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

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

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

I. INTRODUCTION

Two thirds of youths enter the juvenile justice system with some preexisting mental disorder.¹ This simple statistic alone is enough to make anyone question the efficacy of our juvenile legal system. These youths are not in need of punishment, but of treatment given outside the confines of a correctional facility or detention center. In order to redirect the efforts of a flawed system towards providing children and adolescents with the assistance they need, Therapeutic Jurisprudence (TJ) offers a gateway to the true rehabilitative nature of the juvenile justice system. Due to its undeniable links to TJ, the Sequential Intercept Model (SIM) was chosen as the main mechanism for proposing a better management of juveniles with mental illnesses within said system. SIM identifies five intercept points of possible deviation from standard legal norms. It is

*This work is the result of a semester’s worth of work for Professor David Wexler’s seminar on Sentencing Laws and Corrections at the University of Puerto Rico Law School, Fall 2015.
through these entry points that a series of recommendations gathered from legal and mental health experts are employed as a means of improving the juvenile justice system overall. To gain a practical perspective of the usefulness of SIM in the study of legal procedures, possible intercept points within the statute establishing the juvenile justice system in Puerto Rico are identified, analyzed, and critiqued based on TJ principles.

II. THERAPEUTIC JURISPRUDENCE

Therapeutic Jurisprudence (TJ) is a different approach to law. It looks to humanize, to mold to people’s well-being, and to analyze the impact of law on people’s lives. As the name suggests, TJ is the use of law as a “therapeutic agent”. Throughout this work there are references to a concept known as the “wine and bottles” metaphor. The “bottle” is the law itself while the “wine” or the “liquid” refers to the roles and practices of legal actors, such as judges and lawyers. To determine the amount of TJ “wine” these bottles can receive, laws and provisions can be either “TJ-friendly”, “TJ-unfriendly”, or “TJ-fair weather friends” for those in the middle ground. TJ principles utilize insights from subjects outside the law, such as social work and psychology, which makes it a perfect framework for analyzing and critiquing the American juvenile justice system alongside the law that regulates said system in Puerto Rico, herein after referred to as Ley de Menores.

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3 *Id.* at 95.
6 *Id.*
III. JUVENILE JUSTICE SYSTEM

An overview of the current state and the challenges faced by the American juvenile justice system in regards to the mentally ill population is of vital importance to comprehend the recommendations that are to follow. Since its inception, the juvenile justice system has seen its fair share of transformation, from a system aimed at rehabilitation in its beginnings; to a shift toward cynicism and punishment as its main goal; to what it is now: a so-called “dumping ground” for adolescents who are deemed untreatable or uncontrollable, worsened by the loss of confidence on mental health institutions.\(^8\) This lack of reliance on mental health treatment institutions or hospitals may have been what convinced an Ohio judge to send a youth suffering from bipolar disorder to a juvenile correctional center rather than referring him to a treatment facility.\(^9\) Said judge determined the youth would receive better care in the state correctional system than he would anywhere else in the country. The boy, a 16 year-old named Donald, was supposed to be serving a maximum of six months for breaking and entering, but his sentence had been repeatedly extended due to bouts of extreme violence against himself and others.

It’s estimated that 2/3 of youths enter the juvenile justice system with some preexisting mental disorder, and at least half of them are in need of clinical care.\(^10\) Juvenile detention began replacing psychiatric emergency rooms,\(^11\) often because there were no other options while awaiting treatment.\(^12\) When it comes to judges, they may not even know the youth suffers from a mental disorder – and when they do know, they may not know what to do with them, as was the case

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\(^8\) Supra, note 1.
\(^10\) Fondacaro, supra note 1, at 7.
of 16 year-old Donald – because they lack knowledge as to the alternatives they have in their power to divert the youth out of the justice system. In some instances, parents of mentally ill children or adolescents voluntarily hand over custody to the juvenile justice system in the hopes of obtaining mental health treatment unavailable to them elsewhere.\textsuperscript{13} Many of the mental health problems in these youths remain undiagnosed and untreated,\textsuperscript{14} due to aggressive behavior perceived as threatening instead of a possible affliction in need of psychiatric clinical care.\textsuperscript{15}

The conditions generated in detention centers and correctional facilities, such as overcrowding and the potential for violence and chaos, lead to an unhealthy environment.\textsuperscript{16} Young people in confinement with existing mental health disorders simply get worse, not better.\textsuperscript{17} These youths are particularly vulnerable psychologically during their time in detention. The general population of confined young offenders is at higher risk of depression.\textsuperscript{18} Over 33\% of incarcerated youths report feelings of hopelessness, 10\% report suicide ideation, and another 11\% actually attempt to take their own lives.\textsuperscript{19} Detention further instills youths with lasting, maladaptive psychological tendencies, including limited impulse or aggression control and lessened abilities to make socially competent decisions.\textsuperscript{20}

Another critical risk factor of detention is what’s known as “peer deviancy training”, a term used to define the outcome of treating youths together, indiscriminately of whether they

\textsuperscript{13} Grisso, \textit{supra} note 11.
\textsuperscript{15} Burns, \textit{supra} note 12.
\textsuperscript{17} \textit{Id}.
\textsuperscript{18} Fondacaro, \textit{supra} note 1.
\textsuperscript{19} \textit{Id}.
\textsuperscript{20} \textit{Id}.
committed a violent or non-violent offense.\textsuperscript{21} Studies found that congregating youth together for treatment in a group setting leads to a higher recidivism rate,\textsuperscript{22} as they are exposed to worse behaviors, which they adapt easily due to an increased susceptibility to peer influence, a common trait among adolescents.\textsuperscript{23} Adolescence as a period of human development is characterized by variability and change.\textsuperscript{24} Contrary to theories of the past, the human brain does not reach anatomical maturity until well into adulthood.\textsuperscript{25} This “developmental immaturity” attributed to developmental imbalances in the brain causes differences in behaviors distinguishable from adults: adolescents have less capacity than adults to exercise self-control of impulses; are less future-oriented than young adults; and are more susceptible to peer influence.\textsuperscript{26} Thus, the failings of juvenile courts and the “inadequate and uneven delivery of mental health services to children and families in the juvenile justice system” is viewed by many as a national crisis in the United States.\textsuperscript{27} Underfunding of juvenile mental health programs only worsen matters.\textsuperscript{28}

The general consensus across studies is that the vast majority of incarcerated youth meet formal criteria for at least one mental disorder; with approximately 20\% of youth meeting diagnostic criteria for a serious mental health disorder.\textsuperscript{29} Mental illness can refer to serious cognitive impairments like schizophrenia or depression, or it can refer to anxiety disorders such as atten-
tion-deficit and disruptive behavior disorders. Other common disorders or conditions are autism, eating disorders, Post-Traumatic Stress Disorder, Substance Use Disorders or Co-Morbidity.\textsuperscript{30}

Accordingly, the role of public agencies as a custodian of these young offenders should be geared toward these three main objectives: safety, rehabilitation, and reducing recidivism.\textsuperscript{31} First, the risk of immediate harm (be it suicide attempts or aggressive behavior) once the youth is detained and while they’re in custody must be addressed and reduced.\textsuperscript{32} As the ultimate goal of the juvenile justice system should be rehabilitation,\textsuperscript{33} mentally ill youths should be guaranteed a spot in rehabilitative programs, unless their impairment is so severe they require intensive psychiatric care.\textsuperscript{34} Finally, rehabilitation should lead to reducing the risk that a youth’s mental disorder will recur and lead to further delinquency.\textsuperscript{35}

### IV. THE SEQUENTIAL INTERCEPT MODEL

The Sequential Intercept Model (SIM) was developed by Mark Munetz and Patricia Griffin, in collaboration with Hank Steadman. Like TJ, it visualizes the law as a “therapeutic agent” through which services are provided to those who would benefit most, not from incarceration, but from treatment for mental illness, drug abuse, or trauma.\textsuperscript{36} As used in this investigation, SIM is a tool for identifying areas in current statutes or systems where TJ principles can be employed. I have not encountered any examples of SIM applied to anything other than the adult criminal

\textsuperscript{30} Id. Co-morbidity is the simultaneous presence of two diseases or conditions. In this young population, the most common is a substance abuse disorder coupled with a mood disorder.

\textsuperscript{31} Grisso, supra note 11.

\textsuperscript{32} Id.

\textsuperscript{33} Burns, supra note 12.

\textsuperscript{34} Grisso, supra note 11.

\textsuperscript{35} Id.

justice system; therefore I will be making the appropriate tweaks throughout in order to transfer this model to a juvenile justice setting.

SIM is comprised of a series of intercept points or opportunities to prevent individuals with mental illnesses from being subjected to standard legal procedures or prosecution, by diverting them out of the system and into appropriate care or treatment.\textsuperscript{37} As applied to the adult criminal justice system, the five intercept points are: 1) law enforcement and emergency services, 2) initial detention and initial hearings, 3) jails\textsuperscript{38} and specialty courts, 4) reentry from jails or state prisons,\textsuperscript{39} and 5) community corrections and community support services.\textsuperscript{40} Each point serves as a “filter”, an opportunity for diversion, so as to decrease admissions to detention centers, engage youths in treatment as soon as possible, and reduce recidivism.\textsuperscript{41}

V. APPLYING SIM TO THE JUVENILE JUSTICE SYSTEM

A. Intercept 1: Law enforcement and emergency services

The initial interaction with law enforcement is the first opportunity to give mentally ill juveniles the treatment they need, making it a crucial – perhaps the most important – point of intervention. The police are often the first called to handle crises involving people who suffer from mental illness.\textsuperscript{42} Police officers possess the authority to solicit psychiatric evaluation and treatment when there is probable cause to conclude a person is a risk to others or themselves.\textsuperscript{43} They are responsible for identifying when individuals are in need of mental health treatment, conse-

\textsuperscript{37} Id.
\textsuperscript{38} Youths in the juvenile justice system are sent to detention centers when detained prior to trial or adjudication hearings.
\textsuperscript{39} In the juvenile justice system, youths are sent to correctional facilities.
\textsuperscript{40} Mark R. Munetz, \textit{Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness}, 57 Psych. Serv. 544, 549 (2006).
\textsuperscript{41} Id.
\textsuperscript{43} Id.
quently connecting them with the appropriate service.\textsuperscript{44} Hence the importance of properly training police officers to respond and defuse tense exchanges with people suffering from mental health issues, a situation made even more delicate when the subject is a vulnerable youth.

This sort of training is what’s known as Crisis Intervention Training (CIT) or the Crisis Intervention Team Model, first developed in Memphis, Tennessee.\textsuperscript{45} It provides crisis intervention training based on law enforcement for assisting people with mental illnesses while improving the safety of everyone involved, including the community at large.\textsuperscript{46} Trained officers are able to interact with crisis situations using “de-escalation techniques” to then transport the individual in need of special treatment to an appropriate facility, known in CIT literature as a Mental Health Receiving Facility. This facility should provide a source of emergency entry into the mental health system with minimal turnaround and acceptance of all referrals regardless of diagnosis or financial status.\textsuperscript{47} Ideally, a pre-arrest diversion program would also be available to meet the mental health needs of juveniles.\textsuperscript{48}

Collaboration between mental health facilities and law enforcement is essential, since neither can effectively serve the community separately without the assistance and expertise of the other. Additionally, the efficiency of this approach depends on the quality of the emergency services. If the emergency service is lacking or uncooperative, police officers may think twice before transporting the youth in need of help to a treatment facility rather than arresting them. If the “Memphis Model” is utilized correctly, it can eliminate all of these drawbacks. Compared to

\textsuperscript{44} Id., at 1266.
\textsuperscript{46} Id.
\textsuperscript{47} Id.
\textsuperscript{48} Munetz, \textit{supra} note 40.
other diversion programs, the Memphis CIT program has “the lowest arrest rate, high utilization by patrol officers, rapid response time, and frequent referrals to treatment.”

Ley de Menores does not mention any such measures taken before the minor is arrested, but an amendment made to Ley de Salud Mental de Puerto Rico\(^\text{50}\) authorizes the Mental Health and Addiction Services Administration (Administración de Servicios de Salud Mental y Contra la Adicción, ASSMCA) to establish an intervention protocol for mental health patients in coordination with the Puerto Rico Police, mental health services providers, and hospital emergency rooms. Yet the current ASSMCA bylaw regulating the application of the Puerto Rico Mental Health Law\(^\text{52}\) does not detail any protocol done in coordination with police in regards to receiving mentally ill adults under the custody of an officer, much less one for minors.

**B. Intercept 2: Initial detention and initial hearings**

The youth’s safety is a fundamental concern in this second stage of SIM. Reducing the risk of self-harm and harm to others should be the guiding principle in deciding whether to send the youth home or to a secure detention facility or hospital. If the youth is held in a detention facility due to security concerns or risk of aggression, treatment is an imperative to reduce said risk when they are eventually released from custody.\(^\text{53}\) Youths should be kept in secure detention facilities until the risk of aggression or harm is low enough that they can be treated in their community, as it is universally established among diverse studies on rehabilitation that young of-
fenders benefit most from treatment in a family and community context.\textsuperscript{54} Moreover, a detention center is no place for receiving mental health treatment. Detention centers are intended to temporarily house and supervise the most at-risk youth before their adjudicative hearing once it’s been determined that confinement is the best course of action.\textsuperscript{55} Yet in the last years, detention has been steadily relied upon to handle youths from all over the spectrum, who do not pose a risk of re-offending before trial or were not involved in violent offenses.\textsuperscript{56}

The first step to ensure youths are not wrongly sent to a detention facility when they are in need of treatment is to screen all incoming juveniles for mental illness. Screening is a “relatively brief process used to identify youth at an increased risk for mental disorders or in need of immediate attention and more complete review.”\textsuperscript{57} It requires reliable and standardized screening instruments along with knowledge on how to best utilize these instruments in order to distinguish a set of exceptionally troubled youth for whom special immediate response is necessary.\textsuperscript{58} However, it should not be limited to just a testing instrument. The medical histories for both the youth and their family should be obtained for a more complete assessment.\textsuperscript{59}

The length of screening procedures depend upon the amount of information needed to make an accurate determination of mental health status. This process is most likely to take place in the first interview once the juvenile justice system gets involved with the minor, upon admission into a detention center prior to trial, or once admitted into a correctional facility or commu-

\textsuperscript{54} Id.
\textsuperscript{55} Holman, supra note 16.
\textsuperscript{56} Id.
\textsuperscript{58} Id.
\textsuperscript{59} Geary, supra note 14.
nity program post-adjudication. However, it’s especially important for the youth to be screened before they appear in court because it’s more likely than not that juvenile court personnel lack the knowledge and training necessary to identify mental health needs. Therefore, court staff should be allowed opportunities for education and training, so as to understand mental health assessments, the mental needs of individual youths, and the appropriate treatment options.

In regards to detention, Article 20 of Ley de Menores allows detention of minors before the adjudicative hearing under six circumstances. The article reads as follows:

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

Theoretically, the chances of admitting a minor into a detention center as a first resource are seriously diminished by requiring that all pre-adjudication detention be authorized by the court and under these strict circumstances. In Ley de Menores, detention appears to be the exception, not the default. As discussed earlier, minors should only be detained before any trial or adjudicative hearing for safety concerns, as is taken into account in the first scenario contemplated.

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61 See Burns, *supra* note 12.
63 Ley de Menores, *supra* note 7, at § 2220.
in Article 20. The rest of the criteria relates to the inability of locating the parents or guardians of the youth, fear of non-appearance, and certain types of previous offenses. I consider these factors to be in furtherance of a genuine interest in the minor’s well-being and in accordance with what scholars agree to be the particular circumstances that warrant pre-trial detention.

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

*Article 13. Family Relations Specialist.*

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

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64 Ley de Menores, *supra* note 7, at § 2213.
From a screening standpoint, no one else in the juvenile justice statute before us is so aptly equipped to conduct a proper screening and determine whether a minor will benefit more from a hospital bed than a detention center, which is what makes this provision so crucial. However, this is only possible if they have the right tools for it. These social workers are to be well trained in identifying key indicators of mental disorders in youths and classifying any type of aggression or odd behavior as what it is: a by-product of an illness. Otherwise, I recommend having a forensic mental health professional on hand to do this work.65

As per the fourth function, the Family Relations Specialist has the authority to recommend an initial treatment plan, but this will only come into effect once the adjudication process has been completed and the minor has been found to have committed an offense. The main goal of SIM is to provide people with mental disorders or drug abuse issues the help they need as soon as possible.66 Ideally, the Specialist would not have to be the one to coordinate the treatment plan, as the minor would have been referred out of the justice system at this early stage after a screening process. Nonetheless, I would posit that the Specialist should have this authority as soon as the minor has an initial hearing.

Utilizing the TJ wine-bottle methodology,67 a few drops of TJ-friendlier wine is needed to ensure that the Family Relations Specialist is well equipped to conduct an accurate screening process. That can be accomplished by providing the Specialist with the appropriate training or having a mental health expert on hand as part of these efforts. In order to push forward the moment in which the Specialist can recommend a treatment plan, the “bottle” (the law itself) must be tweaked. Additionally, as the youth’s mental health issues are only mentioned once in the law

65 See Grisso, supra note 11.
66 See Heilbrum, supra note 36.
67 Wexler, supra note 5.
(in a provision I will examine further along), I also recommend a separate article or an additional function within Article 13 to address the role of the Family Relations Specialist in relation to mental health issues in a more direct manner.

On the other hand, the Family Relations Technician\(^{68}\) takes on the role of supervisor and has less discretion in implementing screening practices or recommending treatment. Coordination of treatment and services for the minor must be done “pursuant to the Family Relations Specialist’s recommendations”\(^{69}\) and any requests for revocation of probation if the minor has not complied with imposed conditions must be done in consultation with the Family Relations Specialist.\(^{70}\) Although not as crucial a figure as the Specialist, the Technician’s role in the well-being of the minor should not be overlooked.

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

 Artikel 21. Diversion of minors from judicial proceedings.

After a complaint has been filed and before the adjudication of the case, the Prosecutor may request the court to refer the minor to an agency or a public or private body if the following circumstances exist:

1. If it is a Class I offense or a first time offender in a Class II offense.
2. An agreement is signed between the Solicitor, the minor, his parents or guardian and the agency to which the minor is referred.
3. The social report of the Family Relations Specialist is taken into consideration.
4. There is an authorization of the court.

The agency to which the minor is referred in accordance with this section shall inform the Solicitor and the court whether the minor is complying with or has complied or not with the conditions of the agreement. In case the minor has complied with said conditions, the Solicitor shall request the court to dismiss the complaint. In case the minor has not complied, the So-

\(^{68}\) See Ley de Menores, supra note 7 at § 2214.
\(^{69}\) See Id. at (3).
\(^{70}\) Id at (5).
licitor shall request a hearing to determine if the procedure should continue.\textsuperscript{71}

Diversion is only available to those whose offense falls within the Class I category\textsuperscript{72} or first time offenders under Class II\textsuperscript{73}. This requirement precludes a sizable population of potentially mentally ill youths. Instead of being a strict exclusion, there should be leeway to make a determination of diversion based on the results of the screening process. The Diversion Program is further regulated by The Handbook of Rules and Procedures.\textsuperscript{74} The most current version (2000) of this rulebook is not available to the public. The 1990 Handbook and the goals of diversion described therein were described as focused mainly on drug abuse issues.\textsuperscript{75} If this approach is still in force, then it is certainly a disadvantage for mentally ill youths as it’s possible that diversion is not well equipped to meet their needs and match them to appropriate services. As the 1990 Handbook is 25 years old and no longer the one in use, this may have very well changed.

C. Intercept 3: Jails and Specialty Courts

The ongoing debate between creating a new juvenile mental health court and reforming the current juvenile justice system brings compelling arguments on both sides of the spectrum. The juvenile justice system was established in the early 20\textsuperscript{th} century – during what’s known as the “Progressive Era” – with the purpose of rehabilitating by employing “informal civil proceed-

\begin{footnotes}
\item[71] Ley de Menores, supra note 7, at § 2221.
\item[72] Id. at § 2203 (k). Conduct that if engaged in by an adult would amount to a misdemeanor.
\item[73] See Id. at § 2203 (l). Conduct that if engaged in by an adult would amount to a felony, except those included in Class III (conduct that if engaged in by an adult would amount to first degree felony, except first degree murder which is excluded from the authority of the court; second degree felony; the following felonies in their third degree: attenuated murder, aggravated burglary, kidnapping, robbery, serious assault involving mutilation, attenuated murder; and the following offenses under special laws: distribution of controlled substances and Articles 5.03, 5.07, 5.08, 5.09 and 5.10 of the Armes Act).
\end{footnotes}
ings” to address children’s needs, differing significantly from the retributive nature and conflict of the modern system. Tools such as indeterminate sentencing, parole and probation were employed as a means of individual treatment – a pillar of juvenile rehabilitation. This all changed in the late 1960s as people lost confidence in the system and mottos like “tough on crime”, “adult time for adult crime”, and “nothing works” became popular. To make things more perilous for mentally ill juveniles, the practice of transferring children to adult courts began spreading. It was this social and institutional transformation that led to the current state of the juvenile justice system.

Thus, separate mental health courts for youths with pronounced mental health needs represents a shift to the rehabilitative goals of the system at its origin. It entails intervening aggressively at an early stage and empowering judges to consider the needs of individuals by incorporating comprehensive treatment plans. These courts would be managed by judges and lawyers capable of interacting with mentally ill youths, as it’s done in adult mental health courts. In 2011, 40 juvenile mental health courts operated across the U.S. The first one opened in Santa Clara County, California in 2001. However, these examples cater to a small fraction of the population. If they were to have a significant impact nationwide, these courts would have to be

77 Id.
78 Id. at 4.
79 Id. at 5.
80 Geary, supra note 14.
83 Id.
implemented on an enormous scale in order to attend to an overwhelmingly large population of children and adolescents in need of this type of care.\textsuperscript{84}

The other side of the debate calls for a change within the existing juvenile justice system to accommodate these needs, as it is already capable of addressing young offenders’ issues on an individual case-by-case basis alongside rehabilitative treatment plans.\textsuperscript{85} It appeals for a return to the system of the past and its fundamental emphasis on treatment, rehabilitation, accountability, healing and long-range successful outcomes for the offender and their family.\textsuperscript{86} Developing institutions that are “child-centered, family-focused, community-based and culturally competent” would be the key to its success.\textsuperscript{87} Still, in many jurisdictions the current juvenile justice system may not be equipped to handle juveniles that have or are at risk of developing psychiatric disorders;\textsuperscript{88} therefore reforms may be necessary to acclimate to modern needs. The starting point for said reform are measures such as screening, education and training for those who intervene with the minor, coordination across systems, and delivery of mental health care during incarceration,\textsuperscript{89} all of which are addressed throughout this investigation.

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

\begin{footnotesize}
\begin{enumerate}
\item Burns, supra note 12.
\item Geary, supra note 14 at 694
\item Id.
\item Id. at 693.
\item Id. at 694.
\item See Geary, supra note 14 at 695.
\end{enumerate}
\end{footnotesize}
The first is the provision concerning bail, which dictates that “whenever possible, the minor should be left in the custody of their parents or a responsible person, under the promise of appearing with them in court on a certain date.” It’s been evidenced that adolescents who suffer from mental disorders that are not severe benefit the most from receiving treatment in their communities. Detained youths are four times more likely to be incarcerated by their early thirties than their community-sanctioned peers. It’s only logical that minors are allowed to spend more time in their communities than in a detention center or correctional facility, but sending them home with their parents without a treatment recommendation defeats the purpose of this imperative. Certain conditions can be imposed to begin community-based treatment while in the custody of their parents or guardians awaiting the adjudication hearing.

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

Article 24. Imposition of measures when the minor is found to have committed an offense.

When the court has determined that the minor committed an offense, the court may impose any of the following provisions:

(A) Nominal: minor is counseled, making sure he understands that his conduct is reprehensible and knows the possible consequences of continuing that behavior, but without imposing conditions on his freedom.

(B) Conditional: place the minor on probation, demanding compliance with one or more of the following conditions:
(1) Reporting periodically to the Technician on Family Relations and complying with the rehabilitation program.
(2) Prohibiting certain acts or companies.

90 Ley de Menores, supra note 7 at § 2219.
91 Fondacaro, supra note 1 at 7.
(3) Ordering the restitution to the affected part, according to the regulations promulgated to that effect.
(4) Ordering the youth to perform community service in cases where the offense leads to measures of six (6) months or less…
(5) Ordering the minor to pay the special penalty established by Article 49-C of the Penal Code of 1974…
(6) Any other conditions as the court deems favorable to protection or treatment.

(C) Custody: order the juvenile to remain under the responsibility of any of the following:
1) The Administration of Juvenile Institutions, in cases the measure imposed lasts more than (6) six months. The Juvenile Institutions Administration, through the Evaluation and Classification Division will determine the location of the juvenile and the services that will be offered.
2) An organization or appropriate public or private institution.
3) The Secretary of Health where the juvenile presents mental health problems.  

As part of the conditional measures, the sixth potential condition is an excellent gateway for introducing mental health services, as any juvenile court can consider said service as “favorable to safety or treatment”. Although it may be vague as to what treatment it is referring to, it is still a well construed bottle and a prime receptor for TJ-friendlier wine. The third measure, custody, is of unique importance as it is the only provision within Ley de Menores that expressly mentions youths’ mental health. The Secretary of Health becomes the custodian of minors suffering from mental health issues, yet no reference to mental health beyond that simple sentence is contained within the law. Who makes the referral? After analyzing the main actors in the juvenile legal process, the work of the Family Relations Specialist once again proves crucial. As we are to surmise that the task of referring to the Puerto Rico Health Department falls under the Specialist’s purview, screening procedures and investigating the medical and mental history of

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92 Ley de Menores, supra note 7, at § 2224.
93 Ley de Menores, supra note 7, at § 2213.
the minor become particularly essential to their well-being. It is through this analysis that the Specialist can recommend transferring custody to the Secretary of Health.

D. Intercept 4: Reentry from Jails or State Prisons

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

Most juvenile facilities only provide crisis intervention and occasional group counseling instead of one on one therapy; despite evidence that bringing youth together for treatment or services may make it more likely that they engage in delinquent behavior due to peer deviancy training. The needs of mentally ill youths and their families are unique, as are their backgrounds and experiences, and as such the treatment and therapy received should be equally individual. Thus, treatment should be comprised of “evidence-based, multimodal interventions” and continued monitoring for suicide risks, mental health or substance abuse disorders, and emo-

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94 Youths in the juvenile justice system are sent to juvenile correctional facilities, not jails or state prisons, once the court determines they have committed an offense punishable by confinement. An increased number of juveniles, however, are tried in adult courts and sent to adult prisons, despite evidence of increased chances of sexual assault, physical abuse and violence. Youths with mental disorders are eight times more likely to commit suicide when sent to an adult prison instead of a juvenile facility (Geary, supra note 14).

95 Id.

96 Holman, The Dangers of Detention, supra note 16.

tional and behavioral problems while confined.\textsuperscript{99} When using psychotropic drugs, it should be done in a safe and clinically appropriate manner.\textsuperscript{100}

As guidelines for reforming treatment during confinement, the National Mental Health Association recommends: 1) round-the-clock mental health services, 2) special treatment for children with histories of family abuse, violence, substance abuse, and educational difficulties, 3) individualized treatment in the least restrictive environment possible, and 4) transfers to appropriate medical or mental health facilities when conditions so warrant.\textsuperscript{101} Any placement of a juvenile in confinement should ultimately work toward preparing them for rehabilitation and subsequent return to the community, as the purpose of the entire juvenile justice system should return to its rehabilitative roots.\textsuperscript{102} Effective treatment plans cannot cease upon release, and plans for discharge should serve to integrate the youth back into their family and community.\textsuperscript{103} As explained previously\textsuperscript{104}, the focus should be on improving the functioning of seriously impaired youths so they can participate in rehabilitation programs and giving them tools to live responsibly within their communities, including written plans for services needed after release as well as the juvenile’s own goals for education, housing and employment.\textsuperscript{105}

Gaps between the juvenile justice system and mental health systems are potential problem areas in what’s known as “care coordination”.\textsuperscript{106} Juvenile court staff must rely on professional mental health reports so as to learn the best way to handle youths, yet often times the opp-

\textsuperscript{100} Id.
\textsuperscript{101} Geary, supra note 14 at 701.
\textsuperscript{102} Burns, supra note 12 at 154.
\textsuperscript{103} Geary, supra note 14 at 701.
\textsuperscript{104} See note 34.
\textsuperscript{105} Burns, supra note 12 at 154.
\textsuperscript{106} Geary, supra note 14 at 699. Care coordination “involves accessing and assembling medical, psychiatric, social and educational support services essential to meeting the youth’s mental health needs”.

posite is the reality.\footnote{Michael Jenuwine, Using Therapeutic Jurisprudence to Bridge the Juvenile Justice and Mental Health Systems, Scholarly Works, Paper 452 (2002), http://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1423&context=law_faculty_scholarship} Budget issues due to underfunding and the recent trend of using the system as a means for punishment rather than rehabilitation worsens the situation, as the number of mentally ill minors coming into the juvenile justice system increases.\footnote{Id.} Thus, for a truly effective system, all agencies involved in the care of youths with mental disorders must collaborate to develop and implement treatment strategies.\footnote{Geary, supra note 14 at 699. The agencies include the criminal and juvenile justice systems, mental health systems, schools, family and social service organizations, law enforcement agencies, medical institutions, and substance service systems.}

While Article 24(c) of Ley de Menores\footnote{Ley de Menores, supra note 7, at § 2224.} addressed mental health issues explicitly, Article 35 refers to treatment centers, detention and social treatment. Through this provision, a minor who has committed an offense can be referred out of a correctional facility and into a treatment center.

\textit{Article 35. Centers of treatment, detention and social treatment.}

The Juvenile Institutions Administration and any other authorized public or private agency will provide centers of treatment and detention for any minor covered by the provisions of this law.

(A) \textit{Income, treatment and removal of children in the custody of the Juvenile Institutions Administration.} When a child is delivered to the custody of the Juvenile Institutions Administration, it will determine the treatment program or institution in which the minor will be placed and the type of rehabilitation treatment provided. The Juvenile Institutions Administration may place minors in any treatment program or institution under its jurisdiction.

(B) \textit{Individualized treatment.} Every child is entitled to receive services or treatment in an individual capacity that meets their individual needs and tends toward their eventual rehabilitation.
(C) *Detention facilities.* The facility receives minors referred by the court in accordance with the provisions of this law and will offer assessment and diagnosis services. The Juvenile Institutions Administration and public or private organizations that provide detention centers are authorized to advise and assist the court to determine the diagnosis and assessment services to be provided to children who are referred.

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

(E) The Juvenile Institutions Administration will establish a support unit for those youths that committed an offense so they know their rights, about job options, education and housing, to thereby ensure their full reintegration into society.\(^{111}\)

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

\(^{111}\) Ley de Menores, supra note 7, at § 2235.
Assessment and diagnosis services within the detention facility are a prime opportunity for screening for mental or substance use disorders, suicide risk factors and behaviors, and other emotional or behavioral problems. Of course, the best scenario is one where the minor was diagnosed before being admitted into a correctional facility, but the safeguards of this provision are certainly convenient. The transfer of minors to public or private organizations based on their best interests is another example of how the needs of the youth are an important influence on deciding where they would be best cared for. Finally, informing youths about employment, housing and education is precisely the sort of approach many call for once the youth is released to his or her community. Article 35 is clearly TJ-friendly and it complies with the purpose of this particular interception point, as its main goal seems to be assuring the minor’s well-being through a series of flexible mechanisms through which their needs can be addressed when confined and offering appropriate re-entry techniques to facilitate the youth’s reintegration into society.

E. Intercept 5: Community Corrections and Community Support Services

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

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

Wraparound services’ philosophy is based on Stroul’s and Freidman’s system of care values and principles framework by formulating an individual treatment plan in accordance with the youth’s needs with services in the home, the school, and the community. It’s oriented toward placing youths in small group homes, allowing the youth and their family an opportunity to participate in their rehabilitation, instilling principles of compassion and unconditional care, integrating formal and informal services and systems, and striving for safety and permanency in their communities. Multi-systemic therapy is one of the best available treatment options for youths with mental health issues involved in the juvenile justice system. A therapist “collaborates with the family to determine the factors in the youth's “social ecology” (peers, school and community) that are contributing to the identified problems and to design interven-

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116 Geary, supra note 14 at 703.
118 The system of care framework focuses on eight overlapping dimensions as areas of need for the child and their families: Mental Health Services, Social Services, Educational Services, Health Services, Substance Abuse Services, Vocational Services, Recreational Services, and Operational Services.
119 Geary, supra note 14.
120 Supra note 118.
121 id. at 5.
tions to address these factors”. Similar to the previous approach, it strives to impact every aspect of the youth’s life including family, friends, discipline, school performance, recreation, and community ties. This program has proven to be particularly useful in reducing recidivism (reported 70% decrease in long-term re-arrest).

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

VI. CONCLUSION

Ley de Menores contains a number of provisions encouraging TJ principles and practices that are advantageous for minors diagnosed with mental illnesses, from those suffering from emotional disorders to bipolar disorder or schizophrenia. The role of the Family Relations Specialist is especially meaningful, as it’s the one figure in the law that can evaluate the youth (pref-
erably through a thorough screening process) and has a direct influence in his or her fate. If every actor within the juvenile justice system does their job correctly (police officers, court staff, social workers, supervisors, judges, and mental health staff), the mentally ill youth should end up where they belong: in community-based treatment or a hospital for the more severe cases. After a careful examination of the literature and recommendations for a better system, I conclude Ley de Menores is an overall TJ-friendly “legal landscape”. Unfortunately, theory can differ greatly from reality. Financial issues, staff shortage, lack of experience – a number of external factors can negatively affect every single phase of the juvenile system process, rendering its “practices and techniques” TJ-unfriendly. As a final reflection or food for thought, the humblest recommendation can often be the most effective. When all else fails, simply raising awareness of mental health issues in the juvenile justice system presents a fine opportunity for bringing justice – therapeutic justice – to mentally ill young offenders.

126 Wexler, supra note 5. In TJ terminology, “legal landscapes” refers to legal rules and legal procedures.
127 Id. “Practice and techniques” refers to legal roles of actors, such as judges, lawyers and other professionals.