

A PROGRAM EVALUATION OF TORONTO'S MENTAL HEALTH COURT FOR YOUTH

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ABSTRACT

In recent years there has been growing concern regarding the mental health needs of young people involved with the criminal justice system. As a result, the Ontario Court of Justice opened its first mental health court for youth in Toronto, Ontario in 2011. Referred to as the Community Youth Court (CYC), the program is designed to provide specialized services to justice-involved youth with mental health needs, including substance use issues. The CYC is one of many mental health courts to have recently been introduced across North America. Despite the rise of such courts, there has been limited empirical research documenting their operation and effectiveness. The current dissertation is comprised of two manuscripts exploring a process evaluation of Toronto's mental health court for youth. The first manuscript includes a theoretical appraisal of the court's program model and a qualitative evaluation of program implementation based on service user (i.e., youth, parents) and key informant (i.e., judges, lawyers, mental health court workers, crown attorneys) views of the program. Interviews were conducted using semi-structured interview guides and analyzed using thematic analysis. The second manuscript documents the population served through the court, predictors of program completion, the operations of the court, as well as how the court addresses the mental health and criminogenic needs of youth. Results from the two studies provide insight into areas of strength, including the program's ability to provide a supportive environment for youth, as well as engage and link youth and their families with treatment. Areas for continued program development are also discussed, with a particular focus on the need to assess and address aspects of criminogenic need in order to help reduce recidivism. Together, these findings provide a framework for an empirically-based mental health court program for youth.

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TABLE OF CONTENTS

Abstract.....	ii
Acknowledgments.....	iii
Table of Contents.....	iv
List of Tables.....	vi
List of Figures.....	vii
Chapter 1.....	1
General Introduction.....	2
Prevalence of mental illness in the criminal justice system.....	2
Theoretical perspectives in adolescent development.....	3
Developmental theories.....	5
Developmental psychopathology.....	6
Theories of criminal behaviour and mental illness.....	10
Criminalization hypothesis.....	10
The impact of incarceration on mental health.....	10
The psychopathology perspective.....	11
Risk, Need, and Responsivity framework.....	12
A moderated mediation model.....	14
Risk and protective factors for recidivism in youth.....	14
Rehabilitation.....	20
Mental Health Courts.....	24
Youth justice legislation.....	24
Development of mental health courts.....	25
Mental Health Court Research.....	26
Problem-solving courts for youth.....	26
Adult mental health courts.....	27
The Community Youth Court.....	30
Overview of the Current Study.....	31
Chapter 2: Theoretical Analysis of the Mental Health Court Program Model.....	36
Abstract.....	37
Introduction.....	38
Mental Health Courts.....	38
Causal Theories of Change.....	38
Youth Justice Legislation.....	40
Process Evaluation.....	41
The Current Study.....	42
Method.....	43
Participants.....	43
Materials.....	44
Procedure.....	45
Results and Discussion.....	46
Program Theory Evaluation.....	46
Program Model Implementation.....	51
Limitations and Future Research.....	61
Conclusion.....	62

Chapter 3: Mental Health Court Operations, Target Population, and Treatment	64
Abstract	65
Introduction	66
Youth Justice Legislation.....	66
Mental Health Court Research.....	67
Risk to Reoffend.....	69
The Current Study	70
Method.....	72
Participants.....	72
Materials	72
Procedure.....	74
Results	74
Description of Court Operations.....	75
Participant Characteristics and Predictors of Program Completion.....	79
Extent to Which Mental health and Criminogenic Needs of Participants Were Addressed	84
Discussion.....	85
Limitations and Future research.....	92
Conclusion.....	93
Chapter 4: Overall Discussion and Conclusion.....	94
Mechanisms of Change.....	94
Screening and Assessment	96
Treatment	97
Youth Justice Legislation	98
Future Research	99
Conclusion.....	100
References	101
Appendices.....	128
Appendix A: Interview Protocols.....	128
Appendix B: Court File Data Collection Form.....	149

LIST OF TABLES

Table 1: Frequency of Youth Mental Health Court Treatment Referral.....	77
Table 2: Characteristics of Youth Mental Health Court Participants.....	80
Table 3: Frequency of Prior Mental Health Diagnoses for Youth in the Mental Health Court....	83
Table 4: Motivation and Diagnoses as Predictors of Program Completion.....	84

LIST OF FIGURES

Figure 1: Mental Health Court Logic Model.....47

Figure 2. Evidence-Based Decision Making Model.....50

Chapter 1

Preventing youth crime has been an area of ongoing public and political interest across North America for over a century. Only recently, however, has the importance of better understanding the mental health needs of justice-involved youth been realized. Within the last decade it has become apparent that mental illness is highly prevalent amongst youth involved in the justice system (Gretton & Clift, 2011; Vieira, Skilling, & Peterson-Badali, 2009; Wasserman, McReynolds, Schwalbe, Keating, & Jones, 2010). These findings have led to increased interest in how to properly intervene and treat this unique population (Vermeiren, Jesper, & Moffitt, 2006). From a legal perspective, such goals are imperative given that the rehabilitation of youth is a key objective of the juvenile justice system, one which must be balanced with the need to protect the young person and society (Grisso, 2008). While there is an overwhelming consensus regarding the importance of treating justice-involved youth with mental health needs, there is little consensus about what services to offer and in what context.

One recent approach to intervention has been the development of mental health courts targeted towards youth. To date, there has been little research evaluating the operations and outcomes of such programs. The current dissertation consists of a process evaluation of a mental health court for youth that recently opened in Toronto, Canada. The court was created to provide specialized services to justice-involved youth experiencing mental health and substance use issues. The overarching goals of the court are to improve access to community treatment services, reduce case processing time, improve the general well-being of youth, reduce the likelihood of re-offense, and increase community safety (Ontario Court of Justice [OCJ], 2011). The purpose of this dissertation is to assess the program based on current empirical knowledge of best practice for treating justice-involved youth with mental health needs. The study is divided

into two separate manuscripts that provide: 1) a theoretical evaluation of the court's program model and a qualitative review of program model implementation; and 2) a detailed look at the functioning of the court, factors that predict program completion, and treatment needs addressed through the court. It is important to note, given the two-manuscript design, that there may be significant areas of overlap in the abstracts and introductions to each paper.

General Introduction

The following introduction provides a review of the prevalence rates of mental health issues amongst justice-involved populations and foundational theories regarding the development of psychopathology during adolescence. Several theories relevant to the treatment of mental illness amongst offender populations are discussed, followed by an outline of the development of mental health courts in Canada and the current state of research regarding mental health courts. The final section includes a description of the mental health court under evaluation.

Prevalence of mental illness in the criminal justice system. Research has consistently revealed higher rates of mental illness among justice-involved youth compared to the general population (Ulzen & Hamilton, 1998). Grisso (2008) estimates that the rate of mental illness amongst youth in the general population is between 15-25% based on research by Costello et al. (1996), Kazdin (2000), and Roberts, Attkinson, and Rosenblatt (1998). These findings are generally in keeping with estimates in Canada suggesting that approximately 14% of children have a diagnosable mental health disorder (Waddell, Offord, Shepard, Hua, & McEwan, 2002). In contrast, upwards to 90% of justice-involved youth have been found to meet criteria for at least one mental health diagnosis (Drerup, Croysdale & Hoffman, 2008; Unruh, Gau & Waintrup, 2009). In a Canadian study of incarcerated youth, 92% met criteria for at least one

mental health disorder, the most common being conduct disorder and substance abuse disorders (Gretton & Clift, 2011). Other studies suggest rates that range between approximately 50% (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, et al., 2010;) to 100% (Vermeiren, 2003). A Canadian study exploring rates of mental illness amongst youth referred for psychological assessments during trial found that 78% of youth were diagnosed with at least one Axis I disorder (Vieira et al., 2009). Thus, even at the low end, the prevalence rate of mental illness is at least double amongst youth in the justice system compared to those in the general population, but is likely somewhere between two to five times higher¹.

Theoretical perspectives in adolescent development. Adolescence is a major developmental period characterized by the onset of puberty and ongoing brain development, as well as the search for autonomy and self-identity (Lerner & Galambos, 1998; Lerner & Steinberg, 2009). Young people must manage these changes within the context of major transitions in the family, peer group, school, and community (Lerner & Galambos, 1998). A look at development across these multiple contexts provides information regarding typical adolescent behaviour and the opportunity for maladjustment at various stages.

The onset of puberty typically marks the beginning of adolescence and is characterized by development within the brain, particularly the prefrontal cortex, and hormonal changes that lead to physical, cognitive, social, and emotional changes in young people (Steinberg, 2005; Susman & Dorn, 2009). Cognitive development, for instance, impacts judgment, decision

¹ It is important to note that there has been some debate about whether conduct disorder should be considered when looking at mental health needs amongst justice-involved youth, given that the definition of conduct disorder almost entirely overlaps with the definition of a 'young offender'. Research has generally found that the rate of psychiatric diagnosis remains high even after conduct disorder is excluded (Teplin et al., 2002). Thus, when conceptualizing the mental health needs of justice-involved youth it may be more useful to look beyond conduct disorder (and other externalizing disorders) and focus on internalizing and developmental disorders as the primary concern.

making, and risk taking behaviours amongst youth. Collins and Steinberg (2006) note that while adolescents over the age of 16 may have developed adult level reasoning abilities, they are still highly susceptible to social and emotional factors, such as peer influences and poor impulse control, that can lead to risk taking and criminal behaviour (Steinberg & Scott, 2003). During adolescence the brain is still undergoing development in regions that are particularly important in the regulation of behaviour and emotion, as well as the perception of risk and rewards (Steinberg, 2005). The differential development of these areas suggests that many adolescents who have developed appropriate intellectual capacity may struggle with impulse control in emotionally laden contexts (Casey, Jones, & Hare, 2008). These biological developments may underlie the trend in risk-taking and sensation-seeking behaviours that are common in adolescence.

The development of autonomy is another important milestone of adolescence, in which young people learn to become emotionally, behaviourally, and cognitively independent from their parents (Cicchetti & Rogosch, 2002; McElhaney, Allen, Stephenson, & Hare, 2009). The search for autonomy is often sought through experimentation with activities that provide a sense of competence (e.g., part-time job), as well as with risky behaviours (e.g., drugs and alcohol) that demonstrate independence and autonomy from the family (Cicchetti & Rogosch, 2002). The search for autonomy has been linked to the development of a cohesive self-identity in adolescence in which young people test out different identities through jobs, travel, schooling, and other explorative behaviours (Coté, 2009). Furthermore, research shows that the desire for autonomy is positively associated with delinquent behaviour (Chen, 2010) and can be thought of as a statement of independence (Moffitt, 1993). It is clear that the transition through adolescence brings about major changes at both an individual and social level that can be challenging for

young people. Although such struggles are considered normative and many youth are able to navigate such changes in a healthy manner, other youth may struggle to adapt and are more susceptible to psychopathology (Garber & Sontag, 2009). Thus, it is not surprising that psychopathology often first appears in adolescence and, if untreated, can impact later development (Garber & Sontag, 2009). Despite the risk inherent in this developmental period, adolescence can also be seen as a window of opportunity for promoting healthy development (Wekerle, Waechter, Leung, & Leonard, 2007). Early intervention for maladaptive behaviour is critical, as there is thought to be inherent plasticity in the relationship between young people and the various levels of their environment, meaning that a positive change in developmental trajectory is possible (Lerner, 2006).

Developmental theories. Developmental theories provide a context from which to view criminal behaviour and psychopathology, as well as possible avenues for intervention to promote healthy functioning. One of the key theories in understanding child and youth development is Bronfenbrenner's (1977) Ecological model. The Ecological model views child development within the context of a young person's social environment, ranging from contexts that are more immediate (i.e., relationship to parents) to those that are much more distal (i.e., neighbourhoods). Within each environment are important factors that interact to influence development. Such factors include those at the biological, individual, psychological, social, interpersonal, institutional, community, and cultural levels (Bronfenbrenner, 1979). Variations among these factors, including the unique characteristics of a young person's family, peers, school, and neighbourhood, will ultimately impact psychosocial development (Collins & Steinberg, 2006). As an extension to the Ecological model, the developmental systems theory highlights the bidirectional interactions that exist between an individual and the various levels of his or her

environment (Lerner, 2006; Lerner & Steinberg, 2009). For instance, while parents have an impact on how their child develops, the child also influences how parents develop across time. It is these interactions that are thought to influence adaptive and maladaptive development in adolescence. Together these theories highlight the importance of understanding the multiple systems that influence young people and how these systems interact to influence development.

Developmental psychopathology. In addition to understanding adolescent development in more general terms, it is also important to consider how psychopathology develops over time. Over the years, child and adolescent psychopathology has become increasingly important in the field of abnormal psychology (Cicchetti & Sroufe, 2000; Mash & Dozois, 2003). This, however, was not always the case, as children were once considered miniature adults and little importance was placed on understanding the unique social, emotional, and cognitive needs of young people (Silk, Nath, Siegel, & Kendall, 2000). A similar shift has taken place within the criminal justice system, as youth, who were once treated under the adult standard, are now recognized to be less culpable than adults. Across both fields, researchers have come to understand that children and youth have unique needs that cannot be determined or addressed solely by our knowledge of adult functioning. For instance, research has shown that disorders of childhood cannot be understood in terms of adult diagnoses and that symptom presentation varies with age (American Psychiatric Association, 2000; Zahn-Waxler, Klimes-Dougan, & Slattery, 2000). In the study of criminal decision making, it has been found that youth do not have the same level of cognitive and psychosocial capacities as adults, meaning that they are less culpable and require alternative approaches to rehabilitation (Caffman & Steinberg, 2000). It has become clear that treatment and intervention programs for justice-involved youth should be tailored towards their unique developmental needs.

Within the field of psychopathology it has become apparent that many disorders diagnosed in childhood continue to influence individuals throughout the life course, that mental health difficulties in adulthood can often be linked to childhood experiences, and that by addressing issues early in life it may be possible to ameliorate later psychopathology (Kim-Cohen et al., 2003, Loeber & Farrington, 2000; Mash & Dozois, 2003, Weissman et al., 1999). The terms multifinality and equifinality have been used to better understand the developmental pathways leading to mental illness. Multifinality indicates that diverse outcomes are likely to develop despite sharing a common starting point, while equifinality indicates that the same outcome can result from diverse starting points (Cicchetti & Rogosch, 2002). Both can be explained by the fact that throughout development individuals are subjected to a range of both protective and adverse experiences that can influence and modify the developmental trajectory (Cicchetti & Rogosch, 2002).

Understanding the risk and protective factors that influence adolescent functioning is central to a developmental psychopathology model. Risk factors consist of environmental or individual characteristics that have been linked to maladaptive outcomes (e.g., sexual abuse, low socio-economic status), whereas protective factors are those that protect young people from, or lessen the probability of, experiencing maladaptive outcomes (e.g., high intellectual functioning, engagement in school). Importantly, it is not the mere presence of risk or protective factors that influences developmental outcome, but the *interaction* between them (Cicchetti & Sroufe, 2000). Research has consistently found that children and youth who are exposed to the same risk factors do not invariably develop mental health problems, some children display resilience and maintain a healthy developmental trajectory, which is thought to result from protective factors that reduce the impact of risk (Rutter & Sroufe, 2000). For instance, Masten, Hubbard, Gest, Tellegen,

Garnezy, & Ramirez (1999) found that high intellectual functioning and positive parenting practices were associated with positive developmental outcomes even among high-risk children and youth who had been exposed to serious, ongoing adversity. In addition to the interaction between risk and protective factors, it is also important to consider how these factors exist within a developmental context and change over time (Cicchetti & Sroufe, 2000; Cicchetti & Rogosch, 2002). For example, as children reach adolescence the peer group becomes a more salient feature and having pro-social peer groups may become a more important protective factor than in childhood. Traumatic events and difficulties in functioning at an early age will continue to have an impact if the child is not redirected onto a healthy developmental trajectory (Sroufe, 2009). These findings highlight the need for early interventions that address areas of both need (i.e., risk factors) and strength (i.e., protective factors).

The field of developmental psychopathology, and many of its principles, has also helped to uncover the developmental trajectory of delinquent behaviour. Moffitt (1993) has identified two distinct groups of delinquent youth with their own unique pathways into crime. The Life-Course-Persistent group is characterized by a small group of individuals who display antisocial behaviours from a very young age (e.g., hitting and biting in the preschool years) and who often go on to commit the most serious and more numerous crimes (Moffitt, 1993). Alternatively, the Adolescent Limited group is characterized by youth who begin to engage in delinquent behaviour in adolescence, but desist in adulthood (Moffitt, 1993). These developmental trajectories were confirmed in a longitudinal study following a birth cohort of boys ($N = 457$) from 3 to 18 years of age (Moffitt, Caspi, Dickson, Silva, & Stanton, 1996). A recent follow-up study of the birth cohort at age 26 found that the Life Course Persistent group had the poorest developmental outcomes, were more elevated on psychopathic personality traits, and had more

mental health problems, substance use problems, financial problems, and serious and violent crimes than the Adolescent Limited group (Moffitt, Caspi, Harrington, & Milne, 2002). The Adolescent Limited group had overall higher status jobs and more positive relationships; however, they were not completely free of crime. Some had accumulated property and drug charges within the year prior to the study and many reported a similar number of mental health symptoms to the Life Course Persistent group (Moffitt et al., 2002). The authors suggested that the Adolescent Limited group had not yet fully transitioned into adulthood.

In a more recent study, researchers tracked offending rates of a Canadian sample of adjudicated youth and found evidence for seven different offending trajectories across development (Day et al., 2012). Trajectories included: 1) *low desister* (low offending rate and the shortest trajectory length), 2) *low persister* (low offending rate and a longer trajectory length), 3) *high late* (high rate of offending with peak in mid-20s), 4) *high early* (high rate of offending with peak in early 20s), 5) *moderate late-persister* (longest trajectory with latest peak in offending trajectory), 6) *moderate adolescence-peaked* (offending that peaked in adolescence), and 7) *moderate early-persister* (long trajectory length with peak offending in early 20s). Risk factors in childhood that differentiated the low-rate desister trajectory from the moderate and high-rate offence trajectories included early antisocial behaviour and poor academic achievement (Day et al., 2012). In adolescence, the groups were differentiated by risk factors related to family functioning difficulties, involvement in alternative care, and poor academic achievement (Day et al., 2012). Together, the above research highlights the importance of understanding how development influences mental health functioning and underscores the need to intervene early to prevent serious criminal behaviour in adulthood.

Theories of criminal behaviour and mental illness.

Criminalization hypothesis. Given the high rate of mental illness found amongst offenders, there has been much research conducted on how to best understand and support this population. One of the first theories for understanding the link between mental illness and criminal behaviour was the “criminalization of mental illness” theory, which posits that mental illness and related behaviours have come to be criminalized by society (Abramson, 1972). Essentially, it is believed that deviant behaviour displayed by those with mental illness is dealt with under the law rather than psychiatric services due to deinstitutionalization and the lack of available community treatment programs (Lamb & Weinberger, 1998). This has led to the widespread belief that treating mental illness will reduce the presence of the mentally ill within the criminal justice system (Andrews & Bonta, 1998; Council of State Government, 2002).

The impact of incarceration on mental health. Alternatively, there has been some evidence to suggest that incarceration may have a negative effect on adjustment and mental health functioning in justice involved populations. For instance, several factors have been identified as possible contributors to mental health dysfunction in prisons, including overcrowding, violence, isolation, lack of privacy, lack of meaningful activities, inadequate access to health/mental health services, and worry about the future (Fraser, Gatherer, & Hayton, 2009). In youth, risk factors associated with institutional life (e.g., worry about peer victimization) have been found to contribute to adjustment above and beyond the vulnerabilities that youth enter custody with (Cesaroni & Peterson-Badali, 2005). Furthermore, the custodial environment is considered one of several factors that contribute to the increase in suicide rate within juvenile justice facilities (Shreeram & Malik, 2008). These findings help shed light on the impact of incarceration on mental health functioning, but are less applicable to youth serving sentences in the community and those who enter the justice system with pre-existing mental

health needs.

The psychopathology perspective. Another approach to understanding and treating justice-involved populations with mental health needs has been to directly address the underlying psychiatric disorder. Robertson, Barnao, and Ward (2011) note that in the absence of a well-documented approach to treating mental illness amongst offender populations, many have turned to evidence-based treatments for non-offending populations, which typically involves interventions that solely address mental health functioning. For instance, research shows that Cognitive-Behavioural Therapy can reduce symptoms of depression in justice-involved youth (Townsend et al., 2010). Such treatments may be appropriate when the focus is primarily on treating mental health symptoms (Veysey, 2008), however, the goal of many criminal justice programs is to reduce recidivism and there is an underlying assumption that treating psychiatric symptoms will also reduce criminal behaviour (Skeem, Manchak, & Peterson, 2011). That is, there is believed to be a direct link between mental illness and the offending behaviour (Abrantes, Hoffmann, & Anton, 2005; Dembo, Schmeidler, Cooper, & Williams, 1997; Timmons-Mitchell et al., 1997). Despite this widespread belief, a causal association between mental illness and criminal behaviour may be found in only a few specific cases in which there is a direct causal link between a young person's offending behaviour and their mental illness (Skeem et al., 2011). For the majority of offenders, criminal behaviour may be associated with other underlying factors.

Research suggests that focusing strictly on mental health disorders may not be the best way to understand and treat offenders, especially if the goal is to reduce recidivism. For instance it has been found that programs targeted specifically at reducing mental illness amongst adult offenders may alleviate symptoms and lead to better mental health functioning, but they do not

consistently reduce recidivism (Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005; Chandler & Spicer, 2006; Clark, Ricketts, & McHugo, 1999; Skeem, Manchak, Vidal, & Hart, 2009; Skeem et al., 2011; Steadman, Dupuis, & Morris, 2009). Morrissey, Meyer, and Cuddeback (2007) suggest that for mental health programs to be successfully implemented within the criminal justice system they must *also* address criminal behaviours and tendencies. Morgan et al. (2012) further found that treatments addressing both mental health needs and criminal needs had the largest effect on both psychiatric functioning and recidivism.

Risk, Need, and Responsivity framework. The Risk, Need, and Responsivity (RNR) framework is one of the leading models for understanding, assessing, and treating adult and juvenile offenders. It focuses specifically on reducing recidivism by addressing the underlying factors that have been linked with criminal behaviour. Developed by Andrews, Bonta, and Hoge (1990), the framework posits that offenders with the highest level of risk should receive the most intensive treatment (Risk Principle), that treatment should address the offender's criminogenic needs (Need Principle), and that treatment service should be matched to the learning style and ability of the offender (Responsivity Principle; Andrews et al., 1990). Criminogenic needs are risk factors that directly predict reoffending behaviour; they are broken down into those that are dynamic and those that are static. Dynamic criminogenic needs are defined as variables that are directly linked to recidivism (e.g., poor use of leisure time, associating with a delinquent peer group; Hollin & Palmer, 2003, Schlager & Pacehco, 2011, Simourd, 2004), are amenable to change, and can be targeted in treatment. Static criminogenic needs, such as criminal history, are strong predictors of recidivism that are not susceptible to change (Cottle, Lee, & Heilbrun, 2001).

Under the RNR model, several aspects of mental health functioning have been identified as

risk factors (e.g., substance abuse, impulsivity). More generally, however, mental illness is not considered an area of risk/criminogenic need. Research has shown that mental illness, while strongly associated with criminal behaviour, does not predict recidivism. For instance, Bonta, Law, and Hanson (1998) conducted a meta-analysis of predictors for recidivism amongst mentally ill offenders and found that many of the predictors were similar to that found amongst general offenders. They also found that clinical predictors of psychopathology were not related to criminal behaviour. Within the adolescent literature, researchers have found that addressing criminogenic needs amongst justice-involved youth, including those with mental health needs, leads to a reduction in recidivism. For instance, Vieira et al. (2009) examined the degree to which justice-involved youth had their criminogenic needs met during treatment. Results revealed that the group with the most needs matched was able to remain crime free for longer and were the least likely to reoffend. Their findings suggest that regardless of mental health status, having criminogenic needs met during treatment is successful in helping justice-involved youth abstain from future criminal behaviour.

Instead of viewing mental illness as a risk for reoffending, the RNR model views mental health issues as an area of responsivity. Responsivity factors refer to the unique characteristics that influence an individual's ability to engage in and learn from treatment (Bonta, 1995). Other important responsivity factors highlighted amongst offender populations include poor social skills, inadequate problem-solving skills, concrete-oriented thinking, and poor verbal skills (Bonta, 1995). According to the RNR framework, responsivity factors, such as mental illness, are important to address in treatment in order to help offenders benefit from interventions designed to reduce criminogenic risk (Bonta, 1995). For instance, a young person who is experiencing psychotic symptoms would be limited in his or her ability to engage in treatment to address

criminogenic needs. Therefore, it would be important to treat the young person's psychological symptoms before engaging in interventions targeted at reducing their criminal behaviour.

A moderated-mediation model. Growing concerns with the high prevalence of mental health issues among offender populations has led to the need for a model that addresses mental health issues more directly. Skeem et al. (2011) have introduced a model for understanding and addressing offender populations with mental health needs that draws specifically on the RNR model. They suggest that the relationship between mental health and criminal behavior is one of moderated-mediation. That is, the relationship between mental health and criminal behaviour is moderated by whether or not the offending behaviour is causally linked to mental illness. A causal relationship between mental illness and criminal behaviour is thought to occur in a minority of cases in which the crime is directly linked to the disorder (e.g., when a young person commits an offence during a psychotic episode). When this causal link exists, psychiatric treatment will likely be more successful in reducing recidivism. In contrast, for most offenders, the relationship between mental illness and criminal behaviour is fully mediated by a third variable that impacts risk factors for recidivism. It is important that individuals in this group receive treatment that addresses risk and criminogenic needs in addition to mental health needs (Skeem et al., 2011).

Risk and protective factors for recidivism in youth. As noted above, the RNR model identifies several areas of risk that are known to influence recidivism amongst youth. Below is a review of the research pertaining to these various areas of risk.

Peer groups. Peer groups are a particularly influential and salient part of adolescent development in the search for autonomy (Wekerle, et al., 2007). Research has consistently shown that antisocial behaviour is associated with having a deviant peer group (Agnew, 1991;

Brendgen, Vitaro, & Bukowski, 2000; Church et al., 2012; Elliot & Mernard, 1996; Farrington, 2004; Heinze, Toro & Urberg, 2004; Monahan, Steinberg, & Cuaffman, 2009; Patterson, Capaldi, & Bank, 1991). For instance, Lipsey and Derzon (1998) conducted a meta-analysis looking at predictors for antisocial behaviour and found that having antisocial peers and a lack of social ties were significant predictors of delinquency. A meta-analysis by Cottle et al. (2001) further revealed that having delinquent peers was a significant predictor of recidivism. The effects of the peer group can be understood as a combination of both a selection effect, in which antisocial youth choose antisocial friends, as well as the socialization effect, in which peer groups influence a young person to engage in antisocial behaviours (Rutter, Giller, & Hagell, 1998). The selection and socialization of peers appears to equally influence individuals in mid-adolescence, whereas socialization appears to be a greater influence during later adolescence (Monahan et al., 2009). Peer groups may influence young people through peer pressure and the modeling of antisocial behaviours, as well as providing increased opportunities to engage in deviant behaviours (Rutter et al., 1998). In contrast to these findings, spending time with family can reduce or even eliminate the influence that peers have on antisocial behaviour (Small, 1995). Furthermore, having a positive peer group has been associated with lower levels of offending and can serve as a buffer in the presence of other high-risk variables. (Hoge, Andrews, & Leschied, 1996).

Family. There are several aspects of family and parenting practices that have been linked to juvenile delinquency. For instance, research has demonstrated that inappropriate discipline, minimal parental monitoring, and attachment problems are all risk factors found amongst youth who engage in delinquent behaviours (Capaldi & Patterson, 1996; Graham & Bowling, 1995; Larzelere & Patterson, 1990; Patterson, DeBaryshe, & Ramsey, 1989). Specifically, discipline

that is inconsistent or severe is particularly related to delinquency (Hawkins et al. (1998). Parents of delinquent youth often fail to monitor their children's whereabouts, are not aware of their child's problem behaviour, show limited engagement with their child, and display a coercive parenting style (Loeber & Stoutham-Loeber, 1986; Rutter et al., 1998). More recent research confirms that poor relationships within the family appear to be a major concern (Cottle et al., 2001), with delinquency being negatively correlated with parental warmth (Church et al., 2012). In contrast, Griffin, Botvin, Scheier, Diaz, and Miller (2000) found that positive parenting practices acted as a buffer for delinquent behaviour and were the most important parenting factor in preventing delinquency. Positive parenting practices, including parental support and monitoring, have been found to promote self-esteem in adolescence (Parker & Benson, 2004).

Education. There are several important educational factors that have been linked to delinquent and criminal behaviour. For instance, poor achievement in school has been consistently linked to antisocial behaviour (Farrington, 2009; Hawkins et al., 1998; Maguin & Loeber, 1996; Simons, Whitbeck, Conger, & Conger, 1991). A meta-analysis conducted by Cottle et al. (2001) revealed that academic achievement on standardized measures was significantly related to recidivism, as was having a history of special education, lower IQ scores, and lower verbal IQ. Truancy is another school factor that has been linked to delinquency (Hawkins et al., 1998), but may act more as a contributory risk factor in the sense that skipping school provides opportunities for involvement in delinquent behaviours (Rutter et al., 1998). School environments characterized by conflict have also been significantly related to conduct problems (Kasen, Johnson, & Cohen, 1990) and young people who are both disruptive at school and defiant towards teachers and school staff have been found to be more likely to engage in delinquent behaviour (Rutter et al., 1998). Promising findings reveal that high educational

achievement (Hoge, Andrews, & Leschied, 1996) and a commitment to school (Catalano & Hawkins, 1996) act as protective factors against criminal behaviour. Schools that foster pro-social behaviour may also be important protective factors and area for intervention for at-risk youth (Rutter et al., 1998).

Substance abuse. Substance abuse is one of the few mental health diagnoses that has consistently been linked to delinquent behaviour. Substance use, like normative levels of delinquency, tends to rise across the adolescent years and may be less concerning than actual abuse of substances. In Cottle et al.'s (2001) meta-analysis they found that substance abuse was a significant predictor of recidivism, whereas substance use was not. Research findings indicate that the relationship between substance abuse and conduct problems is not clear-cut and suggest that there may be a bidirectional relationship. For instance, it has been found that engaging in delinquent behaviour increases the likelihood that an individual will use illicit substances, and that using illicit substances increases the likelihood that an individual will engage in delinquent behaviour (Brook, Whiteman, Finch, & Cohen, 1996; Dobkin, Tremblay, & Sacchitelle, 1997; Hawkins, Catalano, & Miller, 1992; Li et al., 2011). Rutter et al. (1998) suggest that this bidirectional relationship may be due, in part, to the fact that substance abuse and delinquency share many of the same risk factors. Given the strong connection between substance abuse and conduct problems, intervention that addresses substance use issues is an important factor in the rehabilitation of justice-involved youth.

Leisure time. Inappropriate use of leisure time has been associated with delinquent behaviour amongst young people (Hawdon, 1996; Mahoney & Stattin, 2000; Osgood, Wilson, O'Malley, Bachman, & Johnston, 1996; Vazsonyi, Pickering, Belliston, Helsing, & Junger, 2002). Particularly, boredom and excess free time may promote engagement in thrill seeking and

delinquent behaviours (Hoge & Robertson, 2008). Fleming et al. (2008) found that there was a positive correlation between engagement in unstructured activities and antisocial behaviors.

Unstructured leisure time provides situational opportunities in which young people are likely to be rewarded for antisocial behaviour through peer acceptance or material gain and are unlikely to be caught (Osgood et al., 1996). Pro-social activities, however, can be protective against antisocial behaviour when they are goal oriented and supervised by an authority figure (Hawdon, 1996, 1999). Engagement in pro-social activities can also have positive effects on socialization, social competency, identity formation, and peer group affiliation (Eccles & Barber, 1999; Mahoney, 2000; McHale, Crouter, & Tucker, 2001).

Personality. Several personality features have been linked to criminal behaviour. Such features include impulsivity, negative emotionality, a lack of control (i.e., short attention span, emotional lability, restlessness, and negativism), and aggression (Caspi et al., 1994; Caspi, Henry, McGee, Moffitt, & Silva, 1995; Caspi, 2000; Krueger et al., 1994; Loeber, 1996). With regards to impulsivity, White et al. (1994) found that behavioural impulsivity (i.e., the ability to inhibit behaviour) is more strongly associated with delinquency than cognitive impulsivity (i.e., the ability to control cognitive and mental activities). The relationship between cognitive impulsivity and delinquency appears to be moderated by both age and IQ (Loeber et al., 2012). Interestingly, hyperactivity is associated with early-onset delinquency that persists into adulthood, although is usually preceded by some indication of antisocial behaviour in childhood (Rutter et al., 1998). Individuals high in negative emotionality tend to experience events as aversive and attribute such events to malicious intent, which, in turn, leads to angry and aggressive reactions (Agnew, Brezina, Wright, & Cullen, 2002). Negative emotionality and low constraint (i.e., high impulsivity) was found to be associated with delinquent behaviour in youth,

particularly when the young person was experiencing significant stressors or strain within their life (Agnew et al. 2002). Early aggressive behaviours have also been found to predict early initiation into both substance use and delinquent behaviour (Catalano & Hawkins, 1996).

Researchers have also explored the presence of psychopathic personality traits in young people as a predictor of criminal behaviours and suggest that callous and unemotional characteristics may be of primary importance in identifying antisocial youth (Barry et al., 2000). Frick, Stickle, Dandreaux, Farrell, and Kimonis (2005) found that children who displayed callous and unemotional traits along with conduct problems displayed a pattern of both severe and chronic antisocial behaviour. Youth who display callous and unemotional traits also tend to lack guilt, show little remorse, and lack empathy (Essau, Sasagawa, & Frick, 2006). Furthermore, those who score high on these psychopathic traits tend to have more frequent and varied violent offences and engage in more instrumental, as opposed to reactive violence, compared to youth who do not display such traits (Kruh, Frick, & Clements, 2005).

Criminal attitudes. A pro-criminal attitude, which refers to the favourable evaluation of criminal behaviours, has been linked to recidivism and engagement in criminal activities (Hoge, Andrews, & Leschied, 1994; Simourd & Van de Ven, 1999). Meta-analytic studies confirm these findings in both males and females involved in delinquent behaviour (Hubbard & Pratt, 2000; Simourd & Andrews, 1994). Interestingly, when comparing non-violent to violent justice-involved youth, those in the violent group were found to have significantly higher anti-social attitudes. In addition to these findings, measures assessing anti-social attitudes have been found to be useful in predicting recidivism (Skilling & Sorge, 2014). On the opposite end of the spectrum, it has been found that a positive response to authority can be a protective factor for young people (Hoge et al., 1996).

Rehabilitation. An essential goal in the youth criminal justice system is to rehabilitate young persons involved in crime. Guerra, Williams, Tolan, & Modecki (2008) highlight the importance of understanding the causes and correlates of delinquency in order to develop treatment programs that properly address criminal behaviour. An understanding of the risks and protective factors influencing young people is essential to their rehabilitation. Best practice for treating justice-involved youth highlights the need for proper assessment and treatment that adheres to evidence-based programs or principles (Guerra, Hoge, & Boxer, 2008; Hoge, 2008).

Assessment. An essential first step in the rehabilitation of justice-involved youth is the systematic and developmentally sensitive assessment of risk and protective factors (Borum, 2003). Hoge (2008) indicates that reliable and valid assessments are crucial for informed decision-making regarding the rehabilitation of justice-involved youth. In particular, it is important to understand the intensity of services required by youth, so as to reserve the most intensive treatment for those who are at greatest risk, as well as to be able to target particular areas of need (Borum, 2003; Hoge, 2008). Standardized measures are considered the gold standard in assessing justice-involved youth because they provide greater validity, improve decision making (Grove & Meehl, 1996; Grove, Zald, Lebow, Snitz, & Nelson, 2000), ensure standardization in the assessment and decision making process, and are linked to theory and research evidence (Hoge, 2008). Borum (2003) further notes that unsystematic assessments tend to produce decisions that are based on inaccurate or unaccountable findings.

Several measures have been introduced for the assessment of risk, including the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2002), which was developed on the basis of the RNR model and assesses risk/criminogenic needs across a variety of dimensions (i.e., history of criminal conduct, family circumstances and parenting, current

school or employment problems, criminal peer affiliations, alcohol or drug problems, leisure and recreational activities, personality and behavior, and antisocial attitudes and orientation). The YLS/CMI has been found to adequately predict risk among young offenders; those assessed at high levels of risk were the most likely to recidivate (Jung & Rawana, 1999; Onifade et al., 2008; Schmidt, Hoge, & Gomes, 2005). Other important measures that can help identify the needs of young people involved in the criminal justice system include personality tests, behaviour ratings and checklists, assessments of attitudes and beliefs, cognitive and academic achievement measures, and other mental health functioning measures (Hoge, 2008). These measures provide information regarding psychiatric disorders, personality disorders, intellectual functioning, academic achievement, and antisocial attitudes, which can help with treatment planning and case management (Hoge, 2008). Comprehensive assessments should be used to develop targeted treatment plans that address important areas of need in the young person's life.

Intervention. Despite the wealth of research on the causes, risk, and protective factors of delinquent and criminal behaviour, there are relatively few treatment programs that have been found to be effective for justice-involved youth. Multisystemic therapy (MST) is an empirically supported treatment model that helps families to address their child's behavioural problems and other risk factors, such as low parental monitoring, association with delinquent peers, and poor school performance (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). MST is intensive, in that it provides around the clock care from qualified therapists and intervenes in multiple areas of the young person's life (Guerra, Kim, & Boxer, 2008). This type of therapy would be ideal for someone who resides with their family and is considered to be at high-risk for re-offending, but would not be appropriate for those who are at low to moderate risk to re-offend. Other treatment

programs such as Functional Family Therapy and Multidimensional Treatment Foster Care are similarly intensive and require family support (Guerra, Kim, et al., 2008).

Due to the fact that there are so few established interventions for treating justice-involved youth, Guerra, Kim, and colleagues (2008) have established a list of four critical components for treatment programs. These components are based on common features from effective treatment programs that have been explored in the research. The first component indicates that programs must be *highly structured* and should target individual skills and beliefs. Less structured programs, such as group therapy and general counseling, vary widely in their activities and have been found to be less effective (Guerra, Kim, et al., 2008). The second component indicates that treatment programs should involve a *cognitive component* that is linked to specific skills. Cognitive-Behavioural Treatment programs have been shown to be a promising treatment option for justice-involved youth (Andrews, 1980; Bonta, 1995; Izzo & Ross, 1990; Landenberger & Lipsey, 2005). Those that are successful involve training in multiple areas such as self-control, anger management, problem solving, perspective taking, empathy, moral reasoning, and challenging attitudes and beliefs (Guerra, Kim, et al., 2008). The third component for effective treatment involves *engaging families* in treatment and seeking to reduce family risk factors. Family variables are some of the most important risk and protective factors and the only known effective programs for justice-involved youth target this area intensively. The final component involves treatment programs that *address a variety of risk factors* across several contexts, as is consistent with the developmental psychopathology model (Frick, 2012). Programs that address only a single risk factor are less effective as they do not take into account the complexity of risk factors within the young person's life.

Other factors that are thought to influence rehabilitation and treatment of offenders include motivation and access to treatment services. In adults, treatment readiness has been linked to engagement in treatment and intervention services (Wormith & Olver, 2002). Such engagement, in turn, has been linked to treatment success (Knight, Hiller, Broome, & Simpson, 2000) and is particularly important in young people who rarely seek help on their own (Rawana & Brownlee, 2009). Desistance from offending requires motivation to change (Guerra, Williams, et al., 2008) and many youth report that the biggest barriers to service are the fact that they do not believe that they need help or are not sure of how to access help (Abram, Paskar, Washburn, & Teplin, 2008). Such findings highlight the need to engage youth in treatment planning and provide support in accessing services.

Overall, interventions that are informed by valid assessments and adhere to the four components described above are likely to be the most successful in rehabilitating justice-involved youth. Integrating evidence-based treatment programs and evidence-based principles with specialized courts for youth is also likely to increase beneficial effects. For instance, Henggeler, McCart, Cunningham, & Chapman (2012) found that integrating empirically based family interventions into a drug treatment court led to better outcomes in drug use and offending behaviour than treatment as usual. These results are promising and highlight the importance of implementing research based treatment protocols into treatment courts for young people. It is important to highlight that while there is a wealth of information available on evidence-based practice for reducing recidivism amongst justice-involved youth, there are limited guidelines on how to address mental health needs amongst this population. As noted above, many programs tend to focus on treating mental health needs at the exclusion of addressing risk factors and areas of need that have been empirically linked to recidivism (Skeem et al., 2011). While more

research is needed in this area, theoretical developments suggest that treatment of this unique population should involve a combination of treatments addressing both mental health and criminogenic need that is tailored to the characteristics of the young person's level of risk and the characteristics of their crime.

Mental Health Courts

Youth justice legislation. Canada's first formal legislation for justice-involved youth was the Juvenile Delinquents Act (JDA), enacted in 1908, which recognized that young people were more vulnerable than their adult counterparts and, therefore, should not be held accountable in the same manner (Hogeveen, 2005; Bala, 2005). Youth were also thought to be more amenable to rehabilitation than adults and often received more intensive interventions under the criminal justice system (Bala, 2005). After 76 years, the Young Offenders Act (YOA, 1984) was introduced to replace the JDA. In comparison, the YOA was less concerned with the welfare of young people and focused more heavily on due process and holding youth accountable for their actions. The YOA was in effect for a relatively short period of time, as dissatisfaction with the implementation of the YOA across Canada grew in the late 1990's. 'Rehabilitation focused' critics pointed to harsh and ineffective sentencing and lack of attention to interventions to support youth and reduce risk. Indeed, under the YOA, Canada was found to have the highest incarceration rate in the Western world (Endres, 2004). At the other end of the spectrum, 'get tough' critics cited concerns regarding public protection, in part due to intensive media coverage of violent youth crime across North America (Reid, 2005; Sprott, 1996; Stevenson, Tufts, Hendrick, & Kowalski, 1998).

As youth crime became more salient, the focus began to shift to the apparent increase in young people with mental health problems in the criminal justice system (Grisso, 2004, Ulzen &

Hamilton, 1998). During this time, the Youth Criminal Justice Act (YCJA, 2002), Canada's current justice legislation for youth, was introduced to rectify some of the perceived problems with YOA. The YCJA introduced a greater focus on rehabilitation and less reliance on custody as a form of sanction (Bala, 2005). Consistent with this rehabilitative focus and an emphasis on addressing the root causes of youth crime, the YCJA also promoted the development of diversion programs and non-traditional methods for managing youth. This, combined with a surge of research on offenders with mental health issues, contributed to the recent development of specialized programs for justice-involved youth with mental health needs (Leschied, 2011), including the introduction of mental health courts for youth. Despite the apparent progress in the field, there still remains great uncertainty about the effectiveness of current treatment approaches to rehabilitation as well as how treatment programs can address both the mental health and criminogenic needs of justice-involved youth.

Development of mental health courts. Mental health courts were originally developed in the United States to address increasing concerns with the mental health needs of adults coming into contact with the criminal justice system (Schneider, Bloom, & Hereema, 2007). In general, the goal of mental health courts is to divert those with mental illness who have been found guilty out of the criminal justice system and into community treatment, while at the same time upholding public safety (Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011). The first mental health court was introduced in Canada in 1998 along with the first drug treatment court (Slinger & Roesch, 2010). Since their inception, mental health courts have become increasingly popular across North America and have begun to garner research interest. With the apparent success of mental health courts for adults, these courts have recently been adapted for youth.

Before the advent of youth mental health courts in Canada, many youth with mental health needs, like their adult counterparts, were serviced under mental health diversion. Mental health diversion is offered in the traditional, adversarial court system and diverts youth into community treatment programs to address their mental health needs. Research shows that mental health diversion for young people is able to reduce recidivism but the mechanisms for change remain unknown (Cuellar, McReynolds, & Wasserman, 2006). The use of such diversion programs has blossomed since the implementation of the YCJA in 2003. Mental health courts are similar to diversion in that they both seek to divert those with mental illness out of the criminal justice system and into community treatment. Mental health courts, however, operate under a therapeutic jurisprudence model that promotes a treatment focus and less adversarial process than found in a traditional court room (Frailing, 2010). Mental health courts may see diversion cases, but also service other youth with mental health needs who plead guilty to their charges. The first mental health court for youth was opened in Ottawa, Ontario in 2008 (Perkins-McVey, McCormick, Leger, Bretton, & Motayne, 2009). Since that time, mental health courts for youth have also opened in London, Ontario, and most recently in Toronto, Ontario. Anecdotally, there has been a positive reception to these courts, yet little is known about the operation and success of these programs. Below is a review of the limited research available on mental health courts.

Mental Health Court Research

Problem solving courts for youth. Given that mental health courts for youth are a relatively new adaptation, there has been little empirical research exploring their functioning and effectiveness. A published dissertation by Behnken (2008) explored the characteristics and preliminary outcomes of a mental health court for youth in the United States. Youth in the sample met criteria for a wide range of psychiatric disorders, with the most common being

Attention Deficit/Hyperactivity Disorder (60.15%), Bipolar Disorder (38.35%), and Major Depression (34.59%). The study revealed a significant reduction in recidivism rates from pre-to post-program enrollment for 64 youth who successfully completed their court requirements. Such changes were attributed to the treatment services received, as well as the individualized attention and close monitoring provided by the court (Behnken, 2008).

Another study looked specifically at the outcomes of a drug treatment court, which operates similarly to mental health court programs and can provide insight into their potential outcomes. Rodriguez and Webb (2004) conducted a quasi-experimental study comparing recidivism rates for 114 youth drug court defendants and 204 youth on probation. Results revealed that the drug court sample was less likely to recidivate, but more likely to test positive for cocaine use than the comparison group (Rodriguez & Webb, 2004). Drug use was found to be associated with other areas of need (e.g., school and family functioning) that may not have been targeted in treatment (Rodriguez & Webb, 2004). In addition, the majority of youth (70%) in the drug court sample did not successfully complete their program requirements, but were still included in the study. It was recommended that future research and programming look more closely at successful program completion and extralegal variables (i.e., gender, race, socioeconomic status, family functioning) that may impact program outcomes (Rodriguez & Webb, 2004). In both of these studies the magnitude of the effect of specialty court on recidivism were not reported. Given the limited availability of research on mental health courts for youth, a detailed review of the adult literature is discussed below.

Adult mental health courts. One of the primary functions of a mental health court program is to link individuals with treatment services. Boothroyd, Poythress, McGaha, and Pettila (2003) compared the degree of treatment service usage among adult mental health court

defendants ($n = 116$) to defendants with mental health needs from a traditional court ($n = 97$). They found a significant increase in service usage amongst the mental health court group compared to the comparison group. It was also found that mental health court defendants received significantly more mental health services than defendants from the traditional court. A follow up study found, however, that there was no significant difference in the changes in mental health functioning across the two groups (Boothroyd, Mercado, Poythress, Christy, & Petril, 2005). Importantly, the authors highlighted that mental health courts are not responsible for the actual implementation of treatment programs and that perhaps the treatment received by defendants was not sufficient to improve mental health functioning (Boothroyd et al., 2005). Together these studies highlight the difficulties that arise in not only evaluating mental health courts, but in implementing a mental health court program, as the goal of increasing well-being or improving mental health functioning is dependent on the availability and effectiveness of community treatment programs.

While access to treatment is an important aspect of a mental health court program, the long-term goals are typically targeted towards reducing recidivism. Sarteschi, Vaughn, and Kim (2011) conducted a meta-analysis assessing the effectiveness of mental health courts in reducing recidivism. They found an overall effect size of -0.54 , suggesting that mental health courts can be moderately effective in reducing re-arrest amongst mentally ill defendants. More specifically, McNiel and Binder (2007) compared time to subsequent criminal charges among mental health court defendants and a similar group booked at a county jail using a matching strategy based on propensity scores and controlling for potentially confounding variables. Mental health court defendants were able to remain free of criminal charges for a significantly longer period of time than the comparison group, particularly amongst those who completed their mental health court

requirements (McNiel & Binder, 2007). Similar results were revealed by Moore and Hiday (2006), who found that mental health court defendants were arrested significantly less often and for less serious crimes than the comparison group. Those who completed their mental health court requirements had fewer re-arrests and less serious crimes than those who did not complete their requirements. Across these, and other studies (see Dirks-Linhorst & Linhorst, 2012), successful completion of the program appears to be an important factor in improving outcomes.

As Slinger and Roesch (2010) have highlighted, many mental health court evaluations do not use matched control groups and thus there may have been important differences in the two samples prior to the study. To address this issue, Frailing (2010) controlled for jail days prior to study involvement. The results revealed that those who completed the mental health court program had significantly fewer jail days than they had in the year prior to referral and significantly fewer jail days than the control group. Frailing (2010) highlighted several unique aspects of the court, including the non-adversarial approach of the court and the promotion of program engagement (i.e., defendants speaking directly with the judge and being given praise and encouragement for their performance). Steadman et al. (2011) conducted a multi-site evaluation exploring recidivism rates of four mental health court programs. The mental health court samples were found to be similar to the treatment-as-usual group with regards to re-arrest rates and days in jail prior to entering court. The results revealed that within the 18-month follow up period, the mental health court sample had lower arrest rates, fewer arrests, and fewer days in jail than the control group. Taken together, the findings from the above research suggest that mental health courts may be a promising treatment option for justice-involved youth with mental health needs. Further research is needed to understand their functioning in the youth justice system and to identify mechanisms of change.

The Community Youth Court

The youth mental health court under evaluation was officially launched in Toronto, Ontario in June 2011. Its development was spearheaded by a children's mental health agency in Toronto called Turning Point Youth Services. Initial interest in the project stemmed from the success of two similar courts in Ottawa and London, Canada. A steering committee was established in 2009 with representatives from the Department of Justice, the federal and provincial Crown Attorney's offices, the Justice for Children and Youth, Duty Counsel, and the Youth Mental Health Court Worker Program.

Toronto's mental health court for youth was named the Community Youth Court (CYC) to reflect the focus on the collaboration between the court and community services and to reduce possible stigma associated with mental health programming (OCJ, 2011). The program is designed to provide specialized services to young offenders suffering from mental health and substance use issues. It "is intended to create an environment characterized by increased collaboration and cooperation wherein [the court] can identify and respond more sensitively, quickly and effectively to the unique needs of youth with mental health and substance use problems" (OCJ, 2011, p.2). In meeting the goal of responding more quickly and effectively to the needs of the targeted youth, it is hoped that youth processed through this court will encounter fewer barriers to accessing the services and supports they need. The proximal stated goals of the CYC are to improve access to community mental health and substance abuse treatment services, reduce case processing time for youth with mental health needs, and improve the general well-being amongst youth. The more distal goals are to ultimately reduce the likelihood of re-offense and increase community safety.

The court currently services youth who have a major mental health concern (i.e., mood disorders, anxiety disorders, schizophrenia, developmental disorders) or substance use problem, although having a formal diagnosis is not a prerequisite to service (OCJ, 2011). The CYC is a resolution court that was created for youth who wish to resolve their case, not for those who wish to contest their charges (OCJ, 2011). As such, the court typically sees youth who have opted for mental health diversion or those who have plead guilty. Youth who wish to contest their charges are transferred to the traditional court system to resolve their matter (OCJ, 2011). The court sits twice a month and is staffed by a consistent team of judges, lawyers, attorneys, and a youth mental health court worker, who are all sensitive to the unique needs of youth with mental health concerns. The court was created to provide an atmosphere of collaboration and cooperation, which differs from the more adversarial environment of the traditional court system (OCJ, 2011).

Overview of Current Study

Together the current two manuscripts comprise a process evaluation of the CYC, with the overarching goal of assessing the court's operations in the context of current empirical knowledge on best practices for treating justice-involved youth with mental health needs. Process evaluations are distinct from impact assessments. The latter seeks to evaluate whether a program produces the intended outcome (e.g., does a treatment program reduce the symptomatology that it was designed to alleviate?), whereas process evaluations are typically undertaken before beginning an impact assessment to ensure that the program has been implemented properly and to understand how the program leads to change (Rossi & Freeman, 1993). Many of the evaluations highlighted above have revealed important information regarding the outcomes of mental health courts, yet little is known about how these outcomes were achieved and which program elements were responsible for such changes. Given that the CYC

was in the early stages of inception, a process evaluation was considered most beneficial in order to provide program recommendations and to provide guidelines for a future outcomes evaluation.

The current evaluation was guided by the Centers for Disease Control and Prevention's (CDC; 1999) "Framework for Evaluation in Public Health Research". The framework highlights six key steps in conducting an evaluation. These include: 1) engaging stakeholders, 2) describing the program, 3) focusing the evaluation design, 4) gathering credible evidence, 5) justifying conclusions, and 6) ensuring use and sharing lessons learned. This framework provides a guide for practical evaluations that seek collaboration between evaluators and program staff and information that will lead to program improvements and the development of future programs (CDC, 1999). With regards to the current evaluation, stakeholders were consulted at every step of the evaluation to clarify research questions, to determine data collection tools and processes, and to gather feedback in the interpretation of results. Several stakeholders of the program, with the Honourable Mr. Justice Brian Weagant as lead, requested the evaluation to examine the program's processes and to provide recommendations for enhancing the program. More specifically, stakeholders were interested in understanding whether the court had been implemented as designed and whether the program was administered in a way that maximized the impact of the court. Stakeholders also requested an evaluation to explore whether the program was meeting the goals that were set at the outset, and to explore perceptions and knowledge of the court held by service users and key informants. Finally, stakeholders were particularly concerned with understanding the barriers to service and how the CYC could be most successful in servicing youth with mental health needs. The evaluation was designed to address these areas of interest and concern. The results of the evaluation have been shared with key informant groups throughout the studies' progression and regular meetings with the clinical

team have been scheduled for consideration of implementing changes. Upon completion of the project, key informants will be provided a copy of each manuscript and opportunities for discussion will be provided.

For a comprehensive and systematic mental health court evaluation, Steadman (2005) recommends collecting data in key areas related to participant characteristics and services received. The CDC (1999) further recommends gathering evaluation data from multiple sources, both qualitative and quantitative in nature. Accordingly, the evaluation addresses four key areas in two papers. The first manuscript includes a **program theory evaluation** that looks at the program's proposed mechanisms of change in the context of current empirical knowledge on best practice for the treatment of mentally ill offenders, as well as an exploration of **program model implementation** through a qualitative analysis of the knowledge (e.g., understanding of the objectives of the court and its processes) and views (e.g., perspectives, experiences, satisfaction) of the court held by individuals in various stakeholder groups (i.e., youth court judges, crown counsel, members of the defence bar, court staff, community agency staff, youth, and parents). The second manuscript includes an exploration of the **court operations**: basic functioning of the court (e.g., number of cases seen, staff/personnel, and resources), service referrals and services received (e.g., from community mental health and/or addictions programs), and case dispositions (e.g., completion of diversion, pleas, findings of guilt, dispositions). The **target population** is described including: demographic characteristics, criminal justice variables (e.g., current charges, offence history), mental health variables, treatment motivation, and characteristics that predict program completion. **How the court addresses treatment needs** is also described including both the mental health and criminogenic needs of youth. Targeted research objectives and specific methodology are described in greater detail within each paper.

All information was collected directly through participant interviews or through the collection of secondary data (i.e., information held in court/MCYS records). See Appendix A for a copy of interview guides and Appendix B for a copy of the data collection form.

Ethics. Prior to beginning data collection ethical approval was sought and obtained from the University of Toronto, the Centre for Addiction and Mental Health, the Ministry of Children and Youth Services, as well as York University. The research project conforms to the standards outlined in the Canadian Tri-Council Research Ethic Guidelines. All participants who were interviewed for the study provided informed consent. Secondary data were also collected without consent from participants. A court order pursuant to sections 120-126 of the Youth Criminal Justice Act to access court, government, and organization records concerning youth seen in connection with the Community Youth Court (i.e., those who were processed through the CYC as well as those who were screened and/or considered for the CYC but who did not proceed through that court) was obtained. The use of secondary data without consent from the individuals to whom the information pertains meets all the requirements of Article 5.5 in Section 2 of the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (2nd Edition), namely a) this information is essential to the research (i.e., the information outlined above is central to the study), b) the welfare of individuals about whom we obtain information without consent will not be adversely affected by our access to this information without their consent, c) we have appropriate procedures for the collection, maintenance, and safeguarding of such information (see below), d) we will respect any previously known preferences expressed by individuals regarding use of their information (e.g., if we request direct participation in the study and an individual declines, we will not use information about him or her from court records), and e) it is not practicable to obtain consent from all individuals (or parents/guardians in the case of

youth under age 16) to access information about them contained in court records. While the majority of youth were seen in the body of the mental health court, this was not always the case as some youth who were considered participants of the mental health court had their matters heard in alternative courtrooms due to timing issues. The research team was available for each mental health court date, but could not be at court on a daily basis and therefore could not obtain consent for each youth. Court staff indicated that they were already overwhelmed with work and not able to take on additional tasks associated with the study.

Data Management and Storage. Great care was taken to protect all research-related materials. All data were compiled into an electronic file stored on the University of Toronto's secure server. Electronic data that were gathered on court premises were stored temporarily on an encrypted storage key and subsequently transferred to the secure server. Hard data were kept in a secure filing cabinet at the University of Toronto. Once the study is complete, data will be transferred to the university archives where they will be stored for a period of five years and subsequently destroyed. Information gathered from the various records relating to youth before the court was grouped for analysis and reporting so as to protect identifiable information.

Chapter 2:

Theoretical Analysis of the Mental Health Court Program Model

Abstract

Over the last several decades, mental health courts have been developed to help address the overrepresentation of youth with mental health needs amongst offender populations. Research suggests that mental health courts may contribute to reductions in recidivism, yet little is known about the logic behind these programs, how they are implemented and how they facilitate change, particularly in the youth justice system. The current study reports on a process evaluation of a mental health court for youth in Toronto, Canada. Drawing upon observations of the court and interviews with service users and key informants, we addressed two overarching goals: to develop and assess a program model of the court and to explore how the model has been implemented in the context of Canada's youth justice legislation. We used a program theory evaluation to explore the degree to which the model adheres to empirical evidence for treating justice-involved youth with mental health needs. Results provide insight into areas of strength in the program, including the program's ability to provide a supportive environment for youth as well as to engage and link youth and their families with treatment. Areas for continued program development include the need to assess and address aspects of criminogenic need to help reduce recidivism.

Introduction

Mental Health Courts

There is widespread agreement that individuals with mental health needs are overrepresented in the criminal justice system (Grisso, 2008; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Ulzen & Hamilton, 1998). For example, justice-involved youth are generally two to five times more likely to have a diagnosable mental illness when compared to the general population (Drerup, Croysdale & Hoffman, 2008; Unruh, Gau & Waintrup, 2009; Vermeiren, 2003; Wasserman, McReynolds, Schwalbe, Keating & Jones, 2010). Mental health courts have recently been introduced to help link defendants with mental illness to community treatment programs as a way of dealing with their charges (Schneider, Bloom, & Hereema, 2007). Although research on youth mental health courts is sparse, studies of adults have revealed lower recidivism rates amongst mental health court defendants compared to defendants with mental health needs processed through traditional courts (Dirks-Linhorst & Linhorst, 2012; Frailing, 2010; McNiel & Binder, 2007; Moore & Hiday, 2006; Sarteschi, Vaughn, & Kim, 2011). These findings are promising but further research is needed to better understand the mechanisms of change at work in reducing recidivism.

Causal Theories of Change

Given the lack of knowledge regarding the mechanism through which mental health court involvement produces change, it is useful to look more broadly at causal theories for rehabilitation amongst justice-involved populations. Many criminal justice programs that target offenders with mental illness tacitly assume that treating psychiatric symptoms will reduce criminal justice involvement (Skeem, Manchak, & Peterson, 2011). That is, there is believed to be a direct link between mental illness and offending behaviour (Abrantes, Hoffmann, & Anton,

2005; Dembo, Schmeidler, Cooper, & Williams, 1997; Timmons-Mitchell et al., 1997). Despite this widespread belief, evidence of a causal association between mental illness and criminal behaviour is sparse (Skeem et al., 2011). For the majority of offenders, criminal behaviour is not directly related to mental illness and treatment programs targeted at reducing mental illness amongst adult offenders have not been found to reduce recidivism (Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005; Chandler & Spicer, 2006; Clark, Ricketts, & McHugo, 1999; Skeem, Manchak, Vidal, & Hart, 2009; Skeem et al., 2011; Steadman, Dupuis, & Morris, 2009). These findings suggest that treating mental illness may be important for improving mental health symptomatology, but may not be sufficient for reducing recidivism.

The Risk, Need, and Responsivity (RNR) model provides a different approach to understanding criminal behaviour that focuses on reducing recidivism by addressing the underlying factors empirically linked to criminal behaviour. The RNR model, developed by Andrews, Bonta, and Hoge (1990), posits that the most intensive treatment should be reserved for offenders with the highest level of risk (Risk Principle), that treatment should address the factors (i.e., criminogenic needs) that underlie the offender's criminal behaviour (Need Principle), and that treatment service should match the learning style and unique characteristics that influence an individual's ability to engage in and learn from treatment (Responsivity Principle). Dynamic criminogenic needs are factors that have been empirically linked to recidivism and can be changed (Hollin & Palmer, 2003, Schlager & Pacehco, 2011, Simourd, 2004). In youth, these include for example parental and family functioning, delinquent peer groups, and antisocial attitudes, as well as several variables related to mental health functioning (e.g., substance abuse, impulsivity; Hoge & Andrews, 2002). Other areas of mental health (e.g., mood concerns, trauma) are generally considered aspects of responsivity (Bonta, 1995).

Although the RNR model helps to identify specific targets for intervention to reduce recidivism, it lacks clear guidelines for how to treat areas of mental health not related to risk but considered to be responsivity factors.

The treatment of mental health or criminogenic needs in isolation may not be optimal for improving the well being of justice-involved individuals with mental health needs. Morgan et al. (2012) conducted a meta-analysis that found that treatment addressing *both* mental health and criminal needs amongst adult offenders had the largest effect on both psychiatric functioning and recidivism in comparison to treatments that targeted mental health only. Skeem et al. (2011) argue that the relationship between mental health and criminal behavior is moderated by whether or not the offending behaviour is causally linked to mental illness. When the relationship is causal, recidivism is best addressed through psychiatric treatment. For the majority of offenders, however, the relationship between mental illness and criminal behaviour is not direct, but impacted by criminogenic needs (Skeem et al., 2011). For this group it is important to treat both the mental health and criminogenic needs to reduce recidivism. These findings are important to consider in the context of mental health court programming.

Youth Justice Legislation

Mental health courts must not only consider how their programs achieve change, but how to do so while adhering to legislative and constitutional requirements. Canada's youth justice legislation, the Youth Criminal Justice Act (YCJA, 2002), outlines a set of core principles that focus on protecting society through holding youth accountable for their crimes, rehabilitating youth, and preventing crime through community services that address the factors that underlie criminal behaviour. Key aspects of the YCJA relevant to mental health court programming include the need to consider fair and proportionate accountability as well as the diminished moral

blameworthiness of youth compared to their adult counterparts (YCJA, 2002). The Act contains protections to ensure that the consequences youth receive are proportionate to the level of seriousness of the offense and the young person's level of responsibility for his or her actions, and that consequences are similar to that which another youth would receive for the same crime in another jurisdiction (YCJA, 2002). Under the YCJA, youth are also to be provided greater procedural protections of their right to privacy and timely intervention (Bala & Anand, 2012).

Concerns have been raised regarding the protection of legal rights within mental health courts. For instance, mental health courts require an admission of responsibility as a criterion for participation. As such, defendants give up their right to trial and the potential legal protections that accompany that. As a result, concerns have been raised regarding whether mental health court programs are truly voluntary, whether defendants fully understand the court process, and whether plea requirements should be mandatory (Redlich, 2005; Seltzer, 2005). Concerns have also been raised regarding treatment and the potential for increased time spent under the supervision of the court, as well as the need for increased protections for privacy regarding treatment-related information (Seltzer, 2005). These issues have largely been discussed in relation to adult mental health court programs but may be particularly concerning for youth, given the increased vulnerability that stems from their lack of cognitive and social maturity.

Process Evaluations

As noted above, there has been relatively little research exploring the implementation of mental health courts for youth. Research is needed to understand *how* these programs achieve change before their impact can be assessed. Process evaluations provide information regarding program functioning, implementation, and the program components that are responsible for change (Steadman, 2005). They typically include a review of the program model, program

implementation, and target population (Rossi & Devaney, 1997). Data should be gathered from multiple sources, using both qualitative and quantitative procedures (Centers for Disease Control [CDC], 1999). As youth mental health courts continue to develop across Canada, this research is particularly important to inform future program development.

The Current Study

In the current study, we present several aspects of a larger process evaluation of a mental health court for youth in Toronto, Canada. The court sees young people charged with an offense who present with a major mental health problem, including substance use issues, and wish to resolve their charges. The program's goals are to improve access to community treatment services, reduce case processing time, improve general well being, reduce recidivism, and increase community safety. Youth are typically referred to the court through either defence counsel, crown attorneys or judges. Following referral youth undergo a brief screening of their mental health needs and are recommended for acceptance into the program. The defence counsel, crown attorney, and youth mental health worker work together to come up with a treatment plan for the youth within the community. Once the youth has made significant progress in treatment the crown attorney recommends an appropriate disposition (e.g., withdrawal of charge, stayed charge, sentence). For a more detailed description of the court process see chapter three.

The overarching process evaluation was conducted to determine whether the mental health court program has been implemented as intended and *how* the program achieves change. The objectives of the evaluation were to 1) understand and represent the court's *program theory*, 2) explore *program model implementation* within the context of the YCJA, 3) *describe how the court operates* (with a particular focus on whether it is servicing its intended population), 4) examine what *factors predict successful court completion*, and 5) examine *how the court*

addresses the mental health and criminogenic needs of clients. The first two objectives are the focus of the current manuscript; Objectives 3-5 are examined in chapter three (second manuscript).

The first objective of the current paper was to identify and evaluate the mental health court's program theory. This is typically achieved through development of a logic model that provides a visual representation of the program functions and the rationale for expected outcomes (Brouselle & Champagne, 2011). Articulation of a logic model allows for the next step in the evaluation, which is an analysis of how the program theory fits with existing research – in this case, on what is known about best practice for treating justice-involved youth with mental health needs. The second objective was to understand *how* the court model has been implemented and how it adheres to the legislative requirements of the YCJA. To address these objectives, we examined the knowledge, attitudes, and experiences of those involved in the court. If people's 'use' of the court and their interactions with the court are not aligned with the court's purpose or model then the court is not likely to operate as intended or as effectively as it might.

Method

Participants

All youth who completed their court requirements within the body of the court during data collection (approximately one year) were invited for an interview. Of those, 34 adolescent service-users (23 males and 11 females) and 11 parents (4 males and 7 females) chose to participate. The average age of youth was 16.78 ($n = 32$, $SD = .87$) and parents was 51.82 ($SD = 8.39$). The age and gender of participants was in keeping with the overall population of the court found in chapter three. In terms of education level, three parents were high school graduates,

two had some university or college education, five were university or college graduates, and one had post-graduate education.

A total of 30 key informants (i.e., crown attorneys, defence counsel, duty counsel [i.e., a lawyer hired by the government to provide limited legal services to those without legal representation], judges, and treatment providers; 13 males and 17 females) were also interviewed. The majority of participants had postgraduate degree training ($n = 26$); the remaining 13.3% had completed their undergraduate or college training ($n = 4$). In terms of age, 13.3% ($n = 4$) were under 30, 26.7% ($n = 8$) were between 30 and 39, 26.7% ($n = 8$) were between 40 and 49, 26.7% ($n = 8$) were between 50 and 59, and 6.7% ($n = 2$) were over 60.

Materials

Interview protocols. Interview protocols were semi-structured and largely open-ended to allow participants to provide details regarding opinions and experiences that were not the explicit focus of questions. The development of protocols was guided by several sources, including Steadman's (2005) guide to mental health court evaluations, past research (McNiel & Binder, 2010), and the particular needs identified by stakeholders of the mental health court under evaluation. Prior to conducting interviews, key stakeholders reviewed the protocols and recommendations for change were incorporated into the design. The interview protocols were pilot tested and subsequently modified throughout the initial stages of data collection.

Service user (i.e., youth and parent) interview protocols included open-ended questions regarding their decisions for entering the court as well as their thoughts on the helpfulness of the court and treatment programs attended and on the program's weaknesses and areas for improvement. The protocol also included three 5-point Likert scales to assess the helpfulness of

the court and treatment programs, and a set of demographic questions (e.g., age, gender, education). The interview was designed for quick administration and used plain language.

Key informant interview protocols (i.e., for judges, youth mental health court workers, counsel, attorneys, and treatment providers) included questions in seven broad areas: 1) knowledge of the court (i.e., purpose and goals); 2) ratings of the importance of program goals and the degree to which goals had been met (for the latter, participants were asked to provide a rationale); 3) description of the court's population and success in reaching its target population; 4) the court's adherence to legislative requirements; 5) perceived barriers to service, benefits of the court, and areas for improvement; 6) usefulness of treatment and the court's relationship with treatment providers; and 7) demographic information (e.g., age, gender, occupation, education). See Appendix A for service user and key informant protocols.

Procedure

Interviews. Youth and parent participants were recruited by a research assistant who was present on each court date and approached youth to briefly introduce the study and inquire about interest in participating. Voluntary, informed consent was obtained before proceeding with interviews. Interviews were conducted on court premises in a private space near the courtroom. Youth and parent participants received a \$10 gift card as a thank you for participation. Key informants were approached in person, by phone, or by email, to request study involvement. For those who agreed, a time was arranged for an interview at a place of their convenience.

Interview responses were analyzed using thematic analysis (Braun & Clarke, 2006). Transcripts were initially reviewed several times to develop an understanding of the overall data. Data were then reviewed for codes representing interesting or noteworthy features, which were subsequently grouped into major themes. The overall data were reviewed several times to clarify

themes and ensure they properly fit the data. All interview data were coded and organized using NVivo10 qualitative data analysis software (QSR International). Interrater reliability assessing the presence or absence of themes was established for a random subset of 10 parent and youth interviews and 7 key informant interviews. Overall reliability with an independent coder was found to be adequate (Kappa values ranged between .76 and .83).

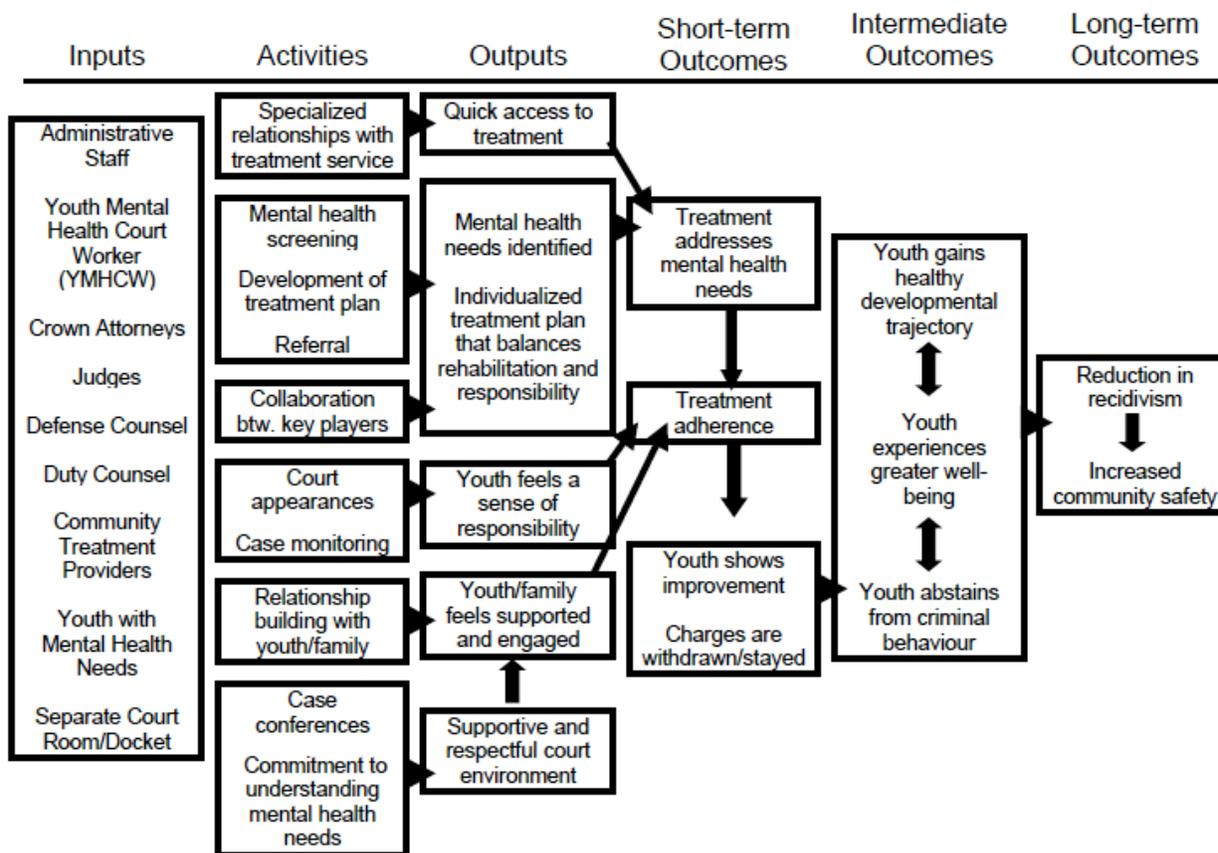
Program Theory Evaluation The program theory evaluation was conducted following Brousselle and Champagne's (2011) logic analysis procedures. The first step involved building a logic model to provide a visual representation of the program's inputs and activities and how these activities are thought to bring about change (W.K. Kellogg Foundation, 2004). Information used in the development of the logic model included documentation on the court program and processes (Ontario Court of Justice [OCJ], 2011), interviews with stakeholders, and observations of the court. Key stakeholders reviewed the logic model and provided feedback on the hypothesized mechanisms of change promoted by the court. The next steps involved reviewing research literature related to the underlying causal mechanisms and using this information to highlight the strengths and weaknesses of the program's model.

Results and Discussion

Program Theory Evaluation

A logic model of the mental health court under evaluation (as it was functioning at the time of the evaluation) is presented in Figure 1. Characteristics of the model, including strengths and weaknesses are highlighted below.

Figure 1. Mental Health Court Logic Model



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

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

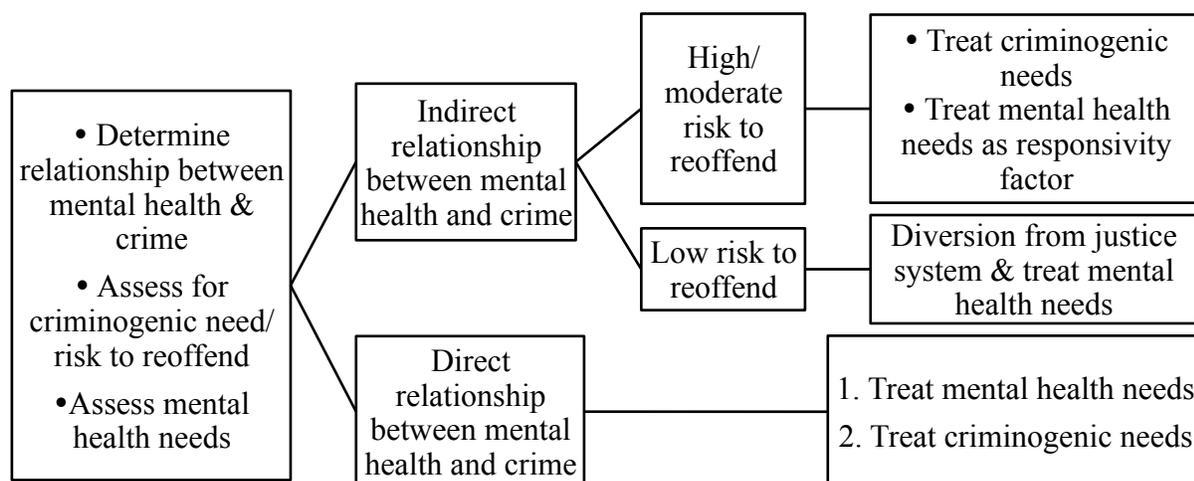
Collaboration. Another important aspect of the logic model is the collaboration between court staff, as well as the mental health interest and expertise amongst these individuals. These findings are in keeping with Thompson, Osher, and Tomasini-Joshi's (2007) essential elements for a successful mental health court program, which include a team that works collaboratively, is able to adapt to a non-traditional court environment, and has a special interest and/or special training in mental health issues. As has been suggested by Thompson et al. (2007), ongoing training in the area of adolescent mental health may be important to bolster the effectiveness of the mental health court team. The collaborative nature of the court provides a less adversarial environment and promotes a focus on treatment as opposed to punishment. Indeed, one of the common themes amongst youth and parents who found the court helpful was the supportive environment and the court's clear focus on helping youth (see below).

Screening and Assessment. Another strength of the model that is in keeping with the literature is the court's use of a standardized, valid, and reliable screening measure to identify mental health needs (Borum, 2003; Grove & Meehl, 1996; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Hills, Shufelt, & Coccozza, 2009; Hoge, 2008). Absent from the mental health court model, however, is widespread screening and a set of formal response policies for screening results (e.g., identifying what is considered clinically meaningful and what steps should be taken based on screening results). Hills et al. (2009) have also called for comprehensive follow up assessments for youth who are accepted into specialized courts in order to better understand each young person's unique strengths and needs and to provide youth with targeted treatment. Successful models in other jurisdictions have implemented empirically supported assessment procedures conducted by either psychiatrists or psychologists (Kahn, O'Donnell, Wernsman, Bushell, & Kavanaugh, 2007). Under the mental health court's model, there are currently not enough resources to conduct thorough assessments. Only select youth are referred for assessments outside of the program and even then there is little uniformity in assessment procedures. A corollary to such in-depth gathering of personal information is the need for clear and well-enforced privacy protocols to protect and limit the amount of mental health assessment information shared within the court.

Treatment and Rehabilitation. The causal mechanism assumed under the mental health court model is that mental health treatment will improve well being *and* reduce recidivism. As has been highlighted above, mental health treatment may be most effective in reducing recidivism for clients whose mental health functioning is directly related to criminal behaviour. In chapter three, it was found that only one in five youth in the mental health court under evaluation had criminal charges that were a direct result of mental health functioning. For most

youth, mental health needs were prominent but not the direct cause of criminal behaviour. When there is not a direct relationship between mental health and criminal behavior, there is little evidence to suggest that solely treating mental health needs will reduce recidivism. For these youth it may be important to also evaluate and address criminogenic needs. A model for evidence-based decision-making can be found in Figure 2. While more research is needed, existing theory and research suggest that it is important in to assess the degree to which the young person's crime is causally linked to his or her mental health issues and that treatment should address both mental health *and* criminogenic need.

Figure 2. Evidence-Based Decision Making Model



With regards to the treatment services that youth receive through the court, there is currently no mechanism in place for selecting and evaluating programs. Guerra, et al. (2008) have highlighted four key components of effective treatment, which may be important to consider within the mental health court. First, treatment programs should be *highly structured* and target individual skills and beliefs. Less structured programs, such as group therapy and general counseling, vary widely in their activities and have been found to be less effective. Second, treatment programs should involve a *cognitive component* that addresses areas such as

anger management, problem solving, perspective taking, and empathy. Third, programs should *engage families* in treatment and seek to reduce family risk factors. Fourth, treatment programs should *address a variety of risk factors* across several contexts. To promote evidence-based practice amongst treatment providers, the mental health court will require clearly articulated treatment plans and a case manager to connect youth to treatment and ensure that treatment does in fact address their needs. Interventions that are informed by valid assessments and adhere to the four principles above are the most likely to be successful.

Program Model Implementation

The following section explores program model implementation with regards to program satisfaction, understanding of the court, target population selection, goal achievement, and how the model adheres to legislative principles (e.g., related to civil liberties and due process).

Program Satisfaction. Program satisfaction of service users is important for understanding whether the program's model has been implemented in a way that meets the needs of the target population. Youth and parents rated their degree of satisfaction with the court and treatment providers on a 5-point Likert scale from 1 (not at all helpful) to 5 (very helpful; see Appendix A). Results indicate that the majority of participants (78.5%, $n = 33$) found the court somewhat or very helpful, while 14.3% ($n = 6$) found the court neither helpful nor unhelpful and 7.2% ($n = 3$) found it not at all helpful or somewhat unhelpful. Nearly all interviewees (94.8%, $n = 37$) found the treatment services to be either somewhat or very helpful, while 5.1% ($n = 2$) indicated they found it neither helpful nor unhelpful. These findings suggest that the majority of youth and parents found the services helpful. Qualitative findings from key informants, youth, and parents discussed below help to shed light on these ratings, including possible reasons for dissatisfaction.

Understanding of the Court. Key informants were asked about their understanding of the mental health court and its goals. Participants identified that the primary goals of the court were to address underlying or mental health issues, link youth with treatment services, and reduce recidivism. Interviewees highlighted the court process as an alternative to the regular court system, noting its problem solving nature, the respectful environment, and/or the more holistic approach. These responses were generally in keeping with the program's stated goals, particularly with regards to improving access to treatment, improving well being, and reducing recidivism (OCJ, 2011). Although not a stated goal of the program, participants picked up on the focus of the court, including its problem-solving nature and sensitivity to youth and their needs. In addition, many participants focused on the positive legal outcomes for youth (i.e., having charges dropped or withdrawn), which is not stated as one of the court's goals but provides insight into possible reasons for referring youth to the court.

Target population. Key informants described a wide range of mental health needs amongst youth who participated in the court. When asked about the court's ability to reach its target population, participants discussed the possibility of missing youth in the regular court stream for legal reasons. For instance, if the youth's charges are serious it may be more beneficial to contest them, an option not available in this resolution court. Participants also noted that youth might not participate due to the stigma surrounding mental health problems. Importantly, participants also indicated that some mental health needs amongst youth might be difficult to detect (e.g., Fetal Alcohol Spectrum Disorder). With regards to the latter point, it was highlighted that it is primarily up to legal professionals (most of whom are not trained in screening for mental health needs) to identify these issues. Best practice guidelines call for

system-wide screening to identify youth with mental health needs in order to provide them with proper services (Grisso & Underwood, 2004; Skowrya & Coccozza, 2007).

Access to Treatment. Key informants were asked to rate on a 5-point Likert scale the degree of importance of each of the mental health court's goals (from 1-not at all important to 5-very important) and the degree to which the court had met each goal (from 1-has not met to 5-completely achieved). When asked about access to treatment, key informants indicated that this was a very important goal ($M = 4.90$, $SD = .40$) and were generally confident that this goal had been met ($M = 3.89$, $SD = .80$). Participants noted that access to treatment had been greatly improved due to the youth mental health court worker's role in coordinating services. Youth and parents also discussed being linked to services or being provided resources that they otherwise would not have received, suggesting that the court has made progress in connecting youth with treatment services. While participants believed that access to treatment was greatly improved, one of the most widespread themes across interviews was the lack of mental health services available in the community. Participants spoke about the lack of residential services, psychologists, and psychiatrists, as well as long waitlists and the need for more mental health supports within the court. These findings are in keeping with Odgers, Burnette, Chauhan, Moretti, and Repucci's (2002) call for policy-level changes focusing on the implementation of evidence-based treatment programs for justice-involved youth in the community.

Rehabilitation. According to the mental health court's stated goals, rehabilitation is sought through improved youth well-being, as well as a reduction in recidivism and improved community safety. With regards to the mental health court's goal to improve youth well-being, key informants reported that this goal was of importance to them ($M = 4.33$, $SD = .96$) and that the court was relatively successful in meeting this goal ($M = 3.79$, $SD .92$). The widespread

consensus was that improved well-being was due to the youth's positive legal outcome, the involvement of parents, the positive court experience (i.e., that youth felt treated differently or that the court cared about them), and the connection to treatment services. These responses were in keeping with those from youth and parents, who described the court as being superior to their experiences in other youth courts and discussed the importance of receiving a positive legal outcome. Youth and parents specifically highlighted that in comparison to typical courts the mental health court was less intimidating, more focused on success, provided young people the opportunity to share their story, and was more focused on parent involvement. For example, one youth reported, "*they look at who you are, not just what you did*". Another parent reported, "*someone finally cared about us as people...the court encouraged and acknowledged his hard work. The judge said 'I believe in you' and congratulated him*". These findings suggest that the court has successfully been able to produce an environment of understanding, support, and respect.

Similarly, participants noted that they found members of the mental health court team helpful and enjoyed working with them. Youth and parents also highlighted the importance of collaboration, noting their experience of being involved in treatment planning and being updated on the youth's progress. Others highlighted the collaboration between members of the mental health court team and the importance of working together for youths' best interests. These results are in keeping with the program's logic model, which highlighted the positive relationships and engagement of families as important factors in engaging youth in the court process.

Key informants also believed that reduction in recidivism ($M = 4.57, SD = .77$) and an increase in community safety ($M = 4.10, SD = 1.09$) were important goals, but only moderately achieved by the court ($M = 3.44, SD = .87$; $M = 3.68, SD = .90$). It is important to note that the

majority of participants reported that they did not have enough knowledge to be able to determine the court's impact with respect to these goals. Participants assumed that by addressing the underlying factors that brought the youth to court there would be a reduction in recidivism and improved community safety. Youth talked about how the treatment program helped them make important life changes (e.g., getting their life on track, a reduction in mental health symptoms, improvements in their own lives and in their relationships). The latter finding highlights the importance of treatment services within the mental health court and suggests that at least a handful of youth thought that these services helped redirect them onto a healthy developmental trajectory.

Others, however, expressed concern that the treatment received may not be enough to reduce criminal behaviour. Youth and parents discussed the desire for increased or better supports. For instance, youth sometimes reported that the treatment services did not actually help with their problems and parents spoke about the need for more treatment or treatment that addressed issues related to the youth's court involvement. The need for treatment that addresses criminogenic factors was also prevalent amongst key informants, a perspective that is consistent with current research (Skeem et al., 2011) on mental health and criminal justice involvement.

Additional concerns were raised by key informants regarding the lack of treatment engagement from youth, indicating that youth may not have the appropriate supports, should have more input into their treatment plan, and should be given more incentives to complete treatment. Youth and parents also discussed difficulties in managing treatment expectations. For instance, youth noted the stress of managing multiple systems or being forced into programs they did not want, and parents discussed the large investment required by families. Treatment providers called for more accountability on the part of youth and more structure from the court in

promoting meaningful youth participation, noting problems with treatment attendance. Seltzer (2005) has suggested that when treatment compliance becomes an issue it may be important to revisit the treatment plan. Additional support in the form of case management may be further required to assist youth in attending and engaging in treatment. This is in keeping with findings above which suggested the need for more in-depth assessment of youth and increased communication and follow up with treatment providers.

Adherence to Legislation. Key informants were also asked about how the mental health court adheres to important rights and protections in Canada's youth justice legislation.

Right to counsel. With regards to protecting the right to counsel, interviewees noted that a dedicated duty counsel is assigned to the court to assist youth who are not represented by their own lawyer and that youth who qualify for legal aid are appointed private counsel to represent them. It is important to note that there was some concern amongst participants that the presence of duty counsel has led to a reduction in the number of youth who retain their own lawyer and that duty counsel may not provide the type of in depth legal representation necessary in a mental health court. Similar concerns have been raised in the literature, which highlights the particular need for defence counsel to properly inform mental health court clients of the risk of waiving their right to trial, and to protect clients' privacy and due process rights (Seltzer, 2005).

Right to consent to treatment. Key informants noted that youth have the freedom to choose whether they participate in the mental health court and associated treatment services. In addition, it was noted that youth have access to counsel who explain the process and advise them of their rights. Although mental health courts are considered voluntary, the degree to which defendants fully comprehend what is involved in participation has been questioned (Redlich, 2005). Parents generally articulated a greater understanding of the court than young people.

Youth in the current study expressed a lack of knowledge regarding the mental health court and often appeared not to understand the purpose of the court. For instance, when asked about why they chose to go through the mental health court, 60% ($n = 27$) of interviewees recalled not having a choice and indicated that no one had explained the court, that they did not know it was different from a regular court, or described the court as merely an easier way to get their charges dropped. These results are consistent with findings that justice-involved youth in general struggle to understand aspects of the legal system, and with calls for increased protection to ensure information is communicated in a developmentally appropriate manner (Peterson-Badali, Abramovitch, Koegl, & Ruck, 1999).

Interestingly, research reveals that despite not reporting a choice in participating, many mental health court defendants do not find their court involvement to be coercive (O'Keefe, 2006; Poythress, Petrila, McGaha, & Boothroyd, 2002). Others have argued that having to make difficult choices about participation does not equate to coercion (Stefan & Winick, 2005) and that the mere option to participate in a mental health court is a benefit to defendants (Schneider et al., 2007). While it remains unclear the degree to which youth in the current study felt "coerced" into participation, further protections may be needed to ensure that youth understand the court process and their options through developmentally appropriate communication at every step of the legal proceedings.

Privacy. When asked about the right to privacy, there was a consensus amongst key informants that the court adheres to the requirements outlined in the YCJA. Some highlighted additional measures taken to protect privacy, such as not discussing mental health problems in the body of the court in order to reduce the amount of information stated on public record, which is in keeping with other mental health court programs (Bernstein & Seltzer, 2003). Concerns

have been raised in the literature regarding the use of treatment information within mental health courts (Seltzer, 2005). Indeed, participants in the current study indicated that youth were required to give up a certain amount of privacy due to the nature of the court (i.e., sharing information about mental health and treatment) and youth and parents expressed concerns over having to share mental health information with the entire courtroom. To address these issues, key informants suggested having formal measures in place to protect mental health information and to reduce the number of unnecessary individuals in the court. This is in keeping with Seltzer's (2005) call for rules that limit information spoken on record, the use of case conferencing to discuss sensitive information off record, and the use of defence counsel to protect privacy.

Length, severity, and intrusiveness of dispositions. The length, severity, and intrusiveness of dispositions imposed for youth is important from the perspective of youth justice legislation. A reduction in case processing time was also one of the stated goals of the court. Participants indicated that reducing case processing time was only moderately important ($M = 3.63$, $SD = 1.45$) and they were unsure whether this goal had been met ($M = 3.00$, $SD = 1.23$). They reported that certain aspects of the court that were faster than the typical youth court system but that other aspects were slower, resulting in an overall case processing time that was relatively similar. These perceptions are consistent with youth court statistics from chapter three, which indicate that case processing in the mental health court is similar to that in the regular system. Aspects that were thought to make the court faster included case management (i.e., linking youth with treatment, monitoring treatment progress) and the work done by team members between court dates (i.e., meetings to discuss progress and next steps). Participants also indicated that the initial processing time was much faster. That is, once referred, youth were assigned a court date and linked to treatment more quickly than in the regular system.

Aspects that were identified as lengthening court processing included issues related to treatment (e.g., waitlists) and the time it took for youth to stabilize or complete treatment. Those who rated case processing as one of the least important goals suggested that it is more important to properly treat youth to reduce court involvement in the future. Youth and parents reported concerns over the length of their court involvement and how the court had interrupted their lives. They expressed concern about having to miss work and school to be at court and many thought the process could be shortened. These findings are in keeping with concerns raised with regards to the potential for mental health court defendants to spend longer under the supervision of the court due to treatment (Seltzer, 2005).

With regards to the severity and intrusiveness of dispositions compared to those in regular youth court, participants noted that dispositions themselves tend to be more lenient, but that the requirements *within* the disposition could be more intrusive. For instance, young people were expected to complete treatment programs that were more intensive and emotionally involved than would be the case for dispositions they might have received in the regular youth court (e.g., community service). Other participants noted that the severity and intrusiveness of dispositions was similar to that in the regular youth court but that in the mental health court it was front loaded, meaning that youth completed their requirements before, rather than after, the judge decided on a disposition. Importantly, the more intrusive treatment component was frequently mentioned as a beneficial trade off for youth to receive a less serious sanction. While rehabilitation is an important goal, Seltzer (2005) has cautioned that this approach may lead to increased time within the justice system. Both rehabilitation and timely intervention are important facets of the YCJA. As such it is the court's responsibility to balance both and ensure

that youth are not spending undue time within the court system for their mental health needs. Clearly articulated procedures and guidelines may be required to ensure this does not occur.

Diminished moral blameworthiness, accountability, and responsibility. Participants indicated that the principle of diminished moral blameworthiness was largely upheld by the court's use of diversion for cases that would not normally be diverted, and through consideration of underlying mental health needs impacting criminal behaviour. In addition, participants noted that legal professionals, such as lawyers and judges, were well versed in this area and seek to ensure that this aspect is protected for youth clients. Key informants were also asked about how the court holds youth accountable through measures that are proportionate to the seriousness of the offense and the youth's degree of responsibility for the offence. Participants noted that these aspects were considered in the same manner that they are in a regular youth court and that legal professionals are committed to protecting these principles. For instance, the crown considered each youth individually and weighed the seriousness of the offense in deciding to divert or withdraw a case. In addition, youth were thought to take responsibility for their actions through their engagement in treatment, which was thought to reflect both the seriousness of the offense and the mental health needs of the youth. Thus, it appears that similar processes are used in the mental health court and regular stream. Nevertheless, increased caution should be used to ensure that dispositions are not entirely based on treatment needs, which may result in further penetration into the criminal justice system.

Barriers and Improvements. Several themes emerged in participants' discussion of barriers to the court's success and suggestions for improvement. Participants highlighted, for instance, the lack of resources available to the court itself, which has made it difficult to employ consistent, dedicated court staff (e.g., judges, crowns, duty counsel, defence lawyers, and the

youth mental health court worker). Moreover, many participants requested more court dates and more time for judicial pre-trials and case conferencing. Lack of knowledge of the mental health court amongst youth, families, lawyers, and treatment providers was consistently identified as a barrier to reaching the target population. In the same vein, many participants called for additional education for families, legal professionals, and treatment professionals regarding the intersection between mental health and criminal behaviour. The latter themes suggest the need for formal dissemination of information about the court, as well as training for those involved in the court.

Youth and parents consistently discussed concerns over start time delays as well as lack of organization within the court, noting problems with crowding, no system for the order in which youth are called in front of the judge, and a lack of signage. These findings suggest simple changes that can help to reduce confusion and wait times for youth and their families. It is important to note that there were a subsample of participants who felt the process was efficient and ran smoothly, highlighting, perhaps the inconsistencies of the court and the need for standardization to help improve overall organization and timing.

Limitations and Future Research

There are several important limitations of the current research that should be considered when interpreting results. Only youth who completed their court requirements and parents present at court could be accessed for interviews. The findings, thus, do not include the perspectives of those who did not complete the court, which may have been particularly helpful for identifying issues related to non-completion, and may not be entirely generalizable to parents who are less involved with their child's court proceedings. Similar issues arose with regards to key informant interviews. Those that volunteered to participate in the study may have a particularly vested interest in the court. In addition, the generalizability of the logic model results

are limited to the court under evaluation, as many jurisdictions operate through different mechanisms. Nevertheless, the results provide important information regarding lessons learned and may be useful for developing future mental health court models or adapting existing models.

In terms of future research, ongoing evaluation efforts will be important to ensure that the program adheres to the logic model and to assess implementation of changes. Feedback from service users and key informants may also be useful for monitoring the program and identifying areas for improvement. The next step in the research is to begin to assess the impact that the court has had in achieving its goals related to recidivism and well being.

Conclusion

The results of the current study provide important insights into the functioning of the mental health court under evaluation in terms of strengths of the program and areas for continued growth. A common theme across the program theory evaluation and youth and key informant interviews was the success of the program in developing a supportive and understanding environment for youth and their families. This environment reflects the collaboration between the mental health court team members and promotes engagement from youth and families. Similarly, the focus on developing positive relationships with youth was found to be a strength of the logic model and was also acknowledged by youth and their families. Results also revealed general success in linking youth with treatment services—something that youth reported was one of the more helpful aspects of the court.

In addition to these strengths, several areas for improvement also emerged. In both the program theory evaluation and interviews, there was a common theme calling for more formalized and comprehensive treatment to address multiple areas of need (i.e., mental health and criminogenic needs) experienced by youth. Incorporating aspects of evidence-based practice,

including standardized screening as well as comprehensive assessment and treatment should lead to better overall outcomes for youth (i.e., higher rates of desistance from crime). Continued research will be important for ongoing evaluation of the program and to ensure that the program is meeting the needs of justice-involved youth with mental health needs.

Chapter 3

Mental Health Court Operations, Target Population, and Treatment

Abstract

Mental health courts have been introduced across North America to help address the mental health needs of justice-involved populations. Such courts have been established in the adult system for well over a decade and research has begun to document the effectiveness of these programs for adult populations. In contrast, mental health courts are a relatively new phenomenon in the youth court system and little empirical knowledge has been established regarding their implementation and functioning. The current study is part of a larger process evaluation of a mental health court for youth in Toronto, Canada. Findings from the current study document the population of youth served through the court, predictors of program completion, as well as details regarding the operations of the court. Results also outline how the court addresses the mental health and criminogenic needs of youth participants. Findings are discussed with regards to best practice and empirical knowledge for treating justice-involved youth with mental health needs.

Introduction

Mental health courts are a type of problem-solving court that have been introduced across North America to help address the mental health needs of justice-involved populations (Schneider, Bloom, & Hereema, 2007). The goal of such courts is to divert accused persons with mental illness out of the criminal justice system and into community treatment while upholding public safety (Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011). The key difference from the traditional court system is that mental health courts seek to provide a more collaborative and less adversarial environment (Schneider et al., 2007). Mental health courts originated in the United States and were first introduced to Canada in 1998 (Slinger & Roesch, 2010). With their apparent success, they have recently been adapted for youth. In 2008 Canada opened its first mental health court for youth in Ottawa, Ontario (Perkins-McVey, McCormick, Leger, Bretton, & Motayne, 2009). Since that time, similar programs have been implemented across Ontario, yet little is known about their operations and impact. The current study is part of a larger process evaluation assessing a mental health court for youth in Toronto, Canada. The goals of the larger study are to evaluate the program from an empirical perspective on treating justice-involved youth with mental health needs. The current paper examines the court's operations, predictors of program completion, and how mental health and criminogenic needs are addressed.

Youth Justice Legislation

In Canada, youth mental health court programs must adhere to the legislative requirements of the Youth Criminal Justice Act (YCJA). According to the declaration of principle, the overall purpose of the youth criminal justice system is to protect the public by holding youth accountable, promoting rehabilitation, and preventing crime by referring youth to services in the community that address the underlying causes of criminal behaviour (2002, s.

3[1][a]). In addition to these overarching principles, youth mental health court programs – like traditional youth courts – must adhere to the principle of diminished moral blameworthiness and must hold youth accountable in a way that is consistent with their reduced maturity (YCJA, 2002 s. 3[1][b]). Youth should be provided greater procedural protections of their rights, including their right to privacy and timely intervention that is in keeping with the “rapid development and perception of time of adolescents” (Bala & Anand, 2012, p. 109). Finally, sentencing must be in keeping with the seriousness of the offence and the young person’s responsibility for the offence and must be similar to the sentences imposed on other young people found guilty of the same offence under similar circumstances (YCJA, 2002 sec. 38[2]).

While there has been limited research on how youth mental health courts in Canada adhere to the principles of the YCJA, concerns have been raised that mental health courts in general may interfere with due process rights and principles of proportionality. Concerns include the voluntariness of participation, access to counsel, mandatory plea requirements, the length of judicial supervision, privacy, and the possible reduction in mental health services available to the general public (Hereema, 2005; Redlich, 2005; Seltzer, 2005; Stefan & Winick, 2005). These issues are particularly important to consider in youth mental health court programs given the increased vulnerability of young people relative to adults. As such, findings from the current study will be discussed in relation to the YCJA.

Mental Health Court Research

Given the recent adaptation of mental health courts for young people, there has been relatively little empirical research conducted in this area. A published dissertation exploring preliminary outcomes of an American youth mental health court reported a significant decrease in participants’ mean criminal offenses from pre- to post-court involvement (Behnken, 2008).

Similarly, a quasi-experimental study of a youth drug court (comparable to mental health courts) revealed that youths in the drug court sample were less likely than the comparison group to reoffend (Rodriguez & Webb, 2004). Despite this reduction, the drug court sample was more likely to test positive for drug use at follow up, suggesting the need to further explore program completion and extralegal variables (e.g., school and family functioning) that may have influenced outcomes.

Given the paucity of research on youth mental health courts, the adult literature may provide useful direction. A study examining treatment referrals found an increase in treatment service usage amongst mental health court defendants compared to defendants in the traditional court system (Boothroyd, Poythress, McGaha, & Petrila 2003). At follow-up, however, there were no group differences in changes in mental health functioning (Boothroyd, Mercado Poythress, Christy, & Petrila 2005). Such findings highlight the difficulties that arise in not only evaluating mental health courts but in implementing such programs, as improvements in functioning are largely dependent on the availability and effectiveness of treatment programs.

Researchers exploring the impact of mental health courts on recidivism have found more positive results. For instance, researchers have found that mental health court defendants are able to remain crime free for longer than their non-mental health court counterparts (McNiel & Binder, 2007). Even when controlling for jail days prior to the study, mental health court defendants had significantly lower arrest rates and fewer jail days than the comparison group at follow-up (Frailing, 2010; Steadman et al., 2011). Importantly, it has been consistently found that mental health court defendants who complete their court requirements reoffend less (Dirks-Linhorst & Linhorst, 2012; Moore & Hiday, 2006) and remain crime free for longer (McNiel & Binder, 2007) than those who do not complete their requirements. A meta-analysis examining

the relationship between mental health court processing and recidivism reported an overall effect size of -0.54, suggesting that mental health courts may be moderately effective in reducing re-arrest rates (Sarteschi, Vaughn, & Kim 2011). Frailing (2010) has highlighted the non-adversarial approach of the court and program engagement as factors contributing to program success. Taken together, these findings suggest that mental health courts may be a promising treatment option for justice-involved youth with mental health needs.

Risk to Reoffend

While the research highlighted above provides important insight regarding the success of mental health courts in reducing recidivism, little is known about how these outcomes are achieved. It is important to consider, more broadly, the theoretical and empirical evidence for offender rehabilitation. In the offender rehabilitation research literature, strong and direct predictors of recidivism (termed ‘criminogenic needs’) have been established and are important to address as part of rehabilitation (Andrews & Bonta, 2010; Andrews, Bonta, & Hoge, 1990; Hollin & Palmer, 2003; Schlager & Pacheco, 2011; Simourd, 2004). These variables are a critical aspect of the Risk-Need-Responsivity (RNR) framework, a theoretically-grounded and empirically-supported model that posits that offenders with the highest level of risk should receive the most intensive treatment (Risk Principle), that treatment should address an offender’s criminogenic needs (Need Principle), and that treatment should be matched to the learning style and ability of the offender (Responsivity Principle; Andrews et al., 1990). In the model, several identified criminogenic needs are also features or aspects of mental health diagnoses (e.g., impulsivity, anger and aggression, antisociality, and substance use problems). However, research has shown that psychopathology more broadly defined, while associated with criminal behaviour, does not predict recidivism (Bonta, Law, & Hanson, 1998). Mental health needs (e.g.,

symptoms of mood and/or anxiety disorder) may be better conceptualized as responsivity factors that influence an individual's ability to engage in the treatment of criminogenic factors (Bonta, 1995).

Others have highlighted the importance of understanding the relationship between mental health needs and criminal behaviour, suggesting that for a minority of offenders there is in fact a direct relationship (Skeem, Manchak, and Peterson, 2011). In a direct relationship criminal behaviour is caused by mental illness and is best treated through mental health intervention. For the majority of offenders, however, the relationship between mental illness and criminal behaviour is indirect and mediated by a third variable (i.e., criminogenic needs) that impacts risk to reoffend. Where there is an indirect relationship between mental health and criminal behaviour, it is important that treatment consider *both* criminogenic and mental health needs. Together these models highlight several important features (i.e., criminogenic need, the relationship between mental health and criminal behaviour) to be considered amongst mental health courts and associated research.

The Current Study

The current study is part of a larger process evaluation exploring a youth mental health court established in 2011 in Toronto, Canada. The mental health court under evaluation is a resolution court for young people charged with an offence who present with a significant mental health concern (e.g., mood disorder, anxiety disorder, schizophrenia, developmental disorder) or substance use problem (Ontario Court of Justice [OCJ], 2011). The goals of the program are to improve access to community treatment services, reduce case processing time, improve general well being, reduce the likelihood of re-offence, and increase community safety.

A process evaluation, which examines program implementation and *how* a program facilitates change (Rossi & Freeman, 1993), was an appropriate starting point for the current study given the lack of research on youth mental health courts and the court's early stages of implementation. The objectives of the overarching evaluation were to 1) understand and represent the court's *program theory*, 2) explore *program model implementation* within the context of the YCJA, 3) *describe how the court operates* (with a particular focus on whether it is servicing its intended population), 4) examine what *factors predict successful court completion*, and 5) examine *how the court addresses the mental health and criminogenic needs of its clients*. The last three objectives are the focus of the current paper; Objectives 1-2 are examined in chapter two.

Study Objectives. For a comprehensive and systematic mental health court evaluation, Steadman (2005, p. 3) recommends collecting data on services received and participant characteristics to help answer the key question: “what works, for whom, and under what circumstances?” Accordingly, the first set of objectives aimed to *describe the operations of the court*, including basic court processes (e.g., frequency of sessions, number and type of staff involved), case processing (e.g., admission criteria, length of time between significant court dates, number of court appearances), and treatment services accessed by youth. The second set of objectives focused on *describing the young people seen in the court*, including participant characteristics (e.g., age, sex, mental health needs, criminal history, and treatment motivation), differences in the characteristics of youth who completed the program and those who did not, and sample characteristics that predict successful completion of the program.

Finally, a critical facet of the youth mental health court that requires exploration from a process perspective (and that should be undertaken prior to an evaluation of outcomes) is *how*

the court addresses both the mental health and criminogenic needs of youth. In the present study, we examined the extent to which youths' treatment referrals matched their identified mental health needs as well as the broad areas of criminogenic need identified in the literature: history of criminal conduct, difficulties in family functioning, school or employment problems, criminal peer affiliations, alcohol or drug problems, poor use of leisure time, personality and behavior, and antisocial attitudes and orientation (Hoge & Andrews, 2002).

Method

Participants

Of the 184 young people who participated in the mental health court from its inception in June 2011 until August 2013, information from 127 youth (90 males and 37 females) was collected, representing all youths for whom a file was opened and closed. Youths not included in the study had either not completed their court requirements at the time that data collection ceased ($n = 27$) or had not participated substantially in the program and, thus, a file was not opened (e.g., a young person was placed in the court but transferred out before a file could be opened, $n = 15$). The average age of participants was 16.35 ($SD = 1.78$, range= 12-19). Further details regarding participant characteristics are reported in the results section.

Materials

Government database. Information regarding participants' prior offences (date and type) was obtained through a government database that details charge information on all young people in the province of Ontario who received a formal sanction through the criminal justice system.

Court files. Court dockets and case files are used to track cases across the system. Information gathered from court files for the current study included details of court operations (i.e., number of court dates, staff/personnel resources), as well as information pertaining to

participants' charges and case processing time (i.e., number and type of court appearances, dates of court appearances, and dispositions). All files are maintained by court administrative staff, who document court appearances and decisions made on those appearances. Of note, youths who appeared on the court dockets had an average of 2.27 cases ($SD = 2.05$, $n = 177$, range = 1-12). A total of 401 cases were identified in relation to the youth mental health court. Of these, 362 should have been closed for review, but only 271 (74.86%) could be located. Every attempt was made to locate the missing cases; court staff indicated that they had likely been misfiled.

Client files. Client files are compiled by the youth mental health court worker and include a program intake form, case notes, and correspondence with treatment providers for each young person accepted in the mental health court. A data collection form was developed (see Appendix B) for the current study to standardize the information gathered from files in six key areas: 1) demographics; 2) court processing (e.g., parent involvement, referral information, contact dates, number of appearances, criminal charges); 3) mental health functioning (e.g., previous diagnoses, mental health screening scores); 4) treatment motivation; 5) treatment referral; and 6) program completion (i.e., date completed, court decision, degree of program completion). Treatment motivation was assessed at the beginning and end of service on an 11-point Likert scale that ranged from 0 (completely unmotivated) to 10 (completely motivated). When making an assessment of motivation, the youth mental health court worker was asked to reflect on the young person's willingness to participate in the court, develop a treatment plan, and attend services. The data collection form also included a rating of the young person's degree of treatment and overall court completion: completed all, most, some, or none of the requirements.

The youth mental health court worker collected data on participant mental health needs upon program entrance using the Massachusetts Youth Screening Instrument-Second Version

(MAYSI-2, Grisso & Barnum, 2001). The MAYSI-2 is a youth self-report measure designed to screen for signs of mental or emotional disturbance among youth aged 12-17 involved with the criminal justice system. The measure consists of 52 items to which youth indicate the presence or absence of various symptoms on seven subscales: alcohol/drug use, angry-irritable, depressed-anxious, somatic complaints, suicide ideation, thought disturbance and traumatic experience. Youth are categorized into the non-clinical range, the “caution” range (scored higher than two-thirds of justice-involved youth), or the “warning range” (scored in the top 5-15% of justice-involved youth; Grisso & Barnum, 2001).

Overall, the MAYSI-2 is considered a reliable and valid screening measure (Archer, Simonds-Bisbee, Spiegel, Handel, & Elkins, 2010). The test manual reports adequate to strong internal consistency ($r=.61-.86$) for all subscales except the traumatic experiences subscale ($r=.51$; Grisso & Barnum, 2001). Test-retest reliability coefficients range from .53 to .89 (Grisso & Barnum, 2001). Concurrent validity, described as adequate (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001), was established through correlations between MAYSI-2 scores and scores on the Millon Adolescent Clinical Inventory (MACI; Millon, 1993) and the Youth Self Report (YSR; Achenbach, 1991).

Procedure

A member of the research team reviewed court files and dockets and entered de-identified information into a secure electronic database. Client files were reviewed by the youth mental health court worker, who completed the data collection form. De-identified data from the forms were entered into a secure electronic database and hard copies of the form were transferred to secure storage.

Results

Description of Court Operations

Staff. The youth mental health court sat, on average, twice a month and was consistently staffed by a judge, a crown attorney, a youth mental health court worker, duty counsel, and administrative staff (i.e., a court reporter and courtroom clerk). A single judge staffed a significant proportion of court dates (39.22%, $n = 20$), with the remaining days being staffed from a pool of five judges. The crown, youth mental health court worker, and duty counsel roles are specifically dedicated to the mental health court and only change when there is a change in personnel. Administrative staff vary but are selected from a core set of administrative staff at the courthouse. Youth who were not represented by duty counsel were represented by defence lawyers they retained (and paid for through legal aid or privately). Below is a description of the youth court process from beginning to end.

Referrals. Youths were referred to the mental health court through a variety of sources including: duty counsel (41.60%, $n = 52$), defence lawyers (26.40%, $n = 33$), crown attorneys (15.20%, $n = 19$), bail program (5.60%, $n = 7$), probation officers (4.80%, $n = 6$), judges (2.40%, $n = 3$), and others (e.g., doctors or other court workers; 4.00%, $n = 5$). Prior to being transferred to the mental health court, cases appeared in the regular youth court on average 5.14 times ($SD = 3.45$, $n = 209$, range = 2-15), which took 78.47 days on average ($SD = 80.30$, $n = 209$, range = 1-394). Despite the time it took to be transferred in, once youth were referred it took just over a week ($M = 9.04$ days, $SD = 20.46$, range = 0-151, $n = 110$) for them to be seen by the youth mental health court worker.

Upon referral, the youth mental health court worker conducted a screening that involved the completion of a standard intake form and a brief assessment of mental health needs using the MAYSI-2. Based on screening results, the youth mental health court worker made a

recommendation regarding the young person's suitability for the program as indicated by the presence of significant mental health or substance use concerns that contributed to, or were a complicating factor in, the young person's charges (OCJ, 2011). Following screening, cases were referred to the crown attorney, who further reviewed the case to determine eligibility and whether the youth was suitable for diversion or sentencing based on the seriousness of the offence, the youth's degree of participation, victim impact, and the proposed treatment plan.

According to the program design, once a young person had completed intake and was accepted into the program, he or she was to be assigned a court date (OCJ, 2011). In practice, almost a quarter of youths (22.52%, $n = 25$) had their court date on or before an intake appointment, indicating that they were not formally screened prior to court contact. It took, on average, almost a month (28.97 days) between the date of referral and first court appearance ($SD = 25.27$, range = 0-116, $n = 109$). Based on screening results, the youth mental health court worker developed a treatment plan that linked the young person with appropriate services in the community. Treatment plans were designed to address mental health needs as well as the need for community safety and to hold the youth accountable (OCJ, 2011). Treatment plans were devised shortly after program acceptance to expedite the court process and quickly link the young person with treatment. It took, on average, approximately one month to connect youths requiring a new referral with a treatment provider ($M = 1.07$ months, $SD = 1.67$ months, range = 0-6, $n = 47$).

Treatment services. In terms of treatment services, 49 agencies received referrals for or provided services to young people. Youth were referred to an average of 1.48 unique treatment services ($SD = 0.58$, range = 1-3, $n = 118$) and attended an average of 1.29 different services ($SD = 0.64$, range = 0-3, $n = 103$). Approximately half (49.69%, $n = 79$) of treatment referrals were to

new agencies, while the remaining 50.31% ($n = 80$) were to agencies to which young people were already connected. The types and frequency of referrals are outlined in Table 1.

Table 1. *Frequency of Youth Mental Health Court Treatment Referrals*

Referral	%	<i>N</i>
Intensive Mental Health Treatment	22.28	39
Counselling	32.00	56
Social Support (i.e., family, community)	4.57	8
Educational	4.00	7
Anger and Aggression	6.28	11
Substance Use	16.00	28
Assessments	10.85	19
Developmental Disability	0.57	1
Other	3.43	6

* Note that percentage indicates the percentage of total referrals made.

Case monitoring. As youth progressed through treatment, the youth mental health court worker monitored the case and provided regular updates to the crown attorney and legal counsel. During this process, youth were scheduled to return to court at various points for case monitoring. The average number of court appearances for youths who completed their court requirements was 3.43 ($SD = 2.21$, range = 0-11, $n = 102$). Once youths had completed treatment or made significant progress, the crown attorney reviewed the case to determine an appropriate disposition. On average, youths were in treatment for 3.10 months ($SD = 2.00$ months, range = 0-10, $n = 49$) prior to their final court appearance. Where young people made significant progress, the crown considered a more favourable outcome in keeping with the severity of the charge (e.g.,

withdrawing or staying the charge). Youth who did not make significant progress were still eligible to have their cases dealt with through the mental health court but received a less favourable outcome (e.g., probation disposition). Specifically, 85.58% ($n = 89$) of youth had their charges withdrawn, while 2.88% received a discharge ($n = 3$), 2.88% ($n = 3$) had their charges stayed, and 8.65% ($n = 9$) were sentenced to probation. According to the youth mental health court worker's ratings of treatment program completion 78.85% ($n = 82$) of youths completed all or most program requirements, 20.19% ($n = 21$) completed some program requirements, and 0.96% ($n = 1$) did not complete treatment.

Case processing. The average length of case processing from first court date (regardless of court stream) to disposition in the mental health court was 168.18 days ($SD = 102.90$, range = 2-493, $n = 171$). This number excludes the cases that had been seen in the regular youth court system for extended periods of time *prior* to the opening of the mental health court. Case processing from first mental health court date was also calculated to determine the amount of time spent within the actual mental health court. The average time from first youth mental health court date until completion was 90.47 days ($SD = 68.48$, range = 0-266, $n = 171$).

Non-Completion. For youth who did not complete their mental health court requirements, the most common reason was unwillingness to participate in, or comply with, treatment (65.22% $n = 15$). The remaining cases were transferred back into the regular stream either because the youth mental health court worker recommended that participants were unsuitable for the mental health court (13.04%, $n = 3$), the youth's lawyer directed his or her client away from the court (13.04%, $n = 3$), or the youth was transferred to another courthouse (8.70%, $n = 2$). For cases that were transferred out of the mental health court, the average

number of appearances prior to transfer was 1.88 ($SD = 1.31$, range = 1-6, $n = 52$), which took an average of 40.60 days ($SD = 52.75$, range = 4-274, $n = 52$) until the next court appearance.

Participant Characteristics and Predictors of Program Completion

Sample characteristics. Characteristics of participants, divided into ‘completers’ (i.e., completed court requirements, 81.89%, $n = 104$) and ‘non-completers’ (i.e., did not complete court requirements and were transferred to the regular youth court, 18.11%, $n = 23$), are reported in Table 2. Participants had an average of approximately four charges and 1.49 prior diagnoses. In addition, approximately a third of the sample was identified as experiencing one or more significant stressors including a lack of parent involvement in court proceedings, involvement with child welfare agencies, school disengagement, and unstable housing. Group differences between completers and non-completers on each characteristic were calculated using t-tests (equal variance was not assumed given the unequal sample sizes), chi-squared tests, or non-parametric tests (where non-normal data were a concern). Youths who completed the program were more likely to have at least one diagnosis ($\chi^2(2, N = 113) = 6.68, p = .035$) and exhibited higher motivation at the beginning ($U(113) = 541.50, Z = -2.83, p = .005$) and end ($U(110) = 53.50, Z = -2.84, p < .001$) of treatment.

Table 2. *Characteristics of Youth Mental Health Court Participants*

	Total Sample		Completers		Non-Completers	
	Mean (<i>SD</i>)	<i>N</i>	Mean (<i>SD</i>)	<i>N</i>	Mean (<i>SD</i>)	<i>N</i>
Age ²	16.35 (1.78)	127	16.37 (1.22)	104	16.26 (0.94)	23
Grade	10.75 (0.97)	79	10.73 (0.98)	67	10.83 (0.94)	12
Number of charges	3.97 (3.55)	127	3.75 (3.28)	104	4.96 (4.55)	23
# of diagnoses (including ODD/CD) ³	1.49 (1.08)	113	1.54 (1.24)	91	1.27 (1.28)	22
# of diagnoses (excluding ODD/CD)	1.35 (1.08)	113	1.40 (1.05)	91	1.18 (1.18)	22
Motivation at beginning of program	5.48 (1.95)	115	5.75 (1.75)	96	4.11 (2.38)	19
	<i>% (n)</i>	<i>N</i>	<i>% (n)</i>	<i>N</i>	<i>% (n)</i>	<i>N</i>
Male	70.86 (90)	127	69.23 (72)	104	78.26 (18)	23
Female	29.13 (37)	127	30.77 (32)	104	21.74 (5)	23
Parent involvement at court	63.93 (78)	122	63.64 (63)	99	65.22 (15)	23
Any child welfare involvement	26.83 (33)	123	27.00 (27)	100	26.09 (6)	23
Currently residing with parents	61.98 (75)	121	58.65 (61)	104	63.64 (14)	22
Currently in school	70.25 (85)	121	73.74 (73)	99	54.55 (12)	22
Currently employed	14.75 (18)	122	16.00 (16)	100	9.10 (2)	22
Probation order	18.52 (20)	108	16.85 (15)	89	26.32 (5)	19
At least one diagnosis	82.30 (93)	113	86.81 (79)	91	63.64 (14)	22
Elevation on MAYSI-2	81.73 (85)	104	80.68 (71)	88	87.50 (14)	16
No mental health concerns	6.45 (8)	124	5.94 (6)	101	8.70 (2)	23

² Age was calculated based on either time of referral or, when referral information was not available, first court date.

³ Total number of diagnoses was calculated including *and* excluding diagnoses of Conduct Disorder and Oppositional Defiant Disorder, as these diagnoses highly overlap with the behaviours that result in criminal justice involvement.

Charges. Current and past charges were categorized based on severity, with like charges being grouped together. In terms of criminal history, 37.20% ($n = 45$) of the sample ($n = 121$) had previous charges while 62.80% did not ($n = 76$). The average number of previous charges was 4.28 ($n = 121$, $SD = 12.12$, range = 0-83), with the most frequently occurring number of charges being two. The number of current charges per youth ranged from 1 to 17, with a mean of approximately four charges (see Table 2). When coded for most serious offence, the most common charge was for assault (40.16%, $n = 51$), followed by break and enter/theft/auto theft (16.54%, $n = 21$), drug possession/trafficking (14.96%, $n = 19$), and threatening (7.87%, $n = 10$). Violent charges related to sexual assault were rare (2.36% $n = 3$), as were robbery (3.15%, $n = 4$), possession of a weapon (4.72% $n = 6$), failure to comply/attend court (5.51%, $n = 7$), and miscellaneous charges (4.72%, $n = 6$). Reviewing all charges, the most common were for those related to the administration of justice (i.e., failure to comply; 25.84%, $n = 130$), common assault (17.10%, $n = 86$), and break and enter/theft/auto theft (11.33%, $n = 57$).

The relationship between criminal charges and mental health needs was examined in a subset of 68 youth whose cases were ongoing at the time of data analysis.⁴ With the assistance of a member of the research team, the youth mental health court worker coded participants' charges as directly, indirectly, or not at all related to mental health functioning.⁵ A *direct* relationship, found in 20.59% of youth ($n = 14$), was coded when a criminal charge was incurred during a state of mental health-related distress (e.g., the youth committed an offence during a psychotic episode) or when charges were incurred by the youth to support ongoing mental health problems

⁴ It was not possible to reliably code cases that had closed prior to the study, as sufficient information was not available in participants' files.

⁵ Two independent judges coded a random subset of 14 files; kappa values (1.0) revealed 100% agreement for coding of match between treatment provided and youths' identified mental health needs and criminogenic needs.

(e.g., a youth with a substance use issue was caught with an illegal substance). An *indirect* relationship, found in 69.12% of youth ($n = 47$), was coded when there were other, more prominent, factors related to the offending behaviour (e.g., poor self-control, delinquent peer group, pro-criminal attitudes), but the youth was still experiencing mental health difficulties that significantly impacted his or her ability to engage in treatment, or when a mental health issue directly impacted criminogenic needs (e.g. a youth experienced social anxiety and as a result began to skip school and associate with delinquent peers, which led to him getting caught shoplifting). Finally, *no relationship* was found in 10.29% of youth ($n = 7$) because in fact those youth did not have mental health needs identified.

Mental health functioning. Youths reported an average of 1.49 diagnoses during intake (see Table 2). Mood and anxiety disorders were the most common diagnosis, followed by attention deficit/hyperactivity disorder. Approximately 17.70% of participants reported no prior diagnoses and 6.45% ($n = 8$) had no mental health needs (i.e., diagnoses or elevated scores on the MAYSI-2; see Table 3). With regards to the MAYSI-2, the most commonly identified elevation was on the Somatic Complaints subscale (57.69%, $n = 60$), followed by Traumatic Experience (48.08%, $n = 50$), Angry-Irritable (45.19%, $n = 47$), and Depressed-Anxious (42.86%, $n = 45$); 32.69% ($n = 34$) of participants had elevations with regards to Suicidal Ideation, 29.80% ($n = 31$) of youth reported elevations on the Alcohol/Drug Use subscale, and 36.98% of boys ($n = 27$) reported elevations on the Thought Disturbance scale. As noted above, completers were more likely to have at least one diagnosis, but there were no group differences in the average number of diagnoses or the likelihood of having at least one MAYSI-2 elevation (see Table 2).

Table 3. *Frequency of Prior Mental Health Diagnoses for Youth in the Mental Health Court*

Diagnoses	All Youth	Completers	Non-Completers
	% (n)	% (n)	% (n)
Mood and Anxiety Disorders	53.98 (61)	58.24 (53)	36.36 (8)
Autism Spectrum Disorders	4.42 (5)	5.49 (5)	--
Psychotic Disorders	7.96 (9)	6.59 (6)	13.64 (3)
Substance Abuse Disorders	8.85 (10)	8.79 (8)	9.10 (2)
Fetal Alcohol Spectrum Disorder	9.73 (11)	9.90 (9)	9.10 (2)
Externalizing Disorders	11.50 (13)	12.09 (11)	9.10 (2)
Attention Deficit/Hyperactivity Disorder	28.32 (32)	27.47 (25)	31.81 (7)
Cognitive Disorders	12.39 (14)	12.09 (11)	13.64 (3)
Other (e.g., attachment disorder)	11.50 (13)	13.19 (12)	4.55 (1)
None	17.70 (20)	13.19 (12)	36.36 (8)

Predictors of program completion. A logistic regression was conducted to determine predictors of program completion. Two participant characteristics -- having at least one diagnosis and motivation at beginning of treatment -- were found to differ significantly between completers and non completers and were thus chosen as predictors. When these variables were entered into a logistic regression with court completion as the outcome, the model was significant; both variables were found to be significant predictors (see Table 4). For each one-point increase on the motivation scale youths were 1.65 times more likely to complete the court and youths with mental health needs were 4.71 times more likely to complete the program than those with no needs.

Table 4. *Motivation and Diagnoses as Predictors of Program Completion.*

Variable	β	SE β	Wald's χ^2	D	p	Odds Ratio	
						(Exp B)	CI (95%)
Motivation Time 1	.50	.15	11.27	1	.001	1.65	1.23 2.20
At Least 1 Diagnosis	1.55	.63	6.11	1	.013	4.71	1.38 16.09
Overall Model			18.31	2	.000		

Extent to Which Mental Health and Criminogenic Needs of Participants Were Addressed

The degree of match between participants' treatment referrals and identified mental health needs was evaluated based on previous diagnoses and MAYSI-2 elevations. Half of participants (50.85%, $n = 60$) received treatment targeted towards identified needs (e.g., substance abuse treatment, first episode psychosis programs) or intensive enough to address multiple needs (e.g., hospital stays, psychiatric care, or residential treatment). Comprehensive assessments were sought for 11.02% ($n = 13$) of youth. In contrast, referrals for generalized treatment not directed toward an explicitly identified need (e.g., general counselling, brief therapy) were made for 26.27% ($n = 31$) of youth and treatment referral for needs *not* identified during screening were made for 11.86% ($n = 14$) of youth.

Each participant's treatment referrals were also assessed to determine whether they addressed at least one of the eight domains of criminogenic need. Participants were coded as having received treatment for criminogenic needs (e.g., family counselling for family functioning difficulties; addictions services that addressed substance use needs) or having received treatment for which it was unclear whether criminogenic needs were targeted (e.g., general counselling, individual counselling, brief therapy). Almost half of the sample (48.31%, $n = 57$) was referred

for treatment that addressed at least one criminogenic need domain, while the remaining 51.69% ($n = 61$) did not.⁶

Discussion

The current study reveals a number of important findings regarding the functioning of the youth mental health court under evaluation. The following paragraphs include a discussion of these results in relation to research on treating justice-involved youth with mental health needs, as well as key principles in the YCJA. Possible areas of improvement are included, as well as limitations of the current study and directions for future research.

Characteristics of Youth Seen in the Mental Health Court

A significant sub-sample of participants lacked some of the key supports essential for healthy development. Approximately one third of youth did not have parental support in managing their court requirements, had involvement with the child welfare system, and/or were not living with family. The importance of parental involvement in the criminal justice system has been highlighted within the YCJA (2002) and amongst best-practice guidelines for rehabilitating justice-involved youth (Guerra, Kim, & Boxer, 2008). Without parental support, youth may experience increased stress and struggle to adhere to court requirements. Family functioning difficulties are also a key predictor of recidivism and, thus, engaging this support system may be essential for rehabilitation. Similarly, research has highlighted the added difficulties youth experience when having to navigate multiple systems (i.e., child welfare and justice system; Herz, Ryan, & Bilchick, 2010). Those in shelters or with unstable residences are at particular risk for future mental health and criminal involvement (Cauce et al., 2000). Overall, these findings

⁶ Two independent judges coded a random subset of 26 files; kappa values (1.0) revealed 100% agreement for coding of match between treatment provided and youths' identified mental health needs and criminogenic needs.

are in keeping with research on the lack of parent involvement in youth court proceedings (Peterson-Badali & Broeking, 2010) and the family functioning difficulties found amongst justice-involved youth (Ulzen & Hamilton, 1998; Vieira, Skilling, & Peterson-Badali, 2009; Vitopoulos, Peterson-Badali, & Skilling, 2012)

In addition to these findings, almost a third of youth were not involved in school at the time of referral. Educational underachievement and truancy have both been linked to criminal behaviour in young people and are a risk factor for recidivism (Cottle, Lee, & Heilbrun, 2001; Maguin & Loeber, 1996; Simons, Whitbeck, Conger, & Conger, 1991). In contrast, engagement in school and educational achievement have been identified as important protective factors amongst high risk youths and may be important to consider in intervention (Catalano & Hawkins, 1996; Haqanee, Peterson-Badali, & Skilling, 2013; Hoge, Andrews, & Leschied, 1996). These findings are in keeping with past research documenting the high level of educational needs amongst justice-involved youth (Chitsabesan et al., 2006; Vieira et al., 2009).

Together these results highlight the challenges and potential risk factors that young people involved with the mental health court face on a daily basis. There is no doubt that these stressors, above and beyond mental health needs, impinge on a young person's ability to navigate the legal system and engage in treatment. Because both family functioning and educational difficulties are known risk factors for recidivism (Hoge & Andrews, 2002), a proper assessment of these areas may be important to ensure they are being addressed in treatment.

A broad range of mental health needs was identified amongst participants, with the most common related to mood and anxiety disorders. In addition, approximately half of youth reported elevations on the MAYSI-2 in traumatic experiences, somatic complaints, and angry-irritable symptoms. The high proportion of youth with at least one diagnosis (82%) is consistent with past

findings across North America (Drerup, Croysdale, & Hoffman, 2008; Gretton & Clift, 2011; Unruh, Gau, & Waintrup, 2009; Vieira et al., 2009; Wasserman, McReynolds, Schwalbe, Keating, & Jones, 2010) and suggests the need for comprehensive assessments and services that are trauma informed and address each youth's unique needs.

Interestingly, more than 5% of youth processed through the mental health court had no previous diagnoses and no elevations on the MAYSI-2. This takes on greater significance in light of the fact that *not* having a diagnosis was significantly more common amongst 'non-completers' than those who completed their involvement within the youth mental health court. Youth without mental health needs may not be as motivated or engaged as those who had clear difficulties that could be addressed in treatment. Indeed, 40% ($n = 8$) of those without a diagnosis did not finish their court requirements; of those, two were screened out, but the remaining six were transferred due to lack of engagement or desire to engage in treatment. In addition, treatment motivation at the beginning of service was found to be a significant predictor of program completion. These findings suggest that treatment motivation and the presence of mental health difficulties should be properly appraised during intake and considered during treatment planning. It may be important to include a motivational enhancement component to treatment for youth who express low motivation.

With regards to total charges associated with the mental health court, the most common were related to the administration of justice, assault, and break and enter/theft/auto theft. These findings are generally in keeping with the pattern of most common youth court charges across Canada in 2011/2012 (i.e., theft, common assault, break and enter, and failure to comply; Dauvergne, 2013). Over 90% of youth in the mental health court received dispositions in which their charges were stayed, withdrawn, dismissed or discharged, compared to just over 40% of

such dispositions in the general youth court population (Dauvergne, 2013). Together, these results suggest that, in terms of charges, the court sees similar cases to those in the youth system as a whole, but diverts more youth.

Extent to which Youths' Needs Were Addressed through the Court Process

With regards to the match between mental health needs and treatment, well over half of youths received intensive or targeted treatment or an in-depth assessment of their needs. In contrast, a quarter of youths were referred for treatment services that were unspecified, while 11% were referred for needs not identified in their file. The latter statistics are concerning, as it is unclear the degree to which such treatments are targeting the most prevalent needs of youth. The degree to which treatment mapped onto the broad areas of criminogenic need was also assessed. In almost half the cases, youth were *not* referred for treatment that clearly addressed areas of criminogenic need. Because reducing recidivism is one of the long-term stated goals of the program it is important to consider how the court can meet *both* the criminogenic and mental health needs of justice-involved youth.

Within the youth mental health court, there are several factors that may be contributing to the divergence between needs and treatment. First, the court does not currently assess or address areas of criminogenic need. As highlighted in the introduction, criminogenic needs are important to address for those whose criminal behaviours are *not* directly related to their mental health functioning (Skeem et al., 2011). Our results revealed that for a majority of participants (69%) there was an indirect relationship between their charge and their mental health functioning. For these youth it may be particularly important for treatment to address criminogenic needs. Second, the MAYSI-2 may not be sufficient for conceptualizing the young people's mental health needs, as it was developed as a screening device and not for formal diagnoses or long-

range treatment planning (Grisso et al., 2001). For those who score high on this measure, further assessment may be warranted. Third, results of the intake and screening are not systematically shared with treatment providers, making it difficult for them to tailor treatment towards identified needs. Fourth, treatment can only be as strong as that which is available in the community. Difficulties with waitlists and a lack of evidence-based practice within these services may result in treatment that is less than ideal.

Moving forward, the court would likely benefit from implementation of systematic in-depth assessment of criminogenic need, mental health, and motivation in order to address the varied needs of the youth mental health court population. Evidence-based practice in psychology has highlighted the importance of properly identifying client needs and designing treatment plans that consider each individual's unique profile (American Psychological Association, 2006). It will also be important to systematically share assessment results with treatment services so they can tailor their treatment to meet identified needs, as treatment that does not consider the client's unique profile is less likely to be effective (Mash & Hunsley, 2005).

Operation of the Youth Mental Health Court

The operations and case processing of the mental health court were evaluated to determine inconsistencies and areas for improvement; these findings are discussed below. The operations of the court with respect to its adherence to the YCJA are also discussed.

Admission to the Mental Health Court. Program referrals and admission processes were assessed in order to determine whether the youth mental health court followed the formal procedures outlined in their program design. Results revealed that program referrals were not always implemented as designed. For example, almost a quarter of youth were seen in the court before meeting with the youth mental health court worker. Screening at the outset is imperative

for determining suitability for the program and to ensure that resources are not being misdirected to those who will not benefit from the program.

Case Processing. One of the goals of the youth mental health court was to reduce case processing to ensure timely access to treatment services for youth with mental health need. Based on data provided from the provincial government, the average time to disposition from April 2012 to March 2013 was 138 days in the traditional youth court system. At two other courthouses in the city the average time to disposition was 161 and 154 days. Calculated in the same manner, the average time to disposition for mental health court cases was 168 days, which is generally in keeping with other courts.

A closer look at case processing in the youth mental health court revealed that, once transferred into the court, cases were typically dealt with in a timely fashion, finishing on average in approximately 90 days. Thus, part of the challenge in reducing case processing stems from the time it takes for youths to be transferred into the youth mental health court (nearly 80 days). It took approximately a month from date of referral for youths to have their first mental health court appearance. The court currently sits twice a month, which may partially explain the wait times for youth to make their first appearance. The court may wish to consider adding another court date to accommodate these new referrals. Finally, issues with regards to treatment waitlists and seeking out appropriate program referrals may be responsible for the one-month delay in connecting youth with treatment.

The above discussion of wait times also touches on wider systems issues with recognizing mental health needs earlier in the traditional court process. Case processing could be improved by providing additional training opportunities for judges, defence counsel, and crowns to identify mental health issues and building a greater awareness of the youth mental health

court. For a more comprehensive system, many researchers have also endorsed the use of mental health screening for all youth who come into contact with the court system (Grisso & Underwood, 2004; Skowrya & Coccozza, 2007).

Mental Health Court and YCJA Principles. As noted above, youth mental health courts within Canada must adhere to the legislative requirements outlined in the YCJA. Although an exhaustive discussion of how the mental health court under evaluation adheres to these requirements is not within the scope of this paper, our findings regarding case processing are relevant to the issue. The YCJA (2002) highlights the need for timely intervention and consequences that are in keeping with sanctions received by youth who have been found guilty of similar offences. Generally, concerns have been raised regarding the length of time that mental health court defendants are supervised by the court (Seltzer, 2005). It has been suggested that, due to treatment, mental health court defendants may spend longer under supervision than those who have been found guilty of similar offences in regular court (Seltzer, 2005).

The results from the current study reveal that case processing times in the youth mental health court are generally in keeping with the overall case processing times for other youths within the same city and that, once in the mental health court, youths are processed quickly. This is important, as youth in the mental health court do not appear to spend increased time in the court. Nevertheless, these findings do not allow for charge-related comparisons. It remains possible that youth spend more time in the mental health court for relatively minor offences than youth in the traditional system. Most mental health courts, including the one under evaluation, do not have written procedures regarding the length of supervision (Seltzer, 2005). While flexibility in managing cases is ideal for addressing mental health needs, this can lead to an increase in court supervision. It may be important to have clearly articulated rules regarding case processing

time to ensure that defendants do not spend longer in the mental health court than they would in the regular court.

To help reduce delays in transferring youth into the mental health court we have suggested the need for system-wide screening. While this may be considered an unnecessary infringement on one's privacy, Grisso (2005) has argued that such screening is essential for protecting due process rights related to competency to stand trial. Mental disorders and other developmental disabilities may impact a young person's ability to comprehend and make informed decisions during court processes (Grisso, 2005). Systematic screening ensures these issues are considered up front to protect youth and ensure fairness in criminal proceedings.

Limitations and Future Research

There are several important limitations to keep in mind with regards to the current study. The data collected were based largely on court records but many Ontario courthouses have not developed a systematic means of organizing data electronically and hard copies of files could not always be located. While this is less than ideal, case files included in the study represent a majority of the overall sample. In addition, the results of this study may not be generalizable to other courthouses and districts. Nevertheless, the findings do address the objectives of the current study and provide important details on the functioning of the court that can be applied to other court models. In addition to these limitations, a lack of resources (i.e., limited availability of court staff and limited time with youth) made it difficult to implement formalized and standardized measures to provide a more in-depth understanding of the court population. For instance, standardized measures of mental health functioning, criminogenic need, and treatment motivation could provide more reliable data and further insight into how to best meet the needs of this population. Future research within the court should aim to introduce standardized

measures, formalize data collection procedures, and assess the impact of the court on mental health and criminal justice related outcomes.

Conclusion

The youth mental health court under evaluation has made strong gains since its inception. Positive features of the court include the focus on rehabilitating youth and addressing the needs underlying their offending behaviour. In terms of case processing, a high rate of participant completion was found and cases were dealt with relatively quickly once transferred into the court. The current study has outlined the operations of the court and highlighted inconsistencies with the original design. Recommendations have been made for improving court functioning from an evidence-based practice perspective, namely, the need for formal screening procedures and program inclusion criteria, comprehensive assessments of mental health and criminogenic need, and formalized treatment plans that are shared with treatment providers. Finally, the youth mental health court has demonstrated a dedication to research, which, in itself is an important step in ensuring the court has the impact that it desires.

Chapter 4:

Overall Discussion and Conclusion

The Community Youth Court has been in operation for over two years. In that time the program has made excellent progress in responding to the mental health needs of youth in an engaging and sensitive manner that provides them with much needed community supports. To date, relatively little research has been conducted exploring the functioning of mental health courts and their adaptation to youth populations. The current evaluation has provided a detailed look at the Community Youth Court's target population and processes, as well as a qualitative and theoretical review of the program. Through this evaluation, several areas for improvement and continued growth have been highlighted. Particularly important was the overarching need for incorporating evidence-based practice into court operations.

Mechanism of Change

One of the key goals of the evaluation was to understand the court's proposed mechanism of change and how it relates to the theoretical and empirical evidence for treating justice-involved youth with mental health needs. The key goals targeted by the mental health court are to improve well being amongst youth, reduce recidivism, and increase community safety (Ontario Court of Justice, 2011). The logic model developed in the first manuscript revealed that the mechanism thought to be responsible for achieving these goals is mental health treatment. The focus on treating mental health needs to reduce recidivism is common amongst justice programs, but has generally not been found to be effective (Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005; Chandler & Spicer, 2006; Clark, Ricketts, & McHugo, 1999; Skeem, Manchak, Vidal, & Hart, 2009; Skeem, Manchak, & Peterson, 2011; Steadman, Dupuis, & Morris, 2009). Research suggests that mental health treatment may be most effective in reducing

risk to reoffend amongst those whose criminal behaviours are directly linked to their mental health functioning. For the majority of offenders, the findings indicate the need to address both mental health and criminogenic needs (Skeem et al., 2011). Results from the second manuscript indicated that only about 20% of youth had charges that were directly related to their mental health functioning, while the majority (approximately two thirds) of youth had charges that were indirectly related to their mental health functioning. These findings suggest that there are other important factors that must be addressed in order to reduce risk to reoffend.

Within the literature there is strong evidence suggesting that assessing for and treating areas of criminogenic need, which have been empirically linked to delinquent behaviours, can reduce recidivism (Andrews, Bonta, & Hoge, 1990; Hollin & Palmer, 2003; Schlager & Pacehco, 2011; Simourd, 2004). Furthermore, having criminogenic needs met is an important factor in reducing recidivism, even amongst youth with mental health needs (Vieira, Skilling, & Peterson-Badali, 2009). The mental health court under evaluation does not currently assess or systematically address areas of criminogenic need. In the second manuscript it was revealed that only about half of youth received treatment addressing at least one of the broad areas of criminogenic need outlined in the literature. Assessing for and addressing criminogenic need may be an important factor in enhancing the court's effectiveness in reducing future criminal behaviours amongst youth mental health court defendants. These findings are generally in keeping with interview themes identified by key informants and parents in the first manuscript, many of whom indicated that the court failed to address, or could do more to address problems that got the youth involved with the justice system in the first place. Overall, the research on mechanisms of change suggest the need to consider the relationship between crime and mental

health needs, as well as the criminogenic and mental health needs of youth in order to improve well-being and reduce recidivism.

Screening and Assessment

One of the strengths of the program highlighted in the first manuscript is the mental health screening that is typically conducted prior to youth involvement in the court. Mental health screening is an important aspect of evidence-based practice and has been identified as one of the key factors in treating justice-involved youth (Borum, 2003; Grove & Meehl, 1996; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Hoge, 2008), particularly within the context of treatment courts (Hills, Shufelt, & Coccozza, 2009). Screening is important for identifying those who are at risk of having mental health needs that require intervention or more comprehensive assessment (Grisso & Underwood, 2004). Findings from the current evaluation suggest that there are several ways to enhance current screening procedures within the court. For instance, in the second manuscript it was found that, on average, youth spent approximately 2.5 months in the regular court stream before being transferred into the mental health court and that almost a quarter of youth were not assessed prior to their first court date. Key informants in the first manuscript also highlighted the fact that certain mental health disorders may be difficult to detect by legal professionals who are currently responsible for making referrals into the mental health court. To remedy these difficulties, systematic screening procedures may be necessary to help ensure that all eligible youth are provided the opportunity to participate in the mental health court and are properly screened before being admitted into the program. Screening methods that allow for early identification of eligible participants could also help to reduce the lengthy wait times for referral. Ultimately, this would assist with reducing overall case processing times, a

goal that was identified by the court and would improve adherence to legislative requirements regarding timely intervention.

Another area for improvement with regards to mental health screening is the need for formal acceptance and decision-making criteria based on screening results (i.e., the need for specific guidelines on how to process youth based on screening results; Hills et al., 2009). Within the second manuscript, findings revealed that there was a small proportion of youth (7%) who were admitted into the court without identified mental health needs. Importantly, these youth were the least likely to complete their court requirements. Formalized criteria are needed to screen out individuals without mental health needs to ensure that these youth are not spending undue time in the program and to reserve the service to those who need it most. Furthermore, accepting participants who do not have mental needs to begin with may significantly impact the outcomes of the program.

While screening is an important first step, comprehensive assessments are also needed to better understand the multitude of needs impacting youth (Borum, 2003; Hills et al., 2009; Hoge, 2008). Findings from the second manuscript indicate that in addition to mental health diagnoses, approximately a third of youth reported one or more significant stressors related to a lack of parent involvement in court proceedings, involvement with child welfare agencies, school disengagement, and unstable housing. Furthermore, almost half of youth reported experiencing significant traumatic events. These are important areas of need that must be understood and considered within the context of treatment. Comprehensive assessments would allow for a more detailed look at criminogenic needs and the areas highlighted above.

Treatment

Treatment is an essential component in the rehabilitation of youth mental health court defendants. Interviewees in the first manuscript reported confidence in the court's ability to connect youth with treatment services within the community. Despite this, there appears to be little structure in how the court assigns treatment placements for youth and little structure in how the court monitors treatment plan adherence amongst community treatment agencies. Results from the second manuscript outlined that just over half of youth received services that addressed their mental health needs and close to 40% received services in which it was unclear the degree to which their needs were being met (e.g., general counseling). As noted above, only half of youth had areas of criminogenic need matched during treatment. These findings are not overly surprising given that youth receive only a brief screening of their mental health needs.

Comprehensive assessments are needed, not only to understand the needs of youth, but also to help inform treatment. The literature highlights the need for empirically informed treatment for justice-involved youth including the use of highly structured programs that involve a cognitive component, engage families, and address a variety of risk areas (Guerra, Kim, & Boxer, 2008). The mental health court would benefit from having formalized mechanisms in place for the development of formal treatment plans, the selection of treatment agencies, and the monitoring of treatment adherence within services.

Youth Justice Legislation

Incorporating evidence-based practice into the mental health court can help improve program outcomes, but must be balanced with legal rights and the YCJA. Within the literature, concern has been raised regarding the inherent risk with mental health courts infringing on legal rights (Seltzer, 2005). To help protect these legal rights it will be important for the court to ensure that each young person who enters the court has access to comprehensive legal

representation to assist them in navigating the system and protecting their rights at every stage. Special attention should be given to ensuring that youth are not spending extensive time under the jurisdiction of the court in the name of treatment. Formalized privacy regulations are also needed to protect young people within the context of the mental health court, particularly for those who undergo mental health screening.

Future Research

Results from the evaluation provide insight into potential areas for future research. With regards to the mental health court under evaluation, it will be important to continue to monitor program performance. Future research is needed to better understand the impact and outcome of the program on both mental health functioning and recidivism. Particularly, there has been a call for empirically sound evaluations that involve the use of a control group in order to properly assess outcomes and aspects of change (Slinger & Roesch, 2010). Thus, a rigorous outcomes evaluation will require the use of a control group of youth with similar mental health needs and similar criminal histories who are receiving treatment as usual. Comprehensive assessment measures will be needed to properly assess for mental health and criminogenic needs. Particularly important will be measures that are sensitive to change over time. Once the court has been able to introduce recommended changes regarding the assessment of criminogenic need, it will be important to assess the level of needs amongst the mental health court sample and how these needs are being addressed through treatment. Longitudinal data, including the use of short and long term follow up would be ideal in tracking change over time. Findings from such research will be able to speak to the effectiveness of the court above and beyond the traditional court system.

More broadly is the need for research exploring youth mental health courts across Canada and the United States. Slinger and Roesch (2010) have highlighted the lack of empirical evaluations of problem-solving courts in Canada and have called for methodologically sound evaluations to establish the effectiveness of problem-solving courts over and above the traditional court system. Such evaluations are needed in Canada, and particularly for youth mental health courts, to determine what works and to inform the development of future models.

Conclusion

The Community Youth Court is one of the first mental health courts for youth to undergo an evaluation looking closely at program functioning and mechanisms of change. The findings provide insight into important areas for program development that focus on implementing evidence-based practice to enhance the program's effectiveness in reducing recidivism. While areas for change have been discussed it is important to highlight the many strengths of the program that can be built upon moving forward. The court has a strong foundational base built on a sensitive and engaged mental health court team that includes the use of a mental health expert, as well as the use of mental health screening and a focus on engaging youth and families. Service users reported a high level of satisfaction that was linked to the court's supportive and understanding atmosphere, as well as the court's ability to link youth with treatment. One of the greatest strengths of the program has been the recognition and openness to incorporating evaluation research into the program. Such research is important for determining and strengthening effectiveness.

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Youth Criminal Justice Act, S.C. 2002, c. 1.

Appendix A

Interview Protocols

Semi-Structured Interview for Youth/Parents

I would like to ask you a few questions about your experience with the Community Youth Court.

- 1) Why did you/your son or daughter decide to go through this court?
- 2) What did you/your son or daughter have to do for the court?
- 3) Were you/your son or daughter able to do everything the judge asked?
 - a) If no, what do you think the court have done to help you/your son or daughter?
- 4) On a scale of one to five, please rate how helpful you found the court:

1	2	3	4	5
Not Helpful at all	Somewhat unhelpful	Neither helpful or unhelpful	Somewhat helpful	Very Helpful

- a) If helpful, how?
- b) If not helpful, why not?

- 5) What services did you/your son or daughter attend?
- 6) On a scale of one to five, please rate how helpful you found the treatment services

1	2	3	4	5
Not Helpful at all	Somewhat unhelpful	Neither helpful or unhelpful	Somewhat helpful	Very Helpful

- a) If helpful, how?
- b) If not helpful, why not?

- 7) What were some of the good things about participating in the court?
- 8) What were some of the bad things about participating in the court?
- 9) How likely would you be to recommend this court to another youth in your/your son or daughter's situation?

1	2	3	4	5
Would not recommend	May recommend	Neither	Probably recommend	Definitely recommend

- a) If would recommend, why?
- b) If would not recommend, why not?

- 10) What do you think could make the court better?

We would like to get a little background information about you.

Background Information for Parents:

1. Age: _____
2. Gender: _____
3. What is your current occupation?
5. Please indicate your highest level of education.
 - a. Some High School
 - b. High school graduate
 - c. Some university/college
 - d. University/college graduate
 - e. Post graduate/ professional program

Background Information for Youth:

1. Age: _____
2. Gender: _____
3. Currently in school? _____
4. Grade in school: _____
5. Currently employed?
6. What is your job? _____
7. How many hours/week do you work? ____

Semi-Structured Interview for Judges

I would like to ask you some questions regarding your understanding of the CYC and your experience with the CYC.

Questions regarding knowledge of CYC:

- 1) From your understanding, what is the purpose of the CYC?
- 2) What are the goals of the CYC?
- 3) What population does the CYC serve?

Questions regarding goals of CYC:

- 4) I would like you to rate how important you feel the following goals are for the CYC on a scale from one to five. Remember, that you are not answering the degree to which the goals are being met, but how important you think they are.

- a. The Community Youth Court should help to reduce case processing time for youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- b. The Community Youth Court should improve access to treatment services for youth with mental health needs.

Not at all important 1 2 3 4 5 **Very Important**

- c. The Community Youth Court should improve well-being amongst youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- d. The Community Youth Court should reduce the rate of future criminal behaviour amongst youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- e. The Community Youth Court improves community safety. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- 5) Now I would like you to rate the degree to which you feel the following goals have been met by the CYC on a scale from one to five.

- a. The Community Youth Court has helped to reduce case processing time for youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- b. The Community Youth Court has improved access to treatment services for youth with mental health needs.

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- c. The Community Youth Court has improved well-being amongst youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- d. The Community Youth Court has reduced the rate of future criminal behaviour amongst youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- e. The Community Youth Court has improved community safety. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

Questions regarding the CYC Target Population

- 6) Describe the youth that participate in the CYC. (*Mental health needs? Criminal behaviour?*)
- 7) Describe the youth that do not participate in the CYC. (*Mental health needs? Criminal behaviour?*)
- 8) What are some of the reasons that youth who are eligible do not to participate in the CYC?

- 9) Do you think there are youth who are not being seen by the CYC, but should be?
(*Explain and describe*).

Questions regarding CYC processes

- 10) Are the CYC operations consistent with the CYC philosophy?
- 11) Are the CYC operations consistent with the underlying principles and legislative requirements of the YCJA?
- 12) The YCJA recognizes that the youth justice system must emphasize enhanced procedural protection to ensure that young people are treated fairly and that their rights are protected. Some of the important rights to be protected include the right to counsel, the right to a presumption of diminished moral blameworthiness or culpability, the right to consent to physical or mental health treatment or care, and enhanced rights to privacy.
- a. How does the CYC ensure that the young person's right to be represented by counsel at any stage of the proceedings is respected?
 - b. How is the young person's right to a presumption of diminished moral blameworthiness or culpability taken into account in determining the appropriate disposition of a case before the CYC?
 - c. How does the CYC respect and protect the young person's right to consent to physical or mental health treatment or care?
 - d. How does the CYC ensure that the young person's right to privacy is protected?
- 13) The YCJA also recognizes that the youth criminal justice system must emphasize fair and proportionate accountability. The fundamental principle that responses to youth offending must be proportionate to the seriousness of the offence and the degree of responsibility of the young person applies throughout the YCJA, and in particular, with respect to extrajudicial measures and sentencing.
- a. How does the CYC ensure that the principle of proportionality is respected and applied in dealing with the youth that come before the court?
 - b. How are the seriousness of the offence and the degree of responsibility of the young person for the offence taken into account in determining the appropriate disposition in a given case?
 - c. Are there ways in which the CYC fails to respect and/or apply the principle of proportionality?

- d. How do the dispositions imposed in the CYC compare in terms of severity, length, and intrusiveness of dispositions imposed in similar cases in regular youth court?
- 14) The YCJA also emphasizes the importance of timely intervention in responding to offending behavior by youth.
- a. How does the CYC ensure that cases are dealt with on a timely basis?
 - b. Does involvement with the CYC result in shorter or longer case processing times than would be the case in the regular youth court? How?
 - c. Are there particular stages at which processing times in CYC may be longer than in regular court due to the unique nature of the CYC (e.g. longer time spent on pre-trial release or in pre-trial detention?)
- 15) Does the CYC operate efficiently?
- 16) Does the CYC operate effectively?
- 17) Has the CYC effectively developed case processing tools that differ from “regular” court processes?

Questions regarding barriers and improvements

- 18) Do you see any barriers that may hinder the sustainability of the CYC?
- a. If so, what are they?
- 19) Do you see any barriers to youth receiving service through the court and treatment agencies?
- a. If so, What are they?
- 20) What improvements do you think are needed for the CYC?
- 21) What do you see as the benefits of the CYC for youth?
- 22) What do you see as the drawbacks of the CYC for youth?

Questions regarding treatment

- 23) Are youth being successfully linked to community treatment services? Has this been done in a way that is consistent with the CYCs original design?
- a. If yes, in what way? What do you think has made this possible?

- b. If no, what do you think has prevented this?
- 24) Describe the CYCs relationships with the various community treatment services.
- 25) Do youth attend their treatment services?
- a. If no, what do you think has prevented this?
- 26) Do you believe that the treatment services are addressing youth's needs?
- a. If yes, in what way? What do you think has made this possible?
 - b. If no, what do you think has prevented this?
- 27) Are there any barriers to youth from the CYC accessing treatment services?
- a. If yes, what are they?
 - b. If no, what do you think has prevented this?

Background Information:

1. Please indicate your age range:
 - a) Under 30
 - b) 30-39
 - c) 40-49
 - d) 50-59
 - e) 60+
2. What is your sex?
 - a) Male
 - b) Female
3. What is your current occupation and job title?
4. How many years have you practiced your current occupation?
5. Please indicate your highest level of education.
 - a) High school graduate
 - b) Some university/college
 - c) University/college graduate
 - d) Post graduate/ professional program

Semi-Structured Interview for Crown Attorneys

I would like to ask you some questions regarding your understanding of the CYC and your experience with the CYC.

Questions regarding knowledge of CYC:

- 1) From your understanding, what is the purpose of the CYC?
- 2) What are the goals of the CYC?
- 3) What population does the CYC serve?

Questions regarding goals of CYC:

- 4) I would like you to rate how important you feel the following goals are for the CYC on a scale from one to five. Remember, that you are not answering the degree to which the goals are being met, but how important you think they are.

- a. The Community Youth Court should help to reduce case processing time for youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- b. The Community Youth Court should improve access to treatment services for youth with mental health needs.

Not at all important 1 2 3 4 5 **Very Important**

- c. The Community Youth Court should improve well-being amongst youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- d. The Community Youth Court should reduce the rate of future criminal behaviour amongst youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- e. The Community Youth Court improves community safety. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- 28) Now I would like you to rate the degree to which you feel the following goals have been met by the CYC on a scale from one to five.

- a. The Community Youth Court has helped to reduce case processing time for youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- b. The Community Youth Court has improved access to treatment services for youth with mental health needs.

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- c. The Community Youth Court has improved well-being amongst youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- d. The Community Youth Court has reduced the rate of future criminal behaviour amongst youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- e. The Community Youth Court has improved community safety. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

Questions regarding target population of the CYC:

- 5) Have you ever recommended a case to the CYC?
 - a) If no, why not?
 - b) If yes, what were some of your reasons for referring?
- 6) Would you encourage youth to participate in the CYC?
 - a) Why?

- 7) Do you believe that the CYC is reaching its target population?
- 8) How would you describe the youth that you have seen in the CYC? (*What types of mental health concerns do they have? What was the severity of their crimes?*).
- 9) Do you think there are youth who are not being seen by the CYC, but should be? (*Explain and describe*).

Questions regarding CYC processes

- 10) Are the CYC operations consistent with the CYC philosophy?
- 11) Are the CYC operations consistent with the underlying principles and legislative requirements of the YCJA?
- 12) The YCJA recognizes that the youth justice system must emphasize enhanced procedural protection to ensure that young people are treated fairly and that their rights are protected. Some of the important rights to be protected include the right to counsel, the right to a presumption of diminished moral blameworthiness or culpability, the right to consent to physical or mental health treatment or care, and enhanced rights to privacy.
 - a. How does the CYC ensure that the young person's right to be represented by counsel at any stage of the proceedings is respected?
 - b. How is the young person's right to a presumption of diminished moral blameworthiness or culpability taken into account in determining the appropriate disposition of a case before the CYC?
 - c. How does the CYC respect and protect the young person's right to consent to physical or mental health treatment or care?
 - d. How does the CYC ensure that the young person's right to privacy is protected?
- 13) The YCJA also recognizes that the youth criminal justice system must emphasize fair and proportionate accountability. The fundamental principle that responses to youth offending must be proportionate to the seriousness of the offence and the degree of responsibility of the young person applies throughout the YCJA, and in particular, with respect to extrajudicial measures and sentencing.
 - a. How does the CYC ensure that the principle of proportionality is respected and applied in dealing with the youth that come before the court?
 - b. How are the seriousness of the offence and the degree of responsibility of the young person for the offence taken into account in determining the appropriate disposition in a given case?

- c. Are there ways in which the CYC fails to respect and/or apply the principle of proportionality?
 - d. How do the dispositions imposed in the CYC compare in terms of severity, length, and intrusiveness of dispositions imposed in similar cases in regular youth court?
- 14) The YCJA also emphasizes the importance of timely intervention in responding to offending behavior by youth.
- a. How does the CYC ensure that cases are dealt with on a timely basis?
 - b. Does involvement with the CYC result in shorter or longer case processing times than would be the case in the regular youth court? How?
 - c. Are there particular stages at which processing times in CYC may be longer than in regular court due to the unique nature of the CYC (e.g. longer time spent on pre-trial release or in pre-trial detention)?
- 15) Does the CYC operate efficiently?
- 16) Does the CYC operate effectively?
- 17) Has the CYC effectively developed case processing tools that differ from “regular” court processes?

Questions regarding barriers and improvements

- 18) Do you see any barriers that may hinder the sustainability of the CYC?
- a. If so, what are they?
- 19) Do you see any barriers to youth receiving service through the court and treatment agencies?
- a. If so, What are they?
- 20) What improvements do you think are needed for the CYC?
- 21) What do you see as the benefits of the CYC for youth?
- 22) What do you see as the drawbacks of the CYC for youth?

Questions regarding relationships with treatment agencies

- 23) Are youth being successfully linked to community treatment services? Has this been done in a way that is consistent with the CYCs original design?
- a. If yes, in what way? What do you think has made this possible?
 - b. If no, what do you think has prevented this?
- 24) Describe the CYCs relationships with the various community treatment services.
- 25) Do youth attend their treatment services?
- a. If no, what do you think has prevented this?
- 26) Do you believe that the treatment services are addressing youth's needs?
- a. If yes, in what way? What do you think has made this possible?
 - b. If no, what do you think has prevented this?
- 27) Are there any barriers to youth from the CYC accessing treatment services?
- a. If yes, what are they?
 - b. If no, what do you think has prevented this?

Background Information:

1. Please indicate your age range:
 - a) Under 30
 - b) 30-39
 - c) 40-49
 - d) 50-59
 - e) 60+
2. What is your sex?
 - a) Male
 - b) Female
3. What is your current occupation and job title?
4. How many years have you practiced your current occupation?
5. Please indicate your highest level of education.
 - a) High school graduate
 - b) Some university/college
 - c) University/college graduate
 - d) Post graduate/ professional program

Semi-Structured Interview for Defence Lawyers

I would like to ask you some questions regarding your understanding of the CYC and your experience with the CYC.

Questions regarding knowledge of CYC:

- 1) From your understanding, what is the purpose of the CYC?
- 2) What are the goals of the CYC?
- 3) What population does the CYC serve?

Questions regarding goals of CYC:

- 4) I would like you to rate how important you feel the following goals are for the CYC on a scale from one to five. Remember, that you are not answering the degree to which the goals are being met, but how important you think they are.

- a. The Community Youth Court should help to reduce case processing time for youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- b. The Community Youth Court should improve access to treatment services for youth with mental health needs.

Not at all important 1 2 3 4 5 **Very Important**

- c. The Community Youth Court should improve well-being amongst youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- d. The Community Youth Court should reduce the rate of future criminal behaviour amongst youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- e. The Community Youth Court improves community safety. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- 5) Now I would like you to rate the degree to which you feel the following goals have been met by the CYC on a scale from one to five.

- a. The Community Youth Court has helped to reduce case processing time for youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- b. The Community Youth Court has improved access to treatment services for youth with mental health needs.

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- c. The Community Youth Court has improved well-being amongst youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- d. The Community Youth Court has reduced the rate of future criminal behaviour amongst youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- e. The Community Youth Court has improved community safety. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

Questions regarding with the target population of the CYC

- 6) Have any of your clients ever participated in the CYC? *What types of mental health concerns do they have? What was the severity of their crimes?.*

a) If no, why not?

- 7) Have you ever referred any of your clients to the CYC? *What types of mental health concerns do they have? What was the severity of their crimes?.*

c) If no, why not?

d) If yes, what were some of your reasons for referring?

- 8) Have you ever had a client decline participation in the CYC? *What types of mental health concerns do they have? What was the severity of their crimes?.*
- a) If yes, what were the reasons for declining?
- 9) Would you encourage future clients to participate in the CYC?
- a) Why?
- 10) Do you think there are youth who are not being seen by the CYC, but should be? *(Explain and describe).*
- 11) What would you describe as the target population for the CYC?
- 12) Do you believe that the CYC is reaching its target population?

Questions regarding CYC processes

- 13) Are the CYC operations consistent with the CYC philosophy?
- 14) Are the CYC operations consistent with the underlying principles and legislative requirements of the YCJA?
- 15) The YCJA recognizes that the youth justice system must emphasize enhanced procedural protection to ensure that young people are treated fairly and that their rights are protected. Some of the important rights to be protected include the right to counsel, the right to a presumption of diminished moral blameworthiness or culpability, the right to consent to physical or mental health treatment or care, and enhanced rights to privacy.
- a. How does the CYC ensure that the young person's right to be represented by counsel at any stage of the proceedings is respected?
 - b. How is the young person's right to a presumption of diminished moral blameworthiness or culpability taken into account in determining the appropriate disposition of a case before the CYC?
 - c. How does the CYC respect and protect the young person's right to consent to physical or mental health treatment or care?
 - d. How does the CYC ensure that the young person's right to privacy is protected?
- 16) The YCJA also recognizes that the youth criminal justice system must emphasize fair and proportionate accountability. The fundamental principle that responses to youth offending must be proportionate to the seriousness of the offence and the degree of responsibility of the young person applies throughout the YCJA, and in particular, with respect to extrajudicial measures and sentencing.

- a. How does the CYC ensure that the principle of proportionality is respected and applied in dealing with the youth that come before the court?
 - b. How are the seriousness of the offence and the degree of responsibility of the young person for the offence taken into account in determining the appropriate disposition in a given case?
 - c. Are there ways in which the CYC fails to respect and/or apply the principle of proportionality?
 - d. How do the dispositions imposed in the CYC compare in terms of severity, length, and intrusiveness of dispositions imposed in similar cases in regular youth court?
- 17) The YCJA also emphasizes the importance of timely intervention in responding to offending behavior by youth.
- a. How does the CYC ensure that cases are dealt with on a timely basis?
 - b. Does involvement with the CYC result in shorter or longer case processing times than would be the case in the regular youth court? How?
 - c. Are there particular stages at which processing times in CYC may be longer than in regular court due to the unique nature of the CYC (e.g. longer time spent on pre-trial release or in pre-trial detention)?
- 18) Does the CYC operate efficiently?
- 19) Does the CYC operate effectively?
- 20) Has the CYC effectively developed case processing tools that differ from “regular” court processes?

Questions regarding barriers and improvements

- 21) Do you see any barriers that may hinder the sustainability of the CYC?
- a. If so, what are they?
- 22) Do you see any barriers to youth receiving service through the court and treatment agencies?
- b. If so, What are they?
- 23) What improvements do you think are needed for the CYC?

24) What do you see as the benefits of the CYC for youth?

25) What do you see as the drawbacks of the CYC for youth?

Questions regarding relationships with treatment agencies

26) Are youth being successfully linked to community treatment services? Has this been done in a way that is consistent with the CYCs original design?

- a. If yes, in what way? What do you think has made this possible?
- b. If no, what do you think has prevented this?

27) Describe the CYCs relationships with the various community treatment services.

28) Do youth attend their treatment services?

- a. If no, what do you think has prevented this?

29) Do you believe that the treatment services are addressing youth's needs?

- a. If yes, in what way? What do you think has made this possible?
- b. If no, what do you think has prevented this?

30) Are there any barriers to youth from the CYC accessing treatment services?

- a. If yes, what are they?
- b. If no, what do you think has prevented this?

Background Information:

1. Please indicate your age range:

- a) Under 30 b) 30-39 c) 40-49 d) 50-59 e) 60+

2. What is your sex? a) Male b) Female

3. What is your current occupation and job title?

4. How many years have you practiced your current occupation?

5. Please indicate your highest level of education.

- a) High school graduate
- b) Some university/college
- c) University/college graduate
- d) Post graduate/ professional program

Semi-Structured Interview for Service Providers from Community Agencies Serving CYC Clients

I would like to ask you some questions regarding your understanding of the CYC and your experience with the CYC.

Questions regarding knowledge of CYC:

- 1) From your understanding, what is the purpose of the CYC?
- 2) What are the goals of the CYC?
- 3) What population does the CYC serve?

Questions regarding goals of CYC:

- 4) I would like you to rate how important you feel the following goals are for the CYC on a scale from one to five. Remember, that you are not answering the degree to which the goals are being met, but how important you think they are.

- a. The Community Youth Court should help to reduce case processing time for youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- b. The Community Youth Court should improve access to treatment services for youth with mental health needs.

Not at all important 1 2 3 4 5 **Very Important**

- c. The Community Youth Court should improve well-being amongst youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- d. The Community Youth Court should reduce the rate of future criminal behaviour amongst youth with mental health needs. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- e. The Community Youth Court improves community safety. (circle one)

Not at all important 1 2 3 4 5 **Very Important**

- 5) Now I would like you to rate the degree to which you feel the following goals have been met by the CYC on a scale from one to five.

- a. The Community Youth Court has helped to reduce case processing time for youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- b. The Community Youth Court has improved access to treatment services for youth with mental health needs.

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- c. The Community Youth Court has improved well-being amongst youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- d. The Community Youth Court has reduced the rate of future criminal behaviour amongst youth with mental health needs. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

- e. The Community Youth Court has improved community safety. (circle one)

Goal not met 1 2 3 4 5 **Goal completely achieved**

Please provide a rationale for your response:

Questions regarding the target population of the CYC

- 6) Describe the youth that you have seen from the CYC. *What types of mental health concerns do they have? What was the severity of their crimes?.*
- 7) What would you describe as the target population for the CYC?
- 8) Do you believe that the CYC is reaching its target population?

Questions regarding barriers and improvements

- 9) Do you see any barriers that may hinder the sustainability of the CYC?
- a. If so, what are they?
- 10) Do you see any barriers to youth receiving service through the court and treatment agencies?
- a. If so, What are they?
- 11) What improvements do you think are needed for the CYC?
- 12) What do you see as the benefits of the CYC for youth?
- 13) What do you see as the drawbacks of the CYC for youth?

Questions regarding treatment services

- 14) Describe your agency's relationships with the CYC.
- 15) What types of services do youth receive through your agency? (*Do you address mental health needs only? Do you address criminogenic needs?*)
- 16) Do youth attend their treatment services?
- 17) Do you believe that the treatment services are addressing youth's needs?
- 18) Are there any barriers to youth from the CYC accessing treatment services?

Background Information:

1. Please indicate your age range:
 a) Under 30 b) 30-39 c) 40-49 d) 50-59 e) 60+
2. What is your sex? a) Male b) Female
3. What is your current occupation and job title?
4. How many years have you practiced your current occupation?
5. Please indicate your highest level of education.
 a) High school graduate
 b) Some university/college
 c) University/college graduate
 d) Post graduate/ professional program

b) <input type="checkbox"/> Community	program: _____ New referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment satisfactorily completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Please rate the degree of satisfaction with the youth's performance: <input type="checkbox"/> Completed all program requirements <input type="checkbox"/> Completed some program requirements <input type="checkbox"/> Completed most program requirements <input type="checkbox"/> Did not complete program requirements Comments: _____
<input type="checkbox"/> Educational/Employment Describe:	Start Date: _____ Agency & program: _____ New referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment satisfactorily completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Please rate the degree of satisfaction with the youth's performance: <input type="checkbox"/> Completed all program requirements <input type="checkbox"/> Completed some program requirements <input type="checkbox"/> Completed most program requirements <input type="checkbox"/> Did not complete program requirements Comments: _____
<input type="checkbox"/> Anger/Aggression	Start Date: _____ Agency & program: _____ New referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment satisfactorily completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Please rate the degree of satisfaction with the youth's performance: <input type="checkbox"/> Completed all program requirements <input type="checkbox"/> Completed some program requirements <input type="checkbox"/> Completed most program requirements <input type="checkbox"/> Did not complete program requirements Comments: _____
<input type="checkbox"/> Bail Program	Start Date: _____ Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____
<input type="checkbox"/> Substance Use	Start Date: _____ Agency & program: _____ New referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment satisfactorily completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Please rate the degree of satisfaction with the youth's performance: <input type="checkbox"/> Completed all program requirements <input type="checkbox"/> Completed some program requirements <input type="checkbox"/> Completed most program requirements <input type="checkbox"/> Did not complete program requirements Comments: _____
<input type="checkbox"/> Developmental Disability	Start Date: _____ Agency & program: _____ New referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment satisfactorily completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Please rate the degree of satisfaction with the youth's performance: <input type="checkbox"/> Completed all program requirements <input type="checkbox"/> Completed some program requirements <input type="checkbox"/> Completed most program requirements <input type="checkbox"/> Did not complete program requirements Comments: _____
<input type="checkbox"/> Assessment a) <input type="checkbox"/> Psychiatric/Psychological b) <input type="checkbox"/> Substance Use	Start Date: _____ Agency & program: _____ New referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Assessment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No

