Mental Health Courts and the Lesson Learned in Juvenile Court

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> . . .there is no place in our system of law for reaching a result of such tremendous consequences without ceremony—without hearing, without effective assistance of counsel, without a statement of reasons. It is inconceivable that a court of justice dealing with adults, with respect to a similar issue, would proceed in this manner [Ref. 1, p 554].

Justice Fortas in this quotation was addressing the extent of procedural due process provided in juvenile proceedings in 1966. Well-meaning members of the criminal justice system had developed a court process intent on helping juveniles, rather than punishing them as criminal offenders. Since there was no criminal adjudication, and anonymity was generally assured, it was believed that the niceties of procedural due process could be ignored. Unfortunately, as Justice Fortas observed, "there may be grounds for concern that the child gets the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children" (Ref. 1, p 556). We now face similar issues to those confronting Justice Fortas in 1966, with the proliferation of specialty courts as a solution to the need to protect persons with mental illness from becoming relegated to the criminal justice system for continuing care and treatment.

Criminalization of the Mentally Ill

The current crisis of the "criminalization of the mentally ill," a term recognized in social science literature since 1972,[2] is said to have its origins in the "deinstitutionalization" movement of the 1950s. The phenomenon, however, was first recognized in the 1930s by Penrose,[3] who identified the "hydraulic model" of social control. Penrose found that in the European countries he studied, a low number of persons committed to the mental health system corresponded to a high number of persons committed to the prison system and vice versa. In general, this approach attributes the cause of criminal behavior among the mentally ill to the inadequacy of mental health services. Deinstitutionalization was not a movement, but rather a complex set of concurrent developments. In the 1950s and 1960s, a number of factors contributed to the relocation of persons with serious mental illness from state hospitals to community settings. Legal reforms were spurred by the civil rights movement. Funding streams (including the development of Social Security Disability Income in 1956 and Medicaid and Medicare in 1965) for the care and treatment of mental illness were evolving. There were also significant advances in pharmacological treatment (the development of Thorazine).[4] Today, legal advances are spurred by the passage of the Americans With Disabilities Act and cases interpreting that Act. The evolution of funding streams continues, including managed delivery of mental health services. Pharmacological advances including the development of the new generation of so-called atypical antipsychotic medications continue to change the face of community-based care.

The concept identified as deinstitutionalization has been recognized and studied for 50 years.[5] It has been defined as the translocation of patients from

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state hospitals to alternative settings. It should perhaps better be referred to as "dehospitalization." While the movement of individuals from long-term hospitals into *bona fide* neighborhoods in communities has been a benefit to many, others have not fared so well. This problem may be reflected in increased reliance on other (nonmental health) public human services and increased barriers to service access.[6] A well known outcome, one well documented over the past 20 years, is homelessness.[7] A more recently described outcome, one that was originally suggested 65 years ago,[3] is the housing of persons with severe mental illness in jails and prisons once long-term beds are no longer available.[8] We do not mean to imply that these complex social phenomena are solely the result of the movement of persons with mental illness to community placements, but rather to point out that a relationship appears to exist between the movement to the community and the problems of homelessness and criminalization.

One solution to the growing number of mentally ill persons in jails and prisons has been the development of specialized mental health courts to "address the complex issues that mentally ill defendants present to the courts."[9] A variety of models have developed; in fact almost any special effort by the courts to address better the needs of persons with serious mental illness who engage with the criminal justice system can qualify as a mental health court by current standards.[10] This leads to the criticism that the concept has come to have little meaning.[10]

The analogy has been made to the drug court model of specialty courts that have been in existence for some 15 years. Certain elements have been identified as common to all drug courts: immediate intervention, a nonadversarial process, a hands-on judge, treatment programs with clearly defined rules and goals, and a team approach.[12] Two of these elements should generate particular concern for advocates for the mentally ill. The nonadversarial nature of the proceedings and the hands-on judge recall images of the early days of the introduction of procedural safeguards into juvenile court proceedings. The substantive limits on governmental power protect a sphere of autonomy we believe is fundamental (e.g., one's thoughts and bodily integrity), while the procedural limits ensure legitimacy of the process (i.e., effective fact finding and fairness, among others).[13]

As John Petrila noted at the 2004 Annual Conference of the American Psychology-Law Society, the hands-on nature of the judge's involvement, particularly preadjudication, and the nonadversarial approach by both prosecution and defense counsel in cases in these courts, while well intentioned, compromise any hope of just disposition if the defendant chooses to object to the arrangement.[14] In fact, the question of the defendant's ability to participate competently in the process is often ignored in favor of helping him or her to engage in what is seen as appropriate and required treatment.

The zealousness with which appointed counsel represent their clients in cases involving persons with mental illness has long been a matter of concern. Commitment hearings, for example, have been likened to meaningless rituals, serving only to provide a false coating of respectability.[15] Counsel have been identified as unwilling to pursue necessary investigations, suffering from a lack of role identification, unable to generate professional or personal interest in the patient's dilemma, and lacking a clear definition of the advocacy function.[16] Recent evidence does not suggest a marked improvement in performance. "[T]he myth has developed that organized, specialized and aggressive counsel is now available to mentally disabled individuals in commitment, institutionalization and release matters. The availability of such counsel is largely illusory. . . " (Ref. 17, p 690). Without an adequate identification of their role and a traditional adversarial arena to practice in, attorneys seem unable to ensure the level of procedural due process necessary to guarantee protection of the defendant's interests. They revert to the caretaker role identified in juvenile proceedings in the 1960s.

Another aspect of the specialty court movement is the concept of "diversion." In diversion programs, the criminal justice system seeks alternatives to prosecution of persons with mental illness.[18] In the best of circumstances, courts utilize mental health professionals to evaluate and recommend persons for a treatment disposition. The courts then monitor treatment as a condition of probation or some other sentence less than the sentence the particular crime would ordinarily warrant. The implication of diverting a person to someone else's backyard ignores the underlying behavior without empirical evidence that the programs actually reduce recidivism.[12] In times of shrinking budgets for community-based as well as inpatient services the question of whether links to treatment can actually be established also remains to be answered.[10]

If the promised services that such courts mandate were available and accessible in the community setting, then the *quid pro quo* might justify some loss of autonomy over decision making. "The autonomy principle can be inapplicable. . .when an individual is incapable of exercising autonomy (i.e., incapable of making [competent] treatment decisions), or it can be trumped when a particular exercise of autonomy would invade or compromise the autonomy of others" (Ref. 19, p 360). A person who, through the exercise of his autonomy (for example, by forgoing mental health treatment), poses a serious risk to others can be committed involuntarily to the care and treatment of the state. The severity of these restrictions on autonomy demands that the particular restriction of a criminal conviction be accompanied, not only by significant substantive limitations on its exercise (i.e., there are some inherently private practices that cannot be criminalized[20]), but also by significant procedural requirements before the limitation of autonomy can occur. Such requirements include notice, presence (at trial), counsel, jury trial, cross examination, confrontation, and the presentation of evidence. "It is especially important that any effort to medicate involuntarily a pretrial criminal defendant on the basis of dangerousness be done with the full range of procedural protections" (Ref. 15, p 361). Perhaps a more effective solution would be to create a bifurcated hearing process in which the defendant is offered the full armament of procedural due process. Then, after adjudication, the system could "integrate" the court in the services process. By using the motivational guidance and monitoring of the probation department, criminal justice supervision could be integrated with mental health treatment. Utilization of the threat of sanctions to compel treatment compliance has been shown to be an effective intervention strategy in the drug court model and has been proposed as a model for mental health courts.[21]

This concept has been successful in reducing "drug usage. . .for participants, not just graduates," of the drug courts studied nationwide.[22] By making the court a partner in the treatment process, we could take advantage of the multidisciplinary approach advocated in several recent federal reports on these problems.

For example, in 1999, the Surgeon General issued a report, "Mental Health in America." The report noted:

> Another of the defining trends has been the transformation of the mental illness treatment and mental health services landscapes, including increased reliance on primary health care and other human service providers. Today, the U.S. mental health system is multifaceted and complex, comprising the public and private sectors, general health and specialty mental health providers, and social services, housing, criminal justice, and educational agencies. These agencies do not always function in a coordinated manner [Ref. 6, p 101].

Who suffers from this fragmented, layered-on, disordered approach? The "Interim Report of the President's New Freedom Commission on Mental Health" leaves little doubt.

> Adults with serious mental illness, one of our Nation's most vulnerable groups, suffer greatly from the fragmentation and failings of the system. The evidence of our failure to help them is most apparent and most glaring on our Nation's streets, under our bridges, and in institutions like nursing homes and jails. Some are homeless, and some are dependent on alcohol or drugs. Many are unemployed, and many go without any treatment. Most strikingly, less than 40 percent of those with serious mental illness receive stable treatment. An estimated 25 percent of homeless persons have a serious mental disorder and, for the most part, do not receive any treatment [Ref. 23, p 11].

The Center for Court Innovation report entitled "Rethinking the Revolving Door: A Look at Mental Illness in the Courts" questions the result of decreasing the hospitalized mental health population,[24] while witnessing a jail and prison increase.[25] The 1999 report of the Department of Justice found some 16 percent or 283,000 state prison inmates to be mentally ill.[22] The report then questions the level of care afforded persons with mental illness who become involved with the criminal justice system. Only 17 percent of state prisoners and 11 percent of jail inmates who report mental illness histories actually receive mental health services while incarcerated. Jails and prisons offer 24-hour, seven-day-a-week supervision, but they are not typically institutionally equipped, trained, or staffed to address the treatment needs of people with mental illness.[10] It should thus come as no surprise that many ex-offenders with mental illness find themselves back in the criminal system again in short order.[26] Forty-nine percent of federal prisoners with mental illness have three or more prior probations, incarcerations, or arrests, compared with 28 percent without mental illnesses.[18]

Research suggests that as many as half of the adults who have a diagnosable mental disorder will also have a substance use disorder at some point during their lifetimes. Individuals with co-occurring disor-

ders challenge both clinicians and the treatment delivery system.[11] They most frequently use the costliest services (emergency rooms, inpatient facilities, and outreach intensive services), and often have poor clinical outcomes. The combination of problems increases the severity of their psychiatric symptoms and the likelihood of suicide attempts, violent behavior, legal problems, medical problems, and periods of homelessness. Studies show that few providers or systems that treat mental illnesses or substance use disorders adequately address the problem of co-occurring disorders. "Only 19 percent of people who have co-occurring serious mental illnesses and substance dependence disorders are treated for both disorders; 29 percent are not treated for either problem" (Ref. 27, p 59).

The benefit of integrating treatment modalities and service delivery systems has been identified in a number of different disciplines.[28] The Surgeon General's Report observed that:

> Effective functioning of the mental health service system requires connections and coordination among many sectors (public-private, specialty-general health, health-social welfare, housing, criminal justice, and education). Without coordination, it can readily become organizationally fragmented, creating barriers to access. Adding to the system's complexity is its dependence on many streams of funding, with their sometimes competing incentives [Ref. 6, pp 407–8].

Widespread barriers impede effective treatment for people with co-occurring disorders at all levels, including federal, state, and local governments, and individual treatment agencies.[27] Only by taking a "holistic" approach and integrating services in all the domains in which this very vulnerable population functions can we begin to offer hope that treatment will have any lasting effect.

By advocating vigorously during the adjudication phase, attorneys can avoid exposing their clients to intrusions on autonomy that may not be warranted. This will also decrease the number of persons with mental illness needlessly committed to prison or jail as an alternative to treatment. We must all be willing to work to integrate the criminal justice system in the continuum of care if we are to address the treatment needs of those who should be adjudicated and suffer some loss of freedom. The solution to the growing number of persons with mental illness in the criminal justice system requires research into the precipitant factors in their offending behavior and a commitment on the part of treaters, attorneys, and, in particular, legislatures and electorates to provide funding for adequate community-based services to address the mental health needs of persons who have become "dehospitalized."

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13. See, e.g., Mills v. Rogers, 457 U.S. 291 (1982) (explaining that the question of involuntary psychotropic medication of committed person involves both substantive and procedural aspects, where substantive issue "involves a definition of that protected constitutional [liberty] interest [in avoiding unwanted medication], as well as identification of the conditions under which competing state interests might outweigh it. . .[t]he procedural issue concerns the minimum procedures required by the Constitution for determining that the individual's liberty interest actually is outweighed in a particular instance.") (citations omitted)
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20. See, for example: Griswold v. Connecticut, 381 U.S. 479 (1965) (contraception); Stanley v. Georgia, 394 U.S. 557 (1969) (possession of pornography); Loving v. Virginia, 388 U.S. 1 (1967) (marriage)
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