length of screening procedures depends upon the amount of information needed to make an accurate determination of mental health status. This process is most likely to take place in the first interview once the juvenile justice system gets involved with the minor, upon admission into a detention center prior to trial, or once admitted into a correctional facility or community program post-adjudication.[65] However, it's especially important for the youth to be screened before they appear in court because it's more likely than not that juvenile court

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[60] Holman, *supra* note 18.
[61] *Id.*
[62] Thomas Grisso & Lee Underwood, *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in The Juvenile Justice System*, U.S. DEP'T OF JUST., OFF. OF JUV. JUST. AND DELINQ. PREVENTION REP. (2004), https://www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf.
[63] *Id.*
[64] Geary, *supra* note 16.
[65] Grisso, *supra* note 13.

personnel lack the knowledge and training necessary to identify mental health needs.[66] Therefore, court staff should be allowed opportunities for education and training, so as to understand mental health assessments, the mental needs of individual youths, and the appropriate treatment options.[67]

In regards to detention, Article 20 of Ley de Menores allows detention of minors before the adjudicative hearing under six circumstances:

> A minor can only be detained via court order. The detention of a minor will not be ordered before the adjudicative hearing unless:
> (1) It is necessary for the safety of the minor or because they represent a risk to the community;
> (2) The minor refuses to, or is mentally or physically unable to, give his name, that of his parents or guardian, and the address of their residence;
> (3) When there are no responsible people willing to keep the minor under their custody and ensure his appearance at subsequent proceedings;
> (4) The minor has a known history of non-appearances;
> (5) Having previously been found to have committed an offense that, when committed by an adult, constitutes a felony and having found probable cause in the new charged offense, it could reasonably be expected to seriously threaten public order;

[66] Burns, *supra* note 14.
[67] Geary, *supra* note 16.

> (6) Having been summoned to a hearing to determine probable cause, he does not appear and probable cause is found in his absence.[68]

Theoretically, the chances of admitting a minor into a detention center as a first resource are seriously diminished by requiring that all pre-adjudication detention be authorized by the court and under these strict circumstances. In Ley de Menores, detention appears to be the exception, not the default. As discussed earlier, minors should only be detained before any trial or adjudicative hearing for safety concerns, as is taken into account in the first scenario contemplated in Article 20. The rest of the criteria relates to the inability of locating the parents or guardians of the youth, fear of non-appearance, and certain types of previous offenses. I consider these factors to be in furtherance of a genuine interest in the minor's well-being and in accordance with what scholars agree to be the particular circumstances that warrant pre-trial detention.

Ley de Menores includes two experts who actively work with the minor in the juvenile justice process and upon which the responsibility of screening could be placed: the Family Relations Specialist (a social worker) and the Family Relations Technician (the minor's "supervisor").[69] To comprehend their roles in relation to the minor, it's helpful to evaluate their duties:

> *Article 13. Family Relations Specialist.*
>
> The Family Relations Specialist will be the social worker appointed to intervene in the affairs of minors, who will perform the following functions:

[68] Ley de Menores, *supra* note 7, at § 2220.
[69] *Id.*

> (1) At the request of the court will hold a social preliminary investigation in order to determine whether or not the minor is placed in custody until the hearing of the case is concluded.
> (2) Provide guidance to the parties and refer them to the pertinent agencies in accordance with the provisions of this law.
> (3) Carry out the appropriate studies and social analysis of the minor and prepare reports as required by the judge.
> (4) Recommend the initial treatment plan and services to be offered to minors who after the adjudicative hearing remain under the jurisdiction of the court.
> (5) When exercising as supervisor for the Family Relations Technician, will structure the treatment plan and services to be offered to the minor in probation, providing the Technician with direction and advice.
> (6) Recommend cases in which of an appointment of a guardian or legal custodian should be requested.
> (7) Maintain records of services and interviews held during the investigation process and prepare a concise summary of the facts to the agencies to which referrals are made as well as those forms, statistics, cards and other information as may be necessary for the best functioning of the court.[70]

[70] Ley de Menores, *supra* note 7, at § 2213.

From a screening standpoint, no one else in the juvenile justice statute before us is so aptly equipped to conduct a proper screening and determine whether a minor will benefit more from a hospital bed than a detention center, which is what makes this provision so crucial. However, this is only possible if they have the right tools for it. These social workers are to be well trained in identifying key indicators of mental disorders in youths and classifying any type of aggression or odd behavior as what it is: a by-product of an illness. Otherwise, a forensic mental health professional should be on hand to do this work.[71]

As per the fourth function, the Family Relations Specialist has the authority to recommend an initial treatment plan, but this will only come into effect once the adjudication process has been completed and the minor has been found to commit an offense. The main goal of SIM is to provide people with mental disorders or drug abuse issues the help they need as soon as possible.[72] Ideally, the Specialist would not coordinate the treatment plan, as the minor would have been referred out of the justice system at this early stage after a screening process. Nonetheless, the Specialist should have this authority as soon as the minor has an initial hearing.

Utilizing the TJ "wine-bottle" methodology,[73] a few drops of TJ-friendlier wine is needed to ensure that the Family Relations Specialist is well equipped to conduct an accurate screening process. This can be accomplished by providing the Specialist with the appropriate training or having a mental health expert on hand as part of these efforts. In order to push forward the moment when the Specialist recommends a treatment plan, the "bottle" (the law itself) must be tweaked. Additionally, as the youth's mental health issues are only mentioned

[71] Grisso, *supra* note 13.
[72] Heilbrum, *supra* note 39.
[73] Wexler, *New Wine*, *supra* note 5.

once in the law (in a provision I will examine further along), a separate article or an additional function within Article 13 should be added to address the role of the Family Relations Specialist in relation to mental health issues in a more direct manner.

On the other hand, the Family Relations Technician[74] takes on the role of supervisor and has less discretion in implementing screening practices or recommending treatment. Coordination of treatment and services for the minor must be done "pursuant to the Family Relations Specialist's recommendations"[75] and any requests for revocation of probation if the minor has not complied with imposed conditions must be done in consultation with the Family Relations Specialist.[76] Although not as crucial as the Specialist, the Technician's role in the well-being of the minor should not be overlooked.

The best mechanism within the law to ensure mentally ill youths are given the help they need is desvío (diversion):

> *Article 21. Diversion of minors from judicial proceedings.*
>
> After a complaint has been filed and before the adjudication of the case, the Prosecutor may request the court to refer the minor to an agency or a public or private body if the following circumstances exist:
> (1) If it is a Class I offense or a first time offender in a Class II offense.
> (2) An agreement is signed between the Solicitor, the minor, his parents or

[74] Ley de Menores, *supra* note 7, at § 2214.
[75] *Id*. at 3.
[76] *Id.* at 5.

> guardian and the agency to which the minor is referred.
> (3) The social report of the Family Relations Specialist is taken into consideration.
> (4) There is an authorization of the court.
> The agency to which the minor is referred in accordance with this section shall inform the Solicitor and the court whether the minor is complying with or has complied or not with the conditions of the agreement. In case the minor has complied with said conditions, the Solicitor shall request the court to dismiss the complaint. In case the minor has not complied, the Solicitor shall request a hearing to determine if the procedure should continue.[77]

Diversion is only available to those whose offense falls within the Class I category[78] or first time offenders under Class II.[79] This requirement precludes a sizable population of potentially mentally ill youths. Instead of being a strict exclusion, there should be leeway to make a determination of diversion based on the results of the screening process. The Handbook

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[77] Ley de Menores, *supra* note 7, at § 2221.

[78] *Id*. at § 2203 (k). Conduct that if engaged in by an adult would amount to a misdemeanor.

[79] *Id.* at § 2203 (l). Conduct that if engaged in by an adult would amount to a felony, except those included in Class III (holding that conduct that if engaged in by an adult would amount to first degree felony, except first degree murder which is excluded from the authority of the court; second degree felony; the following felonies in their third degree: attenuated murder, aggravated burglary, kidnapping, robbery, serious assault involving mutilation, attenuated murder; and the following offenses under special laws: distribution of controlled substances and Articles 5.03, 5.07, 5.08, 5.09 and 5.10 of the Arms Act.).

of Rules and Procedures further regulates the Diversion Program.[80] The most current version (2000) of this rulebook is not available to the public. The 1990 Handbook and the goals of diversion described therein focused mainly on drug abuse issues.[81] If this approach is still in force, it is certainly a disadvantage for mentally ill youths as it's possible that diversion is not well equipped to meet their needs and match them to appropriate services. As the 1990 Handbook is twenty-five years old and no longer the one in use, this may have very well changed.

C. Intercept 3: Jails and Specialty Courts

The ongoing debate between creating a new juvenile mental health court and reforming the current juvenile justice system brings compelling arguments on both sides of the spectrum. The juvenile justice system was established in the early 20th century, during what's known as the "Progressive Era," with the purpose of rehabilitating by employing "informal civil proceedings" to address children's needs,[82] differing significantly from the retributive nature and conflict of the modern system. Tools such as indeterminate sentencing, parole, and probation were employed as a means of individual treatment—a pillar of juvenile rehabilitation.[83] This all changed in the late 1960s as people lost confidence in the system and mottos like "tough on crime," "adult time for adult crime," and "nothing works," became popular.[84] To make things more perilous for mentally ill juveniles, the practice of transferring children to

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[80] Programa de Desvío: Manual de Normas y Procedimientos, Departamento de Justicia del Estado Libre Asociado de Puerto Rico, Oficina de Investigación y Procesamiento de Asuntos de Menores y Familia (1990).
[81] Omayra P. Samudio, *The Juvenile Justice System and Diversion Program in Puerto Rico: A therapeutic or anti-therapeutic system?* (2011), http://ssrn.com/abstract=2400767.
[82] Fondacaro, *supra* note 1.
[83] *Id.*
[84] *Id.* at 4.

adult courts began spreading.[85] It was this social and institutional transformation that led to the current state of the juvenile justice system.

Thus, separate mental health courts for youths with pronounced mental health needs, represents a shift to the rehabilitative goals of the system at its origin. This entails intervening aggressively at an early stage and empowering judges to consider the needs of individuals by incorporating comprehensive treatment plans.[86] These courts would be managed by judges and lawyers capable of interacting with mentally ill youths, as done in adult mental health courts.[87] In 2011, forty juvenile mental health courts operated across the U.S.[88] The first one opened in Santa Clara County, California in 2001.[89] However, these examples cater to a small fraction of the population. To have a significant impact nationwide, these courts need to be implemented on an enormous scale in order to attend to an overwhelmingly large population of children and adolescents in need of this type of care.[90]

The other side of the debate calls for a change within the existing juvenile justice system to accommodate these needs, as it is already capable of addressing young offenders' issues on an individual case-by-case basis alongside rehabilitative treatment plans.[91] It appeals for a return of a past system and its fundamental emphasis on treatment, rehabilitation, accountability, healing and long-range successful outcomes for the offender and their family.[92] Developing institutions that are

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[85] *Id*. at 5.
[86] Geary, *supra* note 16.
[87] Burns, *supra* note 14, at 154 (2009).
[88] Patrick Gardner, *An Overview of Juvenile Mental Health Courts*, 30 CHILD L. PRAC. A.B.A. 7 (2011).
[89] *Id.*
[90] Burns, *supra* note 14.
[91] Geary, *supra* note 16, at 694.
[92] *Id.*

"child-centered, family-focused, community-based and culturally competent" would be the key to its success.[93] Still, in many jurisdictions the current juvenile justice system may not be equipped to handle juveniles that have or are at risk of developing psychiatric disorders;[94] therefore reforms may be necessary to acclimate to modern needs. The starting point for this reform are measures such as screening, education and training for those who intervene with the minor, coordination across systems, and delivery of mental health care during incarceration,[95] all of which are addressed throughout this investigation.

In TJ terms, instead of creating a whole new bottle with the difficulties and challenges its implementation may face (a nationwide juvenile mental health court), we keep the one we already have (the current juvenile justice system) and pour TJ-friendlier wine inside. In Ley de Menores, there are two mechanisms that are apt for receiving this TJ-friendlier wine.

The first is the provision concerning bail, which dictates that "whenever possible, the minor should be left in the custody of their parents or a responsible person, under the promise of appearing with them in court on a certain date."[96] Evidence suggests that adolescents who suffer from mental disorders that are not severe, benefit the most from receiving treatment in their communities.[97] Detained youths are four times more likely to be incarcerated by their early thirties than their community-sanctioned peers.[98] It's only logical that minors are allowed to spend more time in their communities than in detention centers or correctional facilities, but sending them home with their parents without a treatment recommendation defeats the purpose of this imperative. Certain conditions can

[93] *Id.* at 693.
[94] *Id.* at 694.
[95] *Id.* at 695.
[96] Ley de Menores, *supra* note 7, at § 2219.
[97] *Id.*
[98] Fondacaro, *supra* note 1, at 7.

be imposed to begin community-based treatment while in the custody of their parents or guardians awaiting the adjudication hearing.

Article 24 is comprised of a series of measures the court can utilize once it determines the minor has committed an offense. Within these measures, treatment for mental illness can and should be ordered when pertinent:

> *Article 24. Imposition of measures when the minor is found to have committed an offense.*
>
> When the court has determined that the minor committed an offense, the court may impose any of the following provisions:
>
> (A) Nominal: minor is counseled, making sure he understands that his conduct is reprehensible and knows the possible consequences of continuing that behavior, but without imposing conditions on his freedom.
>
> (B) Conditional: place the minor on probation, demanding compliance with one or more of the following conditions:
> (1) Reporting periodically to the Technician on Family Relations and complying with the rehabilitation program.
> (2) Prohibiting certain acts or companies.
> (3) Ordering the restitution to the affected part, according to the regulations promulgated to that effect.
> (4) Ordering the youth to perform community service in cases where the of-

> fense leads to measures of six (6) months or less…
> (5) Ordering the minor to pay the special penalty established by Article 49-C of the Penal Code of 1974…
> (6) Any other conditions as the court deems favorable to protection or treatment.
>
> (C) Custody: order the juvenile to remain under the responsibility of any of the following:
> 1) The Administration of Juvenile Institutions, in cases the measure imposed lasts more than (6) six months. The Juvenile Institutions Administration, through the Evaluation and Classification Division will determine the location of the juvenile and the services that will be offered.
> (2) An organization or appropriate public or private institution.
> (3) The Secretary of Health where the juvenile presents mental health problems.[99]

As part of the conditional measures, the sixth potential condition is an excellent gateway for introducing mental health services, as any juvenile court can consider said service as "favorable to safety or treatment." Although the reference to treatment may be vague, it is still a well-construed bottle and a prime receptor for TJ-friendlier wine. The third measure, custody, is of unique importance as it is the only provision within Ley de Menores that *expressly* mentions youths' mental health.

[99] Ley de Menores, *supra* note 7, at § 2224.

The Secretary of Health becomes the custodian of minors suffering from mental health issues, yet no reference to mental health beyond that simple sentence is contained within the law. Who makes the referral? After analyzing the main actors in the juvenile legal process, the work of the Family Relations Specialist[100] once again proves crucial. As we are to surmise that the task of referring to the Puerto Rico Health Department falls under the Specialist's purview, screening procedures and investigating the medical and mental history of the minor become particularly essential to their well being. It is through this analysis that the Specialist can recommend transferring custody to the Secretary of Health.

D. Intercept 4: Reentry from Jails or State Prisons[101]

Up until now, the emphasis has been on diverting or referring youths out of the legal procedure and into treatment, be it at a mental health institution or community care. However, these adolescents will often end up in a correctional facility or detention center post-adjudication. Having not been able to divert the youth, the next opportunity for intervention is providing treatment while in confinement. Unfortunately, mental health services are found to be inadequate both in juvenile facilities and adult prisons or jails.[102]

Most juvenile facilities only provide crisis intervention and occasional group counseling instead of one-on-one thera-

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[100] Ley de Menores, *supra* note 7, at § 2213.

[101] Youths in the juvenile justice system are sent to juvenile correctional facilities, not jails or state prisons, once the court determines they have committed an offense punishable by confinement. An increased number of juveniles, however, are tried in adult courts and sent to adult prisons, despite evidence of increased chances of sexual assault, physical abuse and violence. Youths with mental disorders are eight times more likely to commit suicide when sent to an adult prison instead of a juvenile facility (Geary, *supra* note 16).

[102] Geary, *supra* note 16.

py;[103] despite evidence that bringing youth together for treatment or services may make it more likely that they engage in delinquent behavior due to peer deviancy training.[104] The needs of mentally ill youths and their families are unique, as are their backgrounds and experiences, and as such the treatment and therapy received should be equally individual. Thus, treatment should be comprised of "evidence-based, multimodal interventions"[105] and continued monitoring for suicide risks, mental health or substance abuse disorders, and emotional and behavioral problems while confined.[106] When using psychotropic drugs, it should be done in a safe and clinically appropriate manner.[107]

As guidelines for reforming treatment during confinement, the National Mental Health Association recommends: 1) round-the-clock mental health services, 2) special treatment for children with histories of family abuse, violence, substance abuse, and educational difficulties, 3) individualized treatment in the least restrictive environment possible, and 4) transfers to appropriate medical or mental health facilities when conditions so warrant.[108] Any placement of a juvenile in confinement should ultimately work toward preparing them for rehabilitation and subsequent return to the community, as the purpose of the entire juvenile justice system should return to its rehabilitative roots.[109] Effective treatment plans cannot cease upon re-

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[103] *Id.*
[104] Holman, *supra* note 18.
[105] Louis J. Kraus, *Recommendations for Juvenile Justice Reform*, AM. ACAD. OF CHILD AND ADOLESCENT PSYCHIATRY COMM. ON JUV. JUST. REFORM (2005), https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/JJmonograph1005.pdf.
[106] Joseph v. Penn, *Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities*, J. OF THE AM. ACAD. OF CHILD AND ADOLESCENT PSYCHIATRY, VOL. 44, ISSUE 10, 1085 (2005).
[107] *Id.*
[108] Geary, *supra* note 16, at 701.
[109] Burns, *supra* note 14, at 154.

lease, and plans for discharge should serve to integrate the youth back into their family and community.[110] As explained previously,[111] the focus should be on improving the functioning of seriously impaired youths so they can participate in rehabilitation programs and giving them tools to live responsibly within their communities, including written plans for services needed after release as well as the juvenile's own goals for education, housing and employment.[112]

Gaps between the juvenile justice system and mental health systems are potential problem areas in what's known as "care coordination."[113] Juvenile court staff must rely on professional mental health reports to learn the best way to handle youths, yet often times the opposite is the reality.[114] Budget issues due to underfunding and the recent trend of using the system as a means for punishment rather than rehabilitation worsens the situation, as the number of mentally ill minors coming into the juvenile justice system increases.[115] Thus, for a truly effective system, all agencies involved in the care of youths with mental disorders must collaborate to develop and implement treatment strategies.[116]

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[110] Geary, *supra* note 16, at 701.
[111] *See* note 34.
[112] Burns, *supra* note 14, at 154.
[113] Geary, *supra* note 16, at 699. Care coordination "involves accessing and assembling medical, psychiatric, social and educational support services essential to meeting the youth's mental health needs."
[114] Michael Jenuwine, *Using Therapeutic Jurisprudence to Bridge the Juvenile Justice and Mental Health Systems, Scholarly Works*, PAPER 452 (2002), http://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1423&context=law_faculty_scholarship.
[115] *Id.*
[116] Geary, *supra* note 16, at 699. The agencies include the criminal and juvenile justice systems, mental health systems, schools, family and social service organizations, law enforcement agencies, medical institutions, and substance service systems.

While Article 24(c) of Ley de Menores[117] addressed mental health issues explicitly, Article 35 refers to treatment centers, detention and social treatment. Through this provision, a minor who has committed an offense can be referred out of a correctional facility and into a treatment center:

> *Article 35. Centers of treatment, detention and social treatment.*
>
> The Juvenile Institutions Administration and any other authorized public or private agency will provide centers of treatment and detention for any minor covered by the provisions of this law.
>
> (A) *Income, treatment and removal of children in the custody of the Juvenile Institutions Administration*. When a child is delivered to the custody of the Juvenile Institutions Administration, it will determine the treatment program or institution in which the minor will be placed and the type of rehabilitation treatment provided. The Juvenile Institutions Administration may place minors in any treatment program or institution under its jurisdiction.
>
> (B) *Individualized treatment*. Every child is entitled to receive services or treatment in an individual capacity that meets their individual needs and tends toward their eventual rehabilitation.

[117] Ley de Menores, *supra* note 7, at § 2224.

(C) *Detention facilities*. The facility receives minors referred by the court in accordance with the provisions of this law and will offer assessment and diagnosis services. The Juvenile Institutions Administration and public or private organizations that provide detention centers are authorized to advise and assist the court to determine the diagnosis and assessment services to be provided to children who are referred.

(D) *Transfer to other public or private organizations*. When a child is in the custody of the Juvenile Institutions Administration and with prior authorization of the court, when it's in the minor's best interest to be relocated to another agency, public or private organization… The Juvenile Institutions Administration will formalize with the pertinent agencies all necessary arrangements for the transfer.
In emergency cases, via agreement between the Juvenile Institutions Administration and the court, the transfer will be made to the relevant agency or public or private organization.

(E) The Juvenile Institutions Administration will establish a support unit for those youths that committed an offense so they know their rights, about job options, education and housing, to thereby

> ensure their full reintegration into society.[118]

Several of the recommendations contained in this investigation are illustrated in the provision above. First, in the post-adjudication stage minors under the custody of the juvenile system will have access to treatment. What kind of treatment? Who within the Juvenile Institutions Administration makes that determination? Which institutions are under their jurisdiction? Does it include mental health programs? Where does the Secretary of Health factor in? These are all questions unanswered by the written law. Nonetheless, the bottle (the law) is well construed and ready to receive TJ-friendly wine. That TJ-friendly wine includes forensic mental health experts to determine what treatment the minor would benefit the most from, effective mental health programs and institutions, and rehabilitation as a genuine objective of the legal process. The focus on individualized treatment goes along perfectly with what experts affirm is the best kind of treatment for mentally ill youths—another example of a well-done bottle.

Assessment and diagnosis services within the detention facility are a prime opportunity for screening for mental or substance use disorders, suicide risk factors and behaviors, and other emotional or behavioral problems.[119] Of course, the best scenario is one where the minor is diagnosed before being admitted into a correctional facility, but the safeguards of this provision are certainly convenient. The transfer of minors to public or private organizations based on their best interests is another example of how the needs of the youth are an important influence on deciding *where* they would be best cared for. Finally, informing youths about employment, housing and education is precisely the sort of approach many call for once

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[118] Ley de Menores, *supra* note 7, at § 2235.
[119] Penn, s*upra* note 106.

the youth is released to his or her community.[120] Article 35 is clearly TJ-friendly and it complies with the purpose of this particular interception point, as its main goal seems to be assuring the minor's well-being through a series of flexible mechanisms through which their needs can be addressed when confined and offering appropriate re-entry techniques to facilitate the youth's reintegration into society.

E. Intercept 5: Community Corrections and Community Support Services

The final intercept point takes place in the young offenders' community once they served their time in a correctional facility. Ley de Menores does not mention community corrections beyond the final section of the latter article,[121] which ensures that youths are reintegrated into their community with knowledge about employment, education and housing.

Post-confinement treatment should be focused on preventing further incidences with law enforcement by assessing their mental health needs, determining the best course of treatment, and monitoring their progress continuously.[122] Instead of looking to punish for past behavior, forward-looking mechanisms are to get the youth back on track. Community-based care is considered by many, if not all, as the best course of treatment for all but the most severe mental disorders because it's aimed at not only treating the juvenile, but their families as well.[123] Supportive family involvement is vital, because through them we can fundamentally change lifestyles to reduce recidivism and increase public safety. There are several services available built around these objectives, such as wrap-around services, multi-systemic therapy, and functional family therapy.

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[120] *See* note 105.
[121] Ley de Menores, *supra* note 7, at § 2235.
[122] Burns, *supra* note 14, at 157.
[123] Geary, *supra* note 16, at 703.

Wraparound services' philosophy is based on Stroul's and Freidman's system of care values and principles framework[124] by formulating an individual treatment plan in accordance with the youth's needs with services in the home, the school, and the community.[125] It's oriented toward placing youths in small group homes,[126] allowing the youth and their family an opportunity to participate in their rehabilitation, instilling principles of compassion and unconditional care, integrating formal and informal services and systems, and striving for safety and permanency in their communities.[127] Multisystemic therapy is one of the best available treatment options for youths with mental health issues involved in the juvenile justice system.[128] A therapist "collaborates with the family to determine the factors in the youth's 'social ecology' (peers, school, and community) that contribute to the identified problems and to design interventions to address these factors."[129] Similar to the previous approach, it strives to impact every aspect of the youth's life including family, friends, discipline, school performance, recreation, and community ties. This program has proven to be particularly useful in reducing recidivism (reported 70% decrease in long-term re-arrest).[130]

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[124] Beth A. Stroul, *A Framework for System Reform in Children's Mental Health*, GEO. U. CHILD DEV. CTR., NAT'L TECHNICAL ASSISTANCE CTR. FOR CHILD. MENTAL HEALTH (2002), http://gucchd.georgetown.edu/products/SOCIssueBrief.pdf.
The system of care framework focuses on eight overlapping dimensions as areas of need for the child and their families: Mental Health Services, Social Services, Educational Services, Health Services, Substance Abuse Services, Vocational Services, Recreational Services, and Operational Services.
[125] NAT'L MENTAL HEALTH ASS'N, *Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices* (2004).
[126] Geary, *supra* note 16.
[127] *Supra* note 118.
[128] *Id.* at 5.
[129] *Id.*
[130] *Id.*

Functional Family Therapy ("FFT") is a "family-centered approach for youth ages 11-18 at risk for and/or presenting delinquency, violence, substance use, conduct disorder, oppositional defiant disorder or disruptive behavior disorder."[131] This is the most useful approach for youths exhibiting maladaptive out-of-control behavior. Just like the previous service, an expert works alongside the family to develop a treatment plan, improve communication skills, identify risk factors, and identify support resources in the community. A five-year follow up study found that less than 10% of youth who participated in FFT had a subsequent arrest.[132] All of the approaches described work extensively within the youth's social and family surroundings to improve what needs to be improved (family relations, school performance, communication), eliminate what needs to be eliminated (bad peer influence) and treat what needs to be treated (behavioral and emotional disorders).

VI. CONCLUSION

Ley de Menores contains a number of provisions encouraging TJ principles and practices that are advantageous for minors diagnosed with mental illnesses, from those suffering from emotional disorders to bipolar disorder or schizophrenia. The role of the Family Relations Specialist is especially meaningful, as it's the one figure in the law that can evaluate the youth (preferably through a thorough screening process) and has a direct influence in his or her fate. If every actor within the juvenile justice system does their job correctly (police officers, court staff, social workers, supervisors, judges, and mental health staff), mentally ill youth should end up where they belong: in community-based treatment or a hospital for the more severe cases. Ley de Menores is an overall TJ-

[131] *Id.*
[132] *Id.*

friendly "legal landscape."[133] Unfortunately, theory can differ greatly from reality. Financial issues, staff shortage, lack of experience—a number of external factors can negatively affect every single phase of the juvenile system process, rendering its "practices and techniques"[134] TJ-unfriendly. As a final reflection or food for thought, the humblest recommendation can often be the most effective. When all else fails, simply raising awareness of mental health issues in the juvenile justice system presents a fine opportunity for bringing justice, therapeutic justice, to mentally ill young offenders.

[133] Wexler, *New Wine, supra* note 5. In TJ terminology, "legal landscapes" refers to legal rules and legal procedures.

[134] *Id.* "Practice and techniques" refers to legal roles of actors, such as judges, lawyers and other professionals.

REVIEW OF YA'IR RONEN, RE-UNDERSTANDING THE CHILD'S RIGHT TO IDENTITY: ON BELONGING, RESPONSIVENESS AND HOPE (2016)

Michael L. Perlin*

(All citations to this work will be to RONEN, p. xx)

* Professor Emeritus of Law. Founding Director, International Mental Disability Law Reform Project. Co-Founder, Mental Disability Law and Policy Associates. New York Law School, 185 West Broadway New York, NY 10013. Phone: (212) 431-2183. Email: michael.perlin@nyls.edu & mlperlin@mdlpa.net.

There exists robust therapeutic jurisprudence ("TJ") literature[1] dealing with many areas of juvenile law on questions of: whether juveniles have a right to counsel in civil commitment hearings,[2] the extent of rights to be granted to foster children in juvenile and family court proceedings,[3] the civil commitment trial itself,[4] the implications of TJ for juvenile cases involving *Miranda* issues,[5] whether juveniles can be "waived up" to adult courts in criminal cases, [6] and on punishment

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[1] *See generally* Bruce J. Winick, CIV. COMMITMENT: A THER. JURIS. MODEL (2005); David B Wexler, THER. JURIS.: THE LAW AS A THER. AGENT (1990); David B. Wexler & Bruce J. Winick, LAW IN A THER. KEY: RECENT DEV. IN THER. JURIS. (David B. Wexler & Bruce J. Winick eds., 1996); Michael L. Perlin & Heather Ellis Cucolo, MENTAL DISABILITY L.: CIV. & CRIM. § 2-6, at 2-43 to 2-66 (3d ed. 2016); David B. Wexler, *Two Decades of Therapeutic Jurisprudence*, 24 TOURO L. REV. 17 (2008).

[2] Bruce J. Winick & Ginger Lerner-Wren, *Do Juveniles Facing Civil Commitment Have a Right to Counsel? A Therapeutic Jurisprudence Brief*, 71 U. CIN. L. REV. 115 (2002). *See, e.g.*, M.W. v. Davis, 756 So. 2d 90, 108-09 (Fla. 2000); *Amendment to Rules of Juvenile Procedure*, FLA. R. JUV. P. 8.350, 804 So. 2d 1206 (Fla. 2001); *Amendment to Rules of Juvenile Procedure,* FLA. R. JUV. P. 8.350, 842 So. 2d 763 (Fla. 2003) (adopting rule of juvenile procedure requiring counsel and hearings for children objecting to placement in residential treatment centers); S.C. v. Guardian Ad Litem, 845 So. 2d 953 (Fla. Dist. Ct. App. 2003).

[3] Bernard P. Perlmutter, *George's Story: Voice and Transformation Through the Teaching and Practice of Therapeutic Jurisprudence in a Law School Child Advocacy Clinic*, 17 ST. THOMAS L. REV. 561, 580-81 (2005).

[4] Jan C. Costello, *Why Have a Hearing for Kids if You're Not Going to Listen?: A Therapeutic Jurisprudence Approach to Mental Disability Proceedings for Minors*, 71 U. CIN. L. REV. 19 (2002).

[5] Amy D. Ronner, *Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles*, 71 U. CIN. L. REV. 89 (2002).

[6] Bruce J. Winick, *Redefining the Role of the Criminal Defense Lawyer at Plea Bargaining and Sentencing: A Therapeutic Jurisprudence/Preventive*

schemes for juveniles.[7] With a co-author, the author of this review, writing from a TJ perspective, is in the process of writing an article looking at the ways that court processes in juvenile cases – civil commitment cases and criminal cases – shame and humiliate those subject to those processes.[8] But, with the exception of earlier articles by the author of this volume,[9] there have been no TJ-cased inquiries into the child's right to an *identity*. In a thoughtful, provocative, and important new work, Ya'ir Ronen has expanded his vistas, and has given us a brilliant book-length investigation into this question.

Ronen, a lawyer, social worker, and professor of social work at Ben Gurion University of the Negev in Israel, states his claim immediately: "[T]he state should have a positive duty to safeguard the child's right to identity," and that this right is "derivative of [his] human dignity,"[10] although he concedes that "current legal protection of the child's right to human dig-

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Law Model, 5 PSYCHOL. PUB. POL'Y & L. 1034, 1078 (1999); Thomas J. Mescall II, *Legally Induced Participation and Waiver of Juvenile Courts: A Therapeutic Jurisprudence Analysis*, 68 REV. JUR. U.P.R. 707 (1999).

[7] *See, e.g.*, Michael L. Perlin, *"Yonder Stands Your Orphan with His Gun": The International Human Rights and Therapeutic Jurisprudence Implications of Juvenile Punishment Schemes*, 46 TEX. TECH L. REV. 301 (2013).

[8] Michael L. Perlin & Alison J. Lynch, *"She's Nobody's Child/The Law Can't Touch Her at All": Seeking to Bring Dignity to Legal Proceedings Involving Juveniles* (work in progress).

[9] *E.g.*, Ya'ir Ronen, *Redefining the Child's Right to Identity,* 18 8 INT'L J.L. POL'Y & FAM. 147, 147-177 (2004); Ya'ir Ronen, *Child's Right to Identity as a Right to Belong*, 26 TEL AVIV U. L. REV. 935, 935-984 (2003); Ya'ir Ronen, *On the Child's Need to Be One's Self*, 25 BYU J. PUB. L. 233 (2011).

[10] Ya'ir Ronen, *Re-understanding the Child's Right to Identity: On Belonging, Responsiveness and Hope* 1 (Koninklijke Brill ed., 2016). This book flows, in part, from Ronen's earlier article, *Redefining the Child's Right to Identity,* 18 INT'L J.L. POL'Y & FAM. 147, 147-148 (2004).

nity does not guarantee protection of an individualized identity."[11] In assessing this issue, Ronen explores culture as a "context of personal meaning,"[12] and contends that international human rights law "implicitly reaffirm[s]" a commitment to a "dynamic child-constructed identity."[13]

One of the central principles of therapeutic jurisprudence is a commitment to dignity; [14] Ronen's decision to begin his work by clarifying this important commitment is of inestimable significance to his project. He incorporates this into his consideration of issues of culture; "suppressing distinctness by a dominant or a majority culture [is] the cardinal sin against authenticity."[15] Thus, "protecting a child-constructed identity may be construed as . . . a commitment to dignity."[16] Other scholars have considered the relationship between TJ and culture,[17] but, to the best of my knowledge, virtually none in this specific context.[18]

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[11] *Id.* at 3.
[12] *Id*. at 1.
[13] *Id.* at 2.
[14] *See, e.g.,* Michael L. Perlin, *Understanding the Intersection between International Human Rights and Mental Disability Law: The Role of Dignity*, THE ROUTLEDGE HANDBOOK OF INT'L CRIME AND JUST. STUD. 191 (Bruce Arrigo & Heather Bersot eds., 2013); *see also* Ginger Lerner-Wren, *Mental Health Courts: Serving Justice and Promoting Recovery*, 19 ANNALS HEALTH L. 577, 593 (2010) (explaining dignity in the context of mental health courts).
[15] Ronen, *supra* note 10, at 5.
[16] *Id*. (citing, inter alia, Charles Taylor, *The Politics of Recognition,* Multiculturalism: Examining the Politics of Recognition 25 (Amy Gutmann ed. 1994)).
[17] *See, e.g.,* Ian Freckleton, *Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence*, 30 T. JEFFERSON L. REV.

Ronen looks long and seriously at international human rights law, specifically articulating where he sees existing United Nation Conventions as providing support for his position and where he feels that those instruments are not comprehensive enough to grant the rights to which he believes all children are entitled.[19] I believe it is absolutely essential that TJ scholars turn to international human rights law as a potential source and future direction of TJ scholarship,[20] and Ronen's consideration of these laws in this context is of great importance *beyond* the specific substantive subject on which he has turned his focus. Recently, I expressed my surprise that "puzzlingly little [has been] written about the relationship be-

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575, 594 (2008) ("therapeutic jurisprudence has championed an awareness that crosses over discrete areas of law and draws upon insights from a cross-section of social science and critico-legal perspectives, as well as from different cultures"); *see generally* David B. Wexler, *Therapeutic Jurisprudence and the Culture of Critique*, 10 J. CONTEMP. LEGAL ISSUES 263, 267 (1999).

[18] *See, e.g.*, Susan Brooks, *The Case for Adoption Alternatives*, 39 FAM. & CONCILIATION CTS. REV. 43 (2001) (significantly, Brooks and Ronen have been co-authors in the past); *see also* Susan L. Brooks & Ya'ir Ronen, *The Notion of Interdependence and Its Implications for Child and Family Policy*, THE POL. OF THE PERS. IN FEMINIST FAM. THERAPY 23 (Anne M. Pouty ed., 2005).

[19] Ronen, *supra* note 10, at 14-18 (critiquing the United Nations Convention on the Rights of the Child for not providing explicit answers as to a child's right to preserve his cultural identity or respect for his "individualized identity").

[20] *See, e.g.*, Michael L. Perlin, *The Ladder of the Law Has No Top and No Bottom: How Therapeutic Jurisprudence Can Give Life to International Human Rights,* 37 INT'L J. L. & PSYCHIATRY 535 (2014).

tween TJ and international human rights law."[21] Ronen's focus here, is a welcome corrective to that generic lack of interest.[22]

Ronen bores in on a disconnect that we all too often ignore: "There is no sufficiently deep-rooted recognition that for the youths on trial, [and] their liberty, as well as their dignity, is important,"[23] noting further that we still often refuse to believe children when they complain about injustices caused by their families.[24] I noted in a recent paper that "shame and humiliation … are often exacerbated in [juvenile] cases involving racial minorities and those who are economically impoverished."[25] A palliative here, according to Ronen, is the "politicization of empathy and committing ourselves to psychological mindedness."[26] I agree, and hope that those in the juvenile justice systems read this book carefully and take his words to heart.

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[21] *Id.* at 535.

[22] I have turned my attention to this multiple times in recent years. *See, e.g.*, Michael L. Perlin & Mehgan Gallagher, *Why a Disability Rights Tribunal Must Be Premised on Therapeutic Jurisprudence Principles,* PSYCHOL. INJ. & L. (Dec. 2016); Perlin, *supra* note 7; Michael L. Perlin, *Abandoned Love: The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law*, 35 L. & PSYCHOL. REV. 121 (2011); Michael L. Perlin, *Striking for the Guardians and Protectors of the Mind: The Convention on the Rights of Persons with Disabilities and the Future of Guardianship Law,* 117 PENN. ST. L. REV. 1159 (2013); Michael L. Perlin & Alison J. Lynch, *The Distant Ships of Liberty: Why Criminology Needs to Take Seriously International Human Rights Laws that Apply to Persons with Disabilities,* SSRN (Nov. 19, 2015), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2692109.

[23] Ronen, *supra* note 10, at 48.

[24] *Id.*

[25] Perlin & Lynch, *supra* note 8, manuscript at 4.

[26] Ronen, *supra* note 10, at 90.

The heart of Ronen's work is the potential emancipatory impact of therapeutic jurisprudence on all he writes about. "Therapeutic jurisprudence," he writes, "heals the law of its alienation to human experience."[27] He approaches the topics in question in this vein "to shine a beam of empathy on children" and to "empower children both legally and socially."[28] TJ demands that the "humane objectives of law and lawyering be returned, from being abstractions that drive public policy to become the daily rewards of lawyers and their clients."[29] His aim is thus to create a "child-centered therapeutic jurisprudence."[30] TJ humanizes law, he concludes, in contrast to the "violence, cynicism, and alienation" that pervade everyday life,[31] and the life of the law.[32] It further offers a more "psychologically healing approach,"[33] one essential to the areas of law on which Ronen focuses here.

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[27] *Id.* at 32. *See* Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407 (2000).

[28] Ronen, *supra* note 10, at 32 (citing Wexler, *supra* note 17).

[29] Ronen, *supra* note 10, at 33 (citing Wexler, *supra* note 17, and Perlin, *supra* note 27).

[30] Ronen, *supra* note 10, at 33.

[31] *Id.* at 65.

[32] Over thirty years ago, Professor Robert Cover famously wrote that the "principle by which legal meaning proliferates in all communities never exists in isolation from violence." Robert M. Cover, *The Supreme Court 1982 Term, Foreword: Nomos and Narrative*, 97 HARV. L. REV. 4, 40 (1983). I discuss this in the context of shame and humiliation in the law in Michael L. Perlin & Naomi Weinstein, "*Friend to the Martyr, a Friend to the Woman of Shame": Thinking About the Law, Shame and Humiliation*, 24 S. CAL. REV. L. & SOC. JUST. 1, 3-5 (2014).

[33] Ronen, *supra* note 10, at 75.

These are not easy questions, he is quick to acknowledge; "it is important to recognize the inherent ambiguity and complexity in the lives of children at risk and their families,"[34] but it is precisely the recognition of this ambiguity and complexity that "opens the door to hope."[35] Ronen ties this up with his earlier focus on human rights: "The creation of a human rights regime with a strong declared commitment to the well-being of children followed the overdue recognition of the Other's vulnerability in societies that have considered themselves civilized and enlightened."[36] We can best understand the child's right to identity, he concludes, by creating "hope [that] can empower individuals and families who are in emotional and behavioral distress as well as the helping professionals involved with them professionally."[37]

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[34] *Id.* at 103.
[35] *Id.*
[36] *Id.* at 106. On "The Other," *see* Sander Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness* (1985).
[37] *Id.* at 110.

This hope must be considered in the context of what Professor Amy Ronner has characterized as the "three Vs" of TJ:

> What "the three Vs" commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant's story, the litigant feels a sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronunciation that affects their own lives can initiate healing and bring about improved behavior in the future. In general, human beings prosper when they feel that they are making, or at least participating in, their own decisions.[38]

This is what Ronen demands for juveniles so that they can claim (or reclaim) their right to identity. It is the core of therapeutic jurisprudence, and the core of his arguments. He brings dignity to disempowered children, demands the kids to be treated as authentic and with authenticity, and offers his

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[38] Ronner, *supra* note 5, at 94-95 (footnotes omitted).

hope for emancipatory change. What he seeks is precisely what TJ demands of all of us.

I have only one criticism of the book, and that involves the two pages that Ronen did not write. The foreword, by Professor M.D.A. Freeman, alleges that "we hear much less today of therapeutic jurisprudence than was once the case."[39] This is, to be blunt, dead wrong. TJ is flourishing and prospering worldwide.[40] Significantly, given the fact that Professor Ronen is an Israeli academic, much of the new and invigorating literature is by Israeli academics.[41] However, there is TJ literature by British scholars,[42] which refutes the assertion in question.[43]

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[39] Ronen, *supra* note 10, at xii.

[40] *See, e.g.*, https://law2.arizona.edu/depts/upr-intj/bibliography/.

[41] *See, e.g.*, Tali Gal & David B. Wexler, *Synergizing Therapeutic Jurisprudence and Positive Criminology*, POSITIVE CRIMINOLOGY 85-97 (Natti Ronel & Dana Segev eds., 2015); Hadar Dancig-Rosenberg & Tali Gal, *Criminal Law Multitasking*, 18 LEWIS & CLARK L. REV. 893 (2014); Karni Perlman, *It Takes Two for TJ: Correlation Between Bench and Bar Attitudes Toward Therapeutic Jurisprudence--An Israeli Perspective*, 30 T. JEFFERSON L. REV. 351 (2008); Hadar Dancig-Rosenberg & Dana Pugach, *Pain, Love, and Voice: The Role of Domestic Violence Victims in Sentencing*, 18 MICH. J. GENDER & L. 423 (2012).

[42] Apparently, the author of the forward teaches in the United Kingdom.

[43] *E.g.*, Dana Segev, *The TJ Mainstreaming Project: An Evaluation of the Israeli Youth Act,* 7 ARIZ. SUMMIT L. REV. 527 (2014); Jane Donoghue, *Transforming Criminal Justice? Problem-Solving and Court Specialisation* (2014); David Patton, *The Need for New Emotionally Intelligent Criminal Justice & Criminological Approaches to Help End the 'War on Terror'* (Sept. 12, 2016), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2860881; Christopher Diesen & Hans Koch, *Contemporary 21st Century Therapeutic Jurisprudence in Civil Cases: Building Bridges Between Law and Psychology,* 2 ETHICS, MED. & PUB. HEALTH 13 (2016); Judith Harwin & Mary Ryan, *The Role of the Court in Cases Concerning Parental Substance Misuse and Children at Risk of Harm,* 29 J. SOC'L WELF. & FAM. L.

Nonetheless, this was not the doing of the author. Ronen's book is brisk, bracing, and refreshing. This book deserves to be read by all who care about important topics covered.

277 (2008). *See also*, Anna Grace Kalawek & James Marson, *Analysis of the Helena Kennedy Centre Refugee Law Clinic through TJ Lenses* (last visited Mar. 7, 2017) https://www.researchgate.net/project/Analysis-of-the-Helena-Kennedy-Centre-Refugee-Law-Clinic-through-TJ-lenses.

TJ has, in fact, become a worldwide phenomenon in recent years. *See e.g.*, David Wexler et al, *Editorial: Current Issues in Therapeutic Jurisprudence,* 16 QUT L. REV. 1 (2016); Constance Backhouse, *An Introduction to David Wexler, the Person Behind Therapeutic Jurisprudence,* 1 INT'L J. THER. JURIS. 1 (2016); Mike Jones, Pauline Spencer & David Wexler, *Therapeutic Jurisprudence in the Mainstream*, MAINSTREAM TJ (last visited Mar. 8, 2017), https://mainstreamtj.wordpress.com/about/.