Courts as Therapeutic Agents: Thinking Past the Novelty of Mental Health Courts

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Persons who have mental illness are over-represented among jail and prison inmates.[1] Efforts have been advancing to stem the flow of offenders who have mental illness into the criminal justice system. The best known initiatives are diversion programs situated within the police department or jail.[2–4] The mental health court is the newest of these approaches.[5–7] Although there are currently fewer than a score of mental health courts in the country, the numbers are expected to mushroom with passage of Public Law Number 107-77,[8] which earmarked $4 million for mental health courts in 2002.

Mental health courts are analogous to drug courts. Their intent is to reduce criminal behavior and recidivism by treating the illness that is causing illegal behavior.[9] In following the legal theory of therapeutic jurisprudence, these courts are attempting to improve justice by considering the therapeutic and antitherapeutic consequences that "flow from substantive rules, legal procedures, or the behavior of legal actors (lawyers and judges)."[10] Mental health courts, by embracing the principles of therapeutic jurisprudence, become dual agents, representing both treatment and justice concerns.

Because of their nascence, there is scant empirical evidence on the performance of mental health courts. Available evidence suggests that recruitment is feasible and engagement in treatment is possible.[11] In advance of the evidence, however, it is important to examine the mental health court model in the context of its likely therapeutic and antitherapeutic consequences and to consider whether there are other ways to engage the court as a therapeutic agent that will yield a better portfolio of consequences.

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Likely Therapeutic Consequences of Mental Health Courts

Eligibility

Mental health courts engage in what is referred to in the insurance literature as "preferred selection," or "cream skimming." That is, they take the good risks. They recruit individuals who commit low-level offenses (i.e., panhandling, public nuisance, loitering), have no prior criminal histories of violence, and are willing to accept that they need treatment for mental illness.[7] Although the court mandates that the participant and the service system engage in a therapeutic relationship under the watchful eye of the court, the probable success of the therapeutic intervention is in large measure predetermined by the selection criteria. Mental health programs are more likely to accept such clients because the clients want treatment and have less intimidating and fear-inducing behavioral problems, and there is ample research showing that community-based treatments are effective, especially for motivated clients.[12,13]

Selecting only the good risks, however, limits the ability of mental health courts to depopulate the jails of persons with mental illness. Only 10 to 20 percent of such persons are likely to be diverted from incarceration, given that roughly 25 percent of offenders with mental illness held in jails are charged with pub-

lic nuisance offenses.[1] The most-established mental health court had a caseload of 652, representing roughly 10 percent of inmates with mental illness held in that county's justice system.[11] Mental health courts are unlikely to address the needs of the other 80 to 90 percent of offenders with mental illness who remain confined within the criminal justice system.

Mental health courts could do a better job of depopulating jails if they accepted riskier cases. There are two reasons that this is not likely to occur. First, courts are unlikely to accept a riskier case mix because the survivability of mental health courts requires no bad outcomes. Mental health court judges know that if one of their participants commits a violent act on their watch, the searing light of public scrutiny will in all likelihood end the whole experiment. The lethalness of a bad outcome depends in part on the appearance of lenity by the court. Second, courts are not likely to accept riskier cases, because therapeutic success is less likely with them. Riskier participants are more likely to be resistant to treatment (i.e., they have agreed to treatment as a means to get out of jail, not as an end) and have behavioral problems that make them less appealing to the treatment system. Even though past violence is considered the best single predictor of future violence, it is not a perfect one.[14–16] Evidence shows that only one of three individuals with a history of violence will commit another violent act,[17] and the likelihood of future violence among this group as a whole diminishes over time.[14] The prosecutor, the guardian of the public's safety, is unlikely to want to gamble on these riskier cases. The nonadversarial team approach that underpins the mental health court model cannot function without the active participation of the prosecutor.

Stopping Crime Through Treatment

Mental health courts assume uncritically that criminal behavior is caused by a psychiatric problem and that the only way to stop the criminal behavior is to treat the illness causing the behavior.[18] It follows then that therapeutic justice should be substituted for retributive justice, because punishment is ineffective as a deterrent when the behavior is rooted in psychiatric disorder. In such cases, justice requires treatment for the disorder, not punishment.[9]

The ability of mental health courts to stop crime depends critically on the causal connection between mental illness and criminal behavior. The evidence of the connection is thin. Research shows that persons who have mental illness are more likely to be arrested,[19–22] are over-represented in jails and prisons,[1] are less likely to be released on bail, tend to spend more time in jail,[23] and serve longer prison sentences.[1] In addition, psychotic symptoms and co-occurring substance abuse problems have been found to increase acts of violence and other forms of criminal behavior.[19,20–27] Yet, there is no evidence to show that mental illness *per se* is the principal or proximate cause of offending behavior.

Although belief that mental illness causes criminal behavior is widespread, such beliefs run the risk of homogenizing the mentally ill population in ways that misrepresent the tendencies of those with the illness and in so doing stigmatizes the illness and all those who carry its label. Only some persons who have mental illness are criminally active. Different factors motivate such persons to engage in criminal behavior, and only one of these factors is untreated mental illness. For example, Lewis *et al.*[28] identified three offender types among persons with mental illness who were criminally active ($N = 129$). The first type (42%) included those who commit nuisance offenses (e.g., trespassing) and whose "involvement in crime is likely [a] by-product of their illness" (Ref. 28, p 118). The second type (30%) are people who engage in survival crimes (e.g., petty theft, panhandling) because they are poor. The third type (28%) are repeat offenders who commit serious crimes (e.g., burglary, assault). This offender type has "criminal histories [that] are indistinguishable from those of 'normal' criminals. . .[and] their mental disorder seems incidental or secondary to their criminality" (Ref. 28, p 119).

In looking for effective solutions to the criminality of persons who have mental illness, it is vital to begin with an accurate picture of its causes. It is not just illness that causes crime, although the factors that motivate criminal behavior (e.g., poverty) may be coincident with illness. Persons with and without mental illness share some of the same criminologic motivations and risk factors. They share socioeconomic and historical factors that predispose them to committing crimes,[17,29–31] and these factors are likely to exert a separate impact on criminal behavior. Focusing exclusively on illness and the possibility of treatment as a protective shield is apt to tie the effectiveness of mental health courts to the fallacy of good intentions.

Although believing in treatment as a protective shield is appealing, it is important to consider the evidence. Both Wolff *et al.*[32] and Clark *et al.*[33] found that most clients who were actively involved in assertive community treatment (ACT) programs continued to have frequent contacts with the criminal justice system. Indeed, Wolff and her colleagues[32] found that those clients who were the most criminally active were receiving the most expensive set of services. This evidence suggests that even if mental health courts are able to connect participants to effective treatment, treatment may not stop criminal behavior. Although it is perhaps possible to make the ACT model more effective for these clients, it is unrealistic (and naïve) to believe that treatment will solve problems related to poverty or other social injustices that motivate crime among persons who are not mentally ill. It seems unfair to expect better-than-normal behavior from people who share similar criminologic risk factors and have a mental illness.

Likely Antitherapeutic Consequences of Mental Health Courts

Inducements to Crime

Although mental health courts are expected to improve therapeutic outcomes, such courts may actually increase the amount of criminal behavior within the communities they serve. There are two potential mechanisms by which this can happen. The first concerns a crowding-out effect whereby the court's demand for services on behalf of its participants displaces others who are actively involved in treatment.[5,7] Any impact on the quality and availability of community-based services depends on whether mental health courts affect the demand for services without changing the supply. If the court adds only to demand, two things can happen. The service system could cut back on the services provided to those already in treatment (i.e., lower quality) or discharge some current clients (i.e., reduce caseloads). The extent to which either or both of these impacts occur depends in part on the number of new cases identified by the court and the intensity of the clients' treatment needs. If treatment protects against criminality, then crowding out quality and/or quantity of treatment would be expected to increase persons with untreated symptoms within the community and thus increase the amount of criminality. In a sense, the mental health court may indirectly create its own demand for participants through its effect on the treatment system.

Another potential mechanism for inducing criminality arises from the court's ability to gain priority access to treatment. By invoking the court's power and legitimacy, mental health courts may more effectively jump queues or circumvent access barriers and, as such, be more successful in getting mentally ill offenders into treatment.[5,7] Such priority access has greater relevance and material value in communities where treatment systems are tightly constrained by funding. In this way, the success of the court as a negotiator within the treatment system may actually earn it the reputation of an access turnstile. Such a reputation may encourage individuals in the community to commit the type of crime that makes them eligible for the court. Such unintended consequences would be greatest in communities with the tightest access barriers and where mental health courts negotiate away the charges after the offender is admitted to the court. Again, mental health courts, through their success, may create their own demand for participants by indirectly encouraging criminal behavior.

Perpetuating Discrimination

The premise of the community integration movement, which began in the 1960s with the passage of the Community Mental Health Centers and Construction Act of 1963,[34] are based in the philosophy of normalization. Over the years and through legal reforms, persons with mental illness have been assured citizenship equivalent to everyone else. Equal treatment is an integral part of full citizenship, whether the issue under debate is insurance coverage, education, housing, employment, or criminal processing. Indeed, the behavioral philosophy underpinning the ACT model supports having "patients held responsible for their behavior" (Ref. 35, p 508). Elaborating on this, Stein and Diamond[30] assert that if persons with mental illness engage in goal-directed criminal behavior for which other citizens would be held criminally responsible, then criminal processing should be applied to them as well.

Creating differences among arrestees on the basis of mental illness violates the equal-treatment standard of the normalization philosophy. Whether intended or not, providing different treatment for offenders who have mental illness implies that they are somehow different from "normal" arrestees. Such

segregation implies that it is not normal for persons who have mental illness to make mistakes that have criminal implications. It also suggests that persons who have mental illness should be denied the opportunity to learn from their mistakes as does everyone else. Furthermore, this type of special status for offenders who have mental illness holds the illness responsible for the behavior, not the individual and, as such, opens the opportunity for individuals to use illness to excuse behavior. Such logic suggests that the illness should be blamed for some behavior that is deemed deviant in the case of persons who have mental illness, although many non–mentally ill persons engage in similar behavior under similar conditions.

The therapeutic message that goes along with mental health courts is that bad behavior is the fault of the illness, that the illness is in control of the behavior, and that the individual cannot and should not be held responsible for such deviance. Yet, such thinking is not consistent with modern therapeutic approaches or legal reforms, nor is it consistent with public education campaigns on mental illness. In addition, identifying people by their illnesses is known to mark them in ways that can be shaming. Mental health courts create stigma by segregating people by illness and then defining their uniqueness and irresponsibility in terms of the illness. Furthermore, labeling the court a "mental health" court, focuses public attention on psychiatric issues, and amplifies the mark associated with the court. It is interesting to note that other specialized courts are named after the related offending behavior—for example, drug courts or domestic abuse courts. The label mental health court implicitly equates mental health with a criminal offense. By their existence and behavior, these specialized courts trap persons in their illnesses, distinguish them from "normal" citizens, and return them to a therapeutic state.[36]

A Therapeutically Informed Court System

The court has tremendous potential to alter the therapeutic and antitherapeutic consequences associated with criminal processing and sentencing. The following sections provide an outline of an alternative approach that applies the principles of therapeutic jurisprudence to the case of offenders who have mental illness in ways that allow the law to be applied "fairly, evenhandedly, and non-discriminatorily" (Ref. 37, p 665). I propose a court system that is informed of therapeutic issues and acts to ensure access to treatment in compliance with the framework established in *Ruiz v. Estelle*,[38] with standards articulated by the American Psychiatric Association, and with consent decrees in prison class-action lawsuits (e.g., *Dunn v. Voinovich*[39]).[40] The model that is described herein applies only to those defendants with mental illness who are competent, according to the standards set forth in *Dusky v. U.S.*[41]

Principle of Fairness

In my view, the guiding principle underpinning the court's behavior should be equal treatment under the law. That is, those defendants with equal therapeutic needs should have equal access to equivalent treatment. Also, those with equal criminal offenses should experience equal criminal processing.

Therapeutically Informed Judicial Decision Making

All courts would have access to relevant information regarding the presence of a serious mental illness, history of compliance with treatment, and evidence on the extent to which mental illness contributed to the criminal behavior. Defendants identified at booking or arraignment as having a serious mental illness would be assigned to a mental health representative (who may be the defendant's community-based case manager). This representative would compile information on the defendant's medical condition and treatment history, including history of compliance with medication, and would also explain the criminal process, charges, and options. This form of representation is consistent with the practice described by Stein and Diamond[30] but is different from the advocacy representation proposed by the National Mental Health Association.[42]

Normalized Criminal Processing

Criminal processing would begin with the fast-tracking, on the basis of medical necessity, of all cases involving defendants with serious mental illness. In keeping with the principle of equal treatment under the law, judges would use the same legal standards to determine the guilt or innocence of competent defendants, whether they had mental illness or not. During the criminal processing phase, the central issue would be whether the evidence supported the defendant's guilt or innocence.

Therapeutically Informed Sentencing

Judges consider several factors when setting sentences: criminal history, family support, victim preferences, and so forth. The model I propose adds one more factor to the sentencing equation: therapeutic considerations. To assure that criminal equals are treated equally, I propose that judges begin the sentencing process by first identifying the benchmark sentence for the offense of which the defendant has been found guilty and then adjusting that sentence for traditional mitigating and aggravating factors. This adjusted sentence would be adjusted a second time for therapeutic factors (e.g., mental illness, drug addiction). Here the judge would review information on whether the defendant's illness had a principal or proximate effect on the criminal behavior. Two findings are likely: mental illness contributed directly to the defendant's criminal behavior or it did not. In either case, because the defendant's medical condition requires continuous treatment, the sentence assigned by the judge would stipulate that the defendant receive mental health treatment while confined and have an active discharge plan prior to release from prison or jail.

Cases in Which Mental Illness Is Unrelated to the Criminal Act

Defendants would receive the non-therapeutically adjusted benchmark sentence (e.g., 30 days) in those cases in which mental illness is not considered a causal or proximate factor in the crime. Because the person has been shown to have a mental illness that requires treatment, the judge would attach a stipulation to the sentence requiring mental health treatment while confined and an active discharge plan prior to release. Correctional facilities are constitutionally required to provide a minimum standard of mental health treatment to inmates with mental health problems.[40] However, because the provision of that care and its application are uneven, legislatures have sought to strengthen that requirement. For example, New Jersey law requires, in cases involving defendants who have a mental illness, that "the court must order that the defendant be provided with appropriate treatment in the jail or prison where that person is incarcerated" (Ref. 43, p 2). Wisconsin law also gives judges the power to order drug treatment for offenders confined in prison.[44] Furthermore, in some places—for example, New York City and New Jersey—court decrees require discharge planning for inmates who are treated for mental illness while confined.[40] By attaching these stipulations to the sentence, the court ensures that mental health treatment continue inside the correctional facility and after release.

Cases in Which Mental Illness Is Related to the Criminal Act

In these cases, mental illness has been found to be the principal or proximate cause of the offending behavior. The judge now should be able to adjust the benchmark sentence to encourage preferred therapeutic behavior. Specifically, the judge could leverage the sentence to induce participation in treatment. In many states, judges add a treatment stipulation as a condition for release to the sentence.[44–46] This is most common in cases in which there is a clear connection between the offending behavior and the disorder—for example, drug addiction, domestic violence, and sexual assault. In compliance with the principal of equal treatment, similar stipulations should be extended to offenders when there is a clear connection between the offense and the mental illness.

There are several ways in which the judge might do this. The judge might sentence the defendant to 30 days in jail (the non–therapeutically adjusted benchmark sentence) but allow days of freedom to be earned back if the individual stays in treatment while incarcerated (the equivalent of good-time credits in traditional sentencing). If the earn-back rate were one for one, the minimum sentence would be 15 days. Similar inducements could be crafted for defendants on probation or parole, in cases in which time under supervision is tied to the defendant's participation in treatment (similar to conditional release arrangements already used by the court). For example, judges often substitute years in prison for years in community-based treatment for first-time drug offenders.[47] Compliance with or participation in treatment would be determined by standards worked out between the court and correctional agencies in close collaboration with mental health providers. Regardless of the way the sentence is crafted, stipulations would be attached requiring that the inmate receive mental health treatment while confined and that an active discharge plan be established before release. The mental health representative would work with the correctional staff and probation and parole officers to develop and implement after-care planning.

The therapeutically informed court approach outlined herein is universal. It applies to all offenders

who have a mental illness, regardless of their charges. It affirms the full citizenship of persons who have mental illness and recognizes their need for continuous treatment, independent of where they reside—in the community or in jail. Similar to the mental health court, the therapeutically informed approach brings the treatment system to the individual but, unlike the mental health court, it does not substitute treatment for incarceration. Rather, it draws a clear connection between freedom and compliance, and between criminal behavior and the loss of freedom. Both of these connections are essential if the normalization lesson is to be learned. Similarly, the therapeutically informed approach uses the court's sentencing power as leverage for preferred therapeutic behavior. Whether we like it or not, some percentage of persons who have mental illness will spend time in correctional facilities, and this percentage will be much larger than the percentage of arrestees who will qualify for mental health courts.

Using sentencing stipulations to engage offenders in treatment during and after confinement and to promote cooperation between community providers and the criminal justice system has many possible benefits, including stopping the cost shifting and hiding game that has long characterized the criminal justice and mental health system dynamic.[48] State and local agencies will bear the full cost of treatment, regardless of where persons who have mental illness reside. Only under these cost-bearing arrangements are policy makers likely to see the fiscal wisdom of appropriately funding community-based systems of care and affordable housing in safe neighborhoods. Undoubtedly, courts can and should serve as agents for therapeutic reform. The challenge is to balance the therapeutic and antitherapeutic consequences of their agency role and to align such effects with the values underpinning our treatment system and country.

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