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# Mental Health Assessment of Minors in the Juvenile Justice System

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Legal professionals first joined with social workers and psychologists to seek social reform addressing juvenile delinquency, worker safety, unemployment, and child labor.<sup>1</sup> These legal and non-legal professionals initiated a collaboration to intervene on behalf of troubled children.<sup>2</sup> They explained the criminal behavior of juveniles with the construct of “the omnibus theory of delinquency,” and justified state intervention in the child’s life as “the rehabilitative ideal.” An early interdisciplinary group of reformers, known as the “child-savers,” was the driving force in the development of the juvenile justice system.<sup>3</sup> In 1891, attorney Florence Kelly arrived at social worker Jane Addams’s Hull House Settlement to further “the expansion of civil society in which women could play a substantial role.”<sup>4</sup> Although Kelly was a trained and licensed lawyer, this was not her public identity. She worked for social reform through means

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1. RAYMOND ALBERT, *LAW AND SOCIAL WORK PRACTICE* (2000).

2. ANTHONY M. PLATT, *THE CHILD SAVERS: THE INVENTION OF DELINQUENCY* 3-14 (1969).

3. Albert M. Drukteinis, *Criminal Responsibility of Juvenile Offenders*, 4 *AM. J. OF FORENSIC PSYCHOL.* 33, 37 (1986).

4. KATHRYN KISH SKLAR, *FLORENCE KELLEY AND THE NATION’S WORK: THE RISE OF WOMEN’S POLITICAL CULTURE, 1830-1900* 176 (1995).

more often associated with the modern field of social work.<sup>5</sup> As a result of interdisciplinary collaboration between Hull House reformers, political officials, and local attorneys, Illinois is credited with developing the nation's first Juvenile Court. The Illinois juvenile court first opened its doors to juvenile delinquents and children in need of protection in 1899.<sup>6</sup> Jane Addams believed that the purpose of the initial juvenile court reflected "a determination to understand the growing child and a sincere effort to find ways for securing his orderly development in normal society."<sup>7</sup> Other states soon followed Illinois in passing legislation to create specialized juvenile courts across the country.<sup>8</sup>

More than a century later, our nation remains uncertain over how to address the problem of juvenile crime. Questions remain about how to successfully intervene in the lives of wayward youth, to prevent them from progressing from juvenile delinquents into hardened adult criminals.

Recent reports recognize that children and adolescents with undiagnosed mental illnesses make up a significant proportion of youth in the juvenile justice system.<sup>9</sup> In determining how to rehabilitate youth in the juvenile justice system, judges, lawyers, and probation officers are starting to look at mental health problems as one element contributing to delinquent behavior. It is becoming more common for attorneys to request "mental health assessments" for their juvenile clients. Problems arise, however, in determining what specifically constitutes such an assessment, and in deciding what to do with this information once it is obtained. In 2001, the Illinois Cook County Juvenile Court convened the interdisciplinary Juvenile

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5. See *id.* at 263-65 (analyzing the reasons why Kelley eschewed a public identity as a lawyer).

6. 1899 Ill. Laws 131.

7. JANE ADDAMS, INTRODUCTION TO THE CHILD, THE CLINIC AND THE COURT (1925).

8. See Sanford J. Fox, *Juvenile Justice Reform: An Historical Perspective*, 22 STAN. L. REV. 1187, 1229 (1970) (arguing that other states adopted legislation that imitated the Illinois Juvenile Court). By 1911, twenty-two other states had enacted statutes to create juvenile courts, and forty-five other states followed suit by 1925. DOUGLAS E. ABRAMS & SARAH H. RAMSEY, CHILDREN AND THE LAW: DOCTRINE, POLICY AND PRACTICE 1038 (2000).

9. See generally U.S. PUBLIC HEALTH SERVICE REPORT OF THE SURGEON GENERAL'S CONFERENCE ON CHILDREN'S MENTAL HEALTH: A NATIONAL ACTION AGENDA (1999), available at <http://www.surgeongeneral.gov/topics/cmh/childreport.htm> (last visited Nov. 11, 2002) [hereinafter CHILDREN'S MENTAL HEALTH].

Justice Committee on Mental Health Assessments to address this issue. Specifically, the committee attempted to define the components and protocol for mental health assessments, how to handle the results of such assessments, and, ultimately, what to do with the youth. The following report summarizes the committee's findings, and outlines its relevance to interdisciplinary clinical legal education.

## DEFINING THE PROBLEM

The intent of the Illinois Juvenile Court Act of 1987 is “to promote a juvenile justice system capable of dealing with the problem of juvenile delinquency, a system that will protect the community, impose accountability for violations of law and equip juvenile offenders with competencies to live responsibly and productively.”<sup>10</sup> The statute is based on the theory of balanced and restorative justice (BARJ).<sup>11</sup> This model is viewed as triangular, focusing on a balance of youth accountability, community safety, and competency development. The BARJ model views a juvenile's illegal act as an interpersonal violation against specific people and relationships, with the restorative process serving “to restore victims, restore offenders, and restore communities in a way that all

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10. 705 ILL. COMP. STAT. 405/5-101 (2000).

11. *Id.* The Department of Justice's Office of Juvenile Justice and Delinquency Prevention has advanced the BARJ Model. In general, it set out the principles of balanced and restorative justice including:

- Crime is injury.
- Crime hurts individual victims, communities, and juvenile offenders and creates an obligation to make things right.
- All parties should be a part of the response to the crime, including the victim if he or she wishes, the community, and the juvenile offender.
- The victim's perspective is central to deciding how to repair the harm caused by the crime.
- Accountability for the juvenile offender means accepting responsibility and acting to repair the harm done.
- The community is responsible for the well-being of all its members, including both the victim and offender.

SHAY BILCHICK, U.S. DEP'T OF JUSTICE, GUIDE FOR IMPLEMENTING THE BALANCED AND RESTORATIVE JUSTICE MODEL 5 (1998) [hereinafter BARJ GUIDE].

stakeholders can agree is just.”<sup>12</sup> The goal of competency development emphasizes using and enhancing the strengths of the juvenile, his family, and his community, and is most synonymous with traditional principles of the mental health system. The statute implements the theory of BARJ, in part, by requiring an individualized assessment of each juvenile in the system to determine his or her needs and competencies.<sup>13</sup> Such assessments have increasingly included measures of mental health. As such, the concern with juvenile mental health is consistent with national trends.<sup>14</sup>

The country has taken a closer look at the issues affecting youth and their need for increased mental health services. This is evident in the 1990’s focus on young “superpredators” and the youth who committed school shootings, such as the one at Columbine High School in 1999. The Surgeon General of the United States highlighted the need for better treatment programs for mentally ill youth in his report on juvenile mental health.<sup>15</sup> Cook County, Illinois shares these concerns, both on a case level and on a system level.

On an individual level, in 1994, a Cook County Juvenile Court judge tried the nationally publicized case of two boys, ages ten and eleven, who were accused of dropping Eric Morse, a five year old boy, to his death from a public housing high rise. In what is still being referred to as “a bold experiment,” the judge sentenced the defendants to the Department of Corrections. However, the judge made treatment a condition of that order.<sup>16</sup> With this sentence, the judge attempted to balance calls for punishment, protections of society, and, most importantly, the rehabilitation of these young offenders. Recently, one of those minors responded well enough to his treatment to return to the community.<sup>17</sup>

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12. John Braithwaite, *A Future Where Punishment is Marginalized: Realistic or Utopian?*, 46 UCLA L. REV. 1727, 1743 (1999).

13. BARJ GUIDE, *supra* note 11.

14. *Id.* See generally Joseph J. Coccozza and Kathleen R. Skowyra, *Youth with Mental Health Disorders: Issues and Emerging Responses*, 7 JUV. JUST. 3 (2000).

15. CHILDREN’S MENTAL HEALTH, *supra* note 9, at 4-9.

16. Gary Marx, *I Convicted in Boy’s Death Free, 2d Lives Without Hope*, CHI. TRIB., Jan. 24, 2001, at 1.

17. The Edwin F. Mandel Legal Aid Clinic, of the University of Chicago, represented the youth returned to the community.

On a system level, the Cook County Juvenile Justice System has explored appropriate ways to treat juveniles with mental health issues. In 1998, the Cook County State Attorney's Office formed a Commission on Juvenile Competency, which recommended revisions to the state's law on juvenile offenders' fitness to stand trial. In 1999, the Clinical Evaluation and Services Initiative (CESI) made recommendations for redesigning the Cook County Juvenile Court Clinic, which conducts most of the court's forensic evaluations. In 2000, the court began a pilot program using community-based MultiSystemic Treatment,<sup>18</sup> a program cited by the Surgeon General.<sup>19</sup>

The Juvenile Justice Commission on Mental Health Assessment's report builds on the work of the previously noted commissions and recommends ways for the Cook County Juvenile Justice System to approach mental health assessment.<sup>20</sup> The report describes some of the research that supports the recommendations, as well as the issues identified by the committee, and proposes a plan for administering mental health assessments to juveniles at several levels of court involvement.<sup>21</sup>

The proposed plan is an interdisciplinary solution which recognizes that juveniles function in multiple systems simultaneously. It relies, primarily, on existing resources. Its implementation will depend on how well the Juvenile Court and the various programs can coordinate their efforts in an overall system of care.

## SCOPE OF THE PROBLEM

According to the U.S. Office of Technology Assessment, "approximately 70 percent of children and adolescents in need of

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18. See SCOTT W. HENGGELER ET AL., *MULTISYSTEMIC TREATMENT OF ANTISOCIAL BEHAVIOR IN CHILDREN AND ADOLESCENTS* (1998).

19. U.S. PUBLIC HEALTH SERVICE, *MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL* (1999), available at <http://www.surgeongeneral.gov/Library/MentalHealth/pdfs/c3.pdf> [hereinafter *MENTAL HEALTH*].

20. Illinois Juvenile Justice Commission, 2000. *The Status of Juvenile Detention in Illinois: Annual Report, 1998*. National Juvenile Detention Association: Washington, D.C.

21. *Id.*

treatment do not receive mental health services”<sup>22</sup> and “[t]oo often, children who are not identified as having mental health problems and who do not receive services end up in jail. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low priorities for resources.”<sup>23</sup>

These findings can be extrapolated statewide from the Cook County sample. In 1998, Cook County’s juvenile population exceeded 1,279,000. There were more than 67,000 arrests and over 14,700 delinquency petitions.<sup>24</sup> Furthermore, the secure temporary detention center admitted over 8,200 youth. Clearly, choosing where to intervene in the system has a dramatic effect on determining the scope of services required. The committee, therefore, turned its focus to understanding the juvenile justice process and on the available resources within that process.

### *Issue 1: Intervention Point*

The web of relationships between the juvenile justice system and mental health services offer an excellent example of the Surgeon General’s warning that “[t]he system for delivering mental health services to children and their families is complex, sometimes to the point of inscrutability—a patchwork of providers, interventions, and

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22. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, CHILDREN’S MENTAL HEALTH: PROBLEMS AND SERVICE—A BACKGROUND PAPER 4 (1986).

23. *Id.* at 11. See also LINDA A. TEPLIN, U.S. DEP’T OF JUSTICE, ASSESSING ALCOHOL, DRUG, AND MENTAL DISORDERS IN JUVENILE DETAINEES (Jan. 2001). Sociologist Linda Teplin is Director of Northwestern University’s Psycho-Legal Studies program. She and her colleagues at Northwestern University conducted longitudinal research on 1,800 minors in the Cook County Juvenile Temporary Detention Center (CCJTDC). *Id.* This research served as the basis on which this Article bases its conclusions. Teplin suggests that changes in systems such as Medicaid and managed care have resulted in fewer youth receiving needed mental health treatment. *Id.* As a consequence, these juveniles end up in the juvenile justice system. *Id.* The diagnostic assessments indicate that two-thirds of the males and three-quarters of the females in the CCJTDC have had one or more psychiatric disorders. *Id.* Over fifteen percent of the detainees suffered from a severe mental illness. In addition, two-thirds of the detainees tested positive for drugs. *Id.* Many of the minors had both a mental illness and substance abuse disorder. *Id.* For more information on the Psycho-Legal Studies program’s research, see their website at <http://www.psycho-legal.nwu.edu/staff> (last visited Oct. 30, 2002).

24. Illinois Juvenile Justice Commission, *supra* note 20.

payers.”<sup>25</sup> The committee created a table to list the various steps in the juvenile justice process, the available services currently available at each step in that process, and ideal resources to understand this complex relationship. In fact, this review demonstrated that many services for juveniles, including mental health services, already exist. The review also illustrated a lack of coordination between available services, and how difficult it can be for those involved in the juvenile justice system to access these services. The report thus identified the need to determine how to make a patchwork system more accessible both to the Juvenile Court and to the juveniles requiring services.

The committee’s table lists the various steps in the juvenile justice process:

Figure 1: Steps in the Juvenile Justice Process

1. An act occurs in the community that constitutes a crime or status offense;
2. Police begin investigation and question the juvenile;
3. Arrest / Station adjustment;
4. Decision to hold in custody / Return home / New living arrangement / Shelter care;
5. Detention;
6. State’s attorney screens all cases coming into court;
7. Detention hearing;
8. Arraignment;
9. Pretrial motions;
10. Supervision, plea bargain or trial;
11. Sentencing (preparation);
12. Sentence implemented;
13. Progress Reports to Court / Probation violations / Change status;
14. Return to community / Age out / Case ends.

After a detailed review, the committee determined that Cook County’s juvenile justice system must attempt to address the availability of mental health assessments for all minors who come into contact with the juvenile court. Specifically, the committee

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25. MENTAL HEALTH, *supra* note 19.



targeted juveniles at the screening stage (Point 6 in figure 1), which is the first time in the process when minors must enter the court building. The committee recognized the possibility of multiple intervention points and of multiple interventions. This necessitated a definition of what constitutes a “mental health assessment.”

### *Issue 2: Mental Health Assessment*

The committee reviewed measures that different providers already use to assess the mental health issues of juveniles who are at various steps in the juvenile justice system. In this review, several points became clear. First, no instrument measures absolute truth and, therefore, no existing instrument is essential. Some measures have potential advantages because they are compiled, published, validated, or already in use. However, each measure has its own limitations and costs. The committee concluded that the importance of the overall assessment process is more important than the assessment instrument, and thus the decisions about the process help determine which measures might be useful.

In the assessment process, providers must first ask what to assess. The concept of “mental health” can either have a broad or a narrow definition. “Mental health” can include issues such as suicidality, risk of violence, psychosis, major mental illness, general mental illness, substance abuse, sexual dangerousness, and cognitive functioning. Every category selected requires the provider to ask different questions.

The provider must also decide how to assess. A variety of people can perform mental health assessments, such as a client who completes a self-assessment, or a psychiatrist who uses sophisticated diagnostic interviewing. Other assessors may include a parent, probation officer, attorney, social worker, or psychologist. Assessors can gather either written or verbal information, based on current status or on a record review. Likewise, they can also administer psychological tests. The assessment can occur in a single interview or in multiple sessions.

Next, the provider decides how to use the assessment. Most assessments require the use of cutoff scores to determine the course of future action. Some assessments exist as screenings that lead to

more detailed assessments. Some results may require crisis intervention, while others may require immediate or delayed referrals.

Finally, the assessor must determine where to make referrals. The Juvenile Court itself does not provide direct mental health services. Given the court's involvement in an assessment, however, decisions must be made regarding the types of services that they will make referrals to, who will provide those services, and who will pay for them.

Several ancillary issues exist regarding these assessments. First, any method of assessment will implicate legal issues of consent, confidentiality, and mandatory reporting of child abuse and neglect. Next, questions arise as to which court personnel should receive information about the assessments and what information to keep in a court file or computer system. To varying degrees, the court's staff will need training about the process. Finally, evaluation issues emerge, including who will monitor the overall assessment process, what follow-up to require, and what feedback to give to whom.

#### PROPOSED PLAN

1. The court should use a three-tiered approach. The first level of assessment should be for those juveniles who enter the court for the screening of their cases (over 20,000 juveniles a year in Cook County). The second level of assessment should occur in the courtrooms for those juveniles who actually have cases filed in court (over 14,000 juveniles each year). The third level of assessment should be for juveniles held in the detention center (over 8,000 juveniles each year). Presumably, these levels represent a progression in the severity of a juvenile's case. The severity of cases actually brought into court would surpass that of the cases that are screened but released. The cases of juveniles who are held in detention would be more serious than those who remain in the community during trial. Therefore, the type of mental health assessment would become more complex with each level of intervention.

2. At the first level, professionals would provide basic educational and referral information to families. In determining what to assess, the provider would focus on general mental illness diagnoses, as well as substance abuse and high-risk behavioral problems. When

deciding how to assess, the provider would base the intervention on parental reports and self-assessments. At the screening, the provider would give the parent and child written information about mental illness that would include symptoms, possible treatment, and detailed information about specific topics. The provider would base this information on literature such as “Facts for Families,” distributed by the American Academy of Child and Adolescent Psychiatry.<sup>26</sup> Participation would be entirely voluntary, based on whether the parent and child decide to participate. The referral literature would list the phone number for at least three referral sources, including the Illinois Department of Human Services’ Office of Mental Health (OMH), the Office of Alcohol and Substance Abuse (OASA), and the Mental Health Association in Illinois (MHAI).

3. At the second level, court personnel could request assessments or referrals. In deciding what to assess, the provider would focus on general mental illness diagnoses, substance abuse, and high risk behavioral problems. In deciding how to assess, the provider would make the literature available to families at the first level at each courtroom waiting area. In addition, if the court’s staff has a concern about possible mental health issues they could, in select cases, request an evaluation through the Cook County Juvenile Court Clinic. In other cases, they could consult with a liaison from the Office of Mental Health regarding an appropriate community-based referral. The court could order participation, such as an order for a clinic evaluation, but participation would otherwise be voluntary. The clinic would then order the court evaluations and make referrals to community agencies based on OMH and OASA catchment areas.

4. At the third level, the detention center staff would conduct a mental health screening as part of the intake process. When determining what to assess, the focus would be on major mental illness diagnoses, including psychosis and affective disorders. Personnel would use a one page screening instrument as part of the intake process for all detainees. When a detainee answered “yes” to any item on the page, personnel would refer the detainee to an OMH

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26. AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, FACTS FOR FAMILIES (1997), at <http://www.aacap.org/publications/factsfam/index.htm> (last visited Sept. 9, 2002).

liaison as part of the Mental Health Juvenile Justice Initiative.<sup>27</sup> Upon receiving a positive screening instrument, the liaison would contact the family. With permission, the liaison would then conduct a more detailed psychological interview of the child. If the professional diagnosed the child with a major mental illness after the interview, the liaison would develop a treatment plan. The treatment plan would include the minor's needs and strengths, services required, where to obtain these services, and how to fund those services. The court would use the report in ways that are consistent with the principle of restorative justice. Additionally, the liaison would also make referrals to existing community-based services. The Chicago Public Schools (CPS) would assist in developing the treatment plan, and would also conduct educational assessments at the detention center.

5. Implementing this proposal concerns several other issues. The assessment process should be kept as voluntary as possible. For long-term success, families must be willing to work with the community providers. Educating families and including them in the planning process improves their cooperation.

One goal of this proposal is to overcome the stigma associated with the label of mental illness. Court orders should specify when a child's participation is mandatory. Someone should explain this to the family. Court files should contain reports from mandatory assessments. Referring professionals should note voluntary referrals only as "referral given," without additional details. The law mandates that clinicians who conduct mental health assessments report for issues of child abuse and also have a duty to warn of imminent harm to the client or another. Professionals should inform the families of these limitations at the beginning of any assessment.

6. The court would establish a training committee with

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27. The Mental Health Juvenile Justice Initiative is a statewide project through the Illinois Department of Human Services (DHS). When the court identifies a minor in detention as a potential victim of mental illness then a clinician from a community agency will assess that child. If the child has a major mental illness, the clinician works to identify appropriate community services, including mental health, medication, substance abuse, special education and public health services. The clinician identifies funding sources and provides additional money for recommended services when public funding is unavailable. Finally, the clinician works with the court staff to implement an approved plan. The DHS Office of Mental Health's Juvenile Forensic Program oversees the project and Northwestern University evaluates it.

representatives from the court, detention, probation, court clinic, the Illinois OMH, the Illinois OASA, the CPS, the Court Evaluation Services Initiative, family consumer advocates, and other relevant groups. Consultants would also be made available. Additionally, training would be ongoing and targeted at the various roles played by the court's staff. The training would include periodic sessions where staff could bring case examples for problem solving. Finally, training would be revised based on feedback from the staff and the evaluators.

7. An independent evaluator should study the process to the extent that funding allows. Evaluators could provide simple data in an aggregate and nonidentifiable form, such as the number of handouts distributed, clinical evaluations ordered, and referrals made. Evaluators could track family referral by using consents. The training committee and the court should use the evaluation as feedback, to assure quality in the assessment process.

8. The Presiding Judge for the Juvenile Justice Division would appoint a three person committee to oversee the mental health assessment process. The committee would monitor the three-tiered mental health screening, court, and detention center referral process. Furthermore, the training committee and evaluator would provide quarterly reports to the committee, and the oversight committee would make an annual report to the Presiding Judge.

## SUMMARY

This Article makes recommendations for an overall approach to mental health assessment by the Cook County Juvenile Justice System. It describes some of the research behind the recommendations, as well as issues which the committee identified, and thereafter presents a proposal to allow for mental health assessments of juveniles at several levels of court involvement.

We propose an interdisciplinary solution that primarily relies on existing resources. At the screening level, the court will provide information about mental illness to families, whose participation would be voluntary. At the courtroom level, the court will order assessments and request referral information. At the detention center, all juveniles would receive major mental illness screens. Thus, as juveniles face increased severity in the Juvenile Justice system, the

number of juveniles would decrease, and the mental health intervention would be more focused and mandatory. This proposal is consistent with the intent of the Illinois Juvenile Court Act, with the principle of Restorative Justice, and with the U.S. Surgeon General's call for better treatment programs for youth in the juvenile justice system. The implementation of this proposal depends on how well the Juvenile Court and the various agencies and departments can coordinate their efforts into an overall system of care.

#### IMPLICATIONS FOR INTERDISCIPLINARY LEGAL CLINICS

Like the original Cook County Juvenile Court, which served as a model of interdisciplinary legal advocacy on behalf of troubled children in 1899, the work of the 2001 Committee on Mental Health Assessments provides useful guidance to legal clinics. It is not uncommon for lawyers and law students to misunderstand the scope and limitations of "mental health assessments." Social workers, psychologists, and psychiatrists often become involved in cases where there are questions of the veracity of a client's statements, where a client's behavior seems odd, or where a client otherwise becomes annoying or troublesome to the attorneys. In these cases, the concept of "interdisciplinary" legal work seems more like a desperate plea for outside intervention, because lawyers do not completely understand the scope and limitations of mental health evaluations. When law clinics initially hire mental health professionals, the clinics typically inundate them with requests to evaluate nearly every open client. As the saying goes, "*When the only tool you have is a hammer, every problem looks like a nail.*" Following the example of the Cook County Committee on Mental Health Assessments, law clinics can review their expectations of, and reliance on, interdisciplinary resources.

As one can define mental health broadly or narrowly, it is necessary to delineate referral questions when asking for a mental health evaluation of a legal clinic's client. If the request for a mental health assessment is based on a client's bizarre behavior, it may be best to assess whether the individual suffers from a major mental illness. Broader assessments would consider whether the individual suffered from a personality or character disorder, posed an imminent

risk of violence or suicide, or met diagnostic criteria for substance abuse disorders. Most mental health evaluations focus on an individual's current status, and do not necessarily indicate the individual's mental state at a prior time. The person requesting the evaluation should decide in advance why they want to know the information and how the likely outcome would affect the legal case. Once an attorney requests an evaluation, he or she should be prepared to act on any findings that result.

During the assessment process, the fastest and most economical techniques are self-assessments. Their obvious limitation, however, is their dependence on the client's ability and willingness to honestly and accurately report symptoms. As a check on the validity of the individual's reporting, some of the longer self-assessment measures attempt to capture the consistency of the information that the individual reports. Many clients lack the literacy and/or attention span to complete more complicated self-assessments. Outside assessors such as parents, probation officers, attorneys, social workers, and psychologists provide added dimensions, but they also bring potential biases to the evaluations. When broadly assessing a client, additional measures are necessary to prolong both the client's time spent on the evaluation, the evaluator's time spent with the client, and in interpreting the results. Assessments that rely on only one or two self-assessment measures have very limited reliability, and are vulnerable to attack on cross-examination. Lawyers should take care to request assessments of their clients using self-assessment measures, interviews, and professionally administered tests.

The next decision is how to use the assessment. A lawyer who requests a full mental health evaluation must be prepared to involuntarily hospitalize a suicidal client if the test results indicate that it is necessary. Lawyers must also decide whether their client would be willing to voluntarily undergo therapy services if the assessment is indicative that he or she suffers from a mental illness. Attorneys should also inquire about the cutoff scores in the assessment, and the identity of the normative population to which the assessors compared their patient's responses. Assessment findings that result from a mental health screening will not be as robust as those findings produced by a thorough battery of psychological tests.

The final major question is where to refer. Law clinics are not

designed to provide direct mental health services. Law clinics that inquire about a client's mental health functioning must decide to what services they will refer, who will provide the services, and who will pay for them. To make such decisions, law clinics should utilize a social worker or psychologist familiar with the appropriate services that are available in their respective geographic areas.

## CONCLUSION

The original Juvenile Court of Cook County, by its very nature, was designed to be interdisciplinary in nature, and more therapeutic than the adult criminal justice system. Even in the late 1800s, American society recognized that juveniles differed from adults in both their development and in their needs. The modern Cook County Juvenile Court has maintained this interdisciplinary approach in drafting a plan to serve mentally ill youth who exhibit behavioral problems. Interdisciplinary clinical legal programs can greatly benefit by following the example set by the Cook County Juvenile Court, and should carefully evaluate how to collaborate with mental health professionals in order to assess and treat the mental health needs of their clients.