

Analyzing the Relationship between Mental Health Courts and the Prison Industrial Complex

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Mental health courts (MHCs) were designed to address the high rates of incarcerated individuals with serious mental illness in the United States by providing mental health treatment and social supports to those facing criminal charges. In the setting of national uprisings and grassroots demands for abolition of the prison industrial complex (PIC), which is the broad construct of economic and sociopolitical drivers of imprisonment, we draw upon the scholarship of community activists to examine the role of MHCs within the PIC. Specifically, we explore whether MHCs exacerbate harms caused by the criminal justice system or work to reduce its oppressive power. In this analysis, we argue that MHCs can perpetuate harmful assumptions about mental illness and crime, can legitimize the harsh punishment of individuals unfairly deemed undeserving of policy intervention, and can preserve power differentials between courts and court participants. Our analysis underscores the need for a critical reassessment of the role of MHCs in communities and in the PIC. We advocate for an open discussion between community members and advocates, policymakers, and health professionals about how to address the need for mental health treatment and social support without expanding and entrenching the power of the PIC.

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Despite modest reductions in the incarcerated population in the United States in the past decade (15% decline for state and federal prisons and 12% for local jails),^{1,2} the United States continues to incarcerate more individuals than any other country in the world.³ Approximately 16 percent of those individuals have serious mental illness,⁴ far exceeding rates in the community of about 4 percent.⁵ Advocacy to reduce mass incarceration and the criminalization of mental illness have been steadily growing; more recently they have received additional support and public awareness in the aftermath of national uprisings to protest the

killing of Black Americans, some with a history of mental illness, at the hands of police.⁶

The concept of abolition with respect to mass incarceration involves the dismantling of the prison-industrial complex (PIC), defined as “a set of bureaucratic, political, and economic interests that encourage increased spending on imprisonment, regardless of the actual need” (Ref. 7, para 7). Though directly implicating private prisons and the labor extracted from them, as well as the companies contracted to provide services to private and public jails and prisons, the PIC is not just about profit. It is also conceptualized as a tool by which the United States maintains an unjust economic and racial order through confinement in jails and prisons of low-income, Black, Indigenous, Latinx, LGBTQ+, and undocumented individuals, as well as those with physical and mental disabilities.^{8–13}

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PIC abolition has roots in the theory of abolition of slavery: more than merely the end of the legal institution of slavery, abolitionists advocated for African Americans to be able to fully and freely participate in American society.¹⁴ PIC abolitionists such as activists and scholars Drs. Angela Davis and Ruth Wilson Gilmore, and community organizer Mariame Kaba, similarly call for the end, not just of prisons and jails, but also of retributive justice, of the criminalization of poverty, and of societal investment in carceral solutions (such as pretrial detention, cash bail, and solitary confinement) to sociopolitical problems. An abolitionist approach to harm relies on community solutions and rehabilitative, person-centered methods, not imprisonment, as the primary tools for maintaining a safe society.

Key to this type of abolitionist approach is the practice of “abolitionist discernment” of reforms to policies and practices of incarceration, described by Professor Dean Spade at Seattle University. This practice involves asking whether a reform ultimately upholds the status quo of the PIC or moves it toward its destruction.^{15,16} Some reforms may be framed as promoting justice but actually serve to expand and entrench the power and reach of the PIC.^{17,18} For example, reforms to indeterminate sentencing, which were criticized as creating unjust sentencing disparities due to judicial discretion, led to the passing of mandatory minimum statutes¹⁹ with decades-long sentences for nonviolent drug offenses; recent campaigns to make jails more therapeutic and humane may affirm the role of jails as major providers of health care;^{20,21} and sexual violence against women and transgender and gender-nonconforming individuals has given rise to new “gender-responsive prisons.”^{17,22–24} Abolitionist reforms, by contrast, reduce the power of the PIC or reduce its inhumanity without expanding it, such as by ending solitary confinement, stopping construction of new prisons and jails, and eradicating cash bail.^{17,25}

Mental health courts (MHCs) represent a prominent example of efforts to reduce incarceration rates of individuals with serious mental illness who have been disproportionately affected by mass incarceration. The combined impact of the defunding of state psychiatric hospitals without appropriate resource allocation for community care,²⁶ high rates of poverty and poor access to housing, education and health care,²⁷ and high rates of comorbid substance use²⁸ all render individuals with serious mental illness

more subject to policies such as harsh drug laws and broken-windows policing, which maintains that visible signs of social and civil disorder generate further disorder and crime.²⁹

Although generally lauded, MHCs have not arisen without controversy. The purpose of this article is to analyze MHCs through an abolitionist lens and to evaluate whether they align with the dismantling of the PIC. We will draw on the scholarship of grassroots community organizations like Critical Resistance and Survived & Punished,^{30,31} among others, which are some of the most prominent current sources of abolitionist thought. In doing so, we seek to bridge the divide between academic psychiatry and the communities in which we work. We hope to inspire discussion and critical assessment of practices that the psychiatric and criminal justice communities have generally embraced and supported in the past decades.

Brief Background of Mental Health Courts

The first MHC in the United States was created in the late 1990s about a decade after the establishment of the first drug court.³² Since then, more than 450 MHCs have emerged around the nation.³³ MHCs seek to decrease the number of individuals with mental illness in jails and prisons by more suitably meeting their needs for treatment and support services.^{34,35} In 2007, the Council of State Governments and the Bureau of Justice Assistance established guidelines for implementing MHCs, although these are not binding and there is still wide variability across jurisdictions.³⁶ Generally, defendants who meet a specific MHC’s eligibility requirements voluntarily enroll, sometimes by accepting a plea deal, and then participate in court-mandated interventions such as mental health or substance use treatment, case management, drug screening, housing assistance, and vocational training. Sanctions for nonadherence to MHC mandated interventions can include a range of options up to incarceration for the maximum penalty allowable for the related charge.³⁷ MHCs generally adopt a more therapeutic disposition than traditional courts, with emphasis on healing and recovery rather than punishment.³⁸

Many MHCs apply the criminology concept of Risk-Needs-Responsivity.^{39,40} This concept involves evaluating participants for risks that may predispose them to criminal behavior, then tailoring interventions to a participant’s needs (such as housing, social

services, treatment, and vocational training), while bearing in mind individual responsivity factors (such as mental illness) that may mediate one's response to interventions.⁴¹ A clinical assessment about diagnosis and treatment needs is completed by a qualified mental health professional, who may be a psychiatrist. This assessment is used to help the multidisciplinary team in the court implement a treatment plan based on those interventions. The participant and team then report back to the court at regular intervals. Program completion generally results in a reduced or discharged sentence, and in some cases no criminal conviction.³⁷ There remains, however, a high degree of variability between MHCs in terms of eligibility criteria (e.g., charges, diagnoses, history of violence, plea requirements), treatments offered, intensity and length of supervision, potential sanctions, and impact of program completion on criminal cases.^{37,42}

Given the variability in implementation of MHCs across jurisdictions, there is no single approach to the evaluation of their effectiveness. As a result, despite their rapid proliferation, data about outcomes remain inconsistent.^{43,44} The most relevant outcome measure related to decarceration (i.e., the opposite of incarceration) is recidivism, or repeated involvement in the criminal justice system; however, even this concept is inconsistently defined (e.g., new arrest, new jail detention, new conviction). Many studies assessing individual MHCs indicate a reduction in rates of recidivism.^{45–52} Three meta-analyses^{37,53,54} and two longitudinal studies of four MHCs^{55,56} supported these findings. Additional longitudinal studies^{57–60} have reported that participants who graduate from MHCs experience a longer time in the community prior to re-arrest; by contrast, one study found that those who enroll in but do not graduate from MHCs were 1.6 times more likely to be re-arrested than those in traditional criminal courts.⁴⁹ Other studies have reported no difference in recidivism.^{61–63}

Mental Health Courts and the PIC

One of the central principles of PIC abolition is advocating for policy changes that do not directly or indirectly support unjust practices of incarceration. To evaluate the significance of MHCs within the larger context of the PIC, we attempt an interdisciplinary analysis that applies the contributions of prominent abolitionist scholars and activists such as David, Gilmore, Kaba, and Spade to the key principles of

MHCs.^{18,64–66} We do so with an understanding that we will necessarily be generalizing about the operations of widely variable courts. To our knowledge, MHCs have not yet been evaluated from an abolitionist perspective in the psychiatric academic literature.

Spade and Kaba have suggested an approach to assessing whether a practice is aligned with abolitionist principles; that is, whether that practice further entrenches or seeks to disrupt the PIC.¹⁵ Following this approach, we ask whether MHCs reduce harm for individuals. MHCs can and frequently do provide near-immediate relief to participants in the form of housing assistance, vocational training, education, and psychiatric and substance use treatment, although for some jurisdictions these services may be limited by available community resources.⁶⁷ There is also relief from jail incarceration and associated benefits that accompany freedom from detention: maintenance of family contact and support, continued employment, housing, insurance or public assistance benefits, and arguably, physical safety. In these ways, MHCs directly reduce harm for participants by creating a path that avoids any or further incarceration and generating substantial benefits by providing resources that improve living conditions.

Next, we ask whether these benefits are distributed equitably. MHCs, like other problem-solving courts, select a group of people (i.e., individuals with serious mental illness who meet specific eligibility criteria and are willing, in some cases, to accept a plea) and provide them with a more humane court process that facilitates access to community resources and diverts them away from incarceration. The selection of individuals with serious mental illness is based on a core principle underlying MHCs that the treatment of serious mental illness will reduce one's likelihood of violent criminal behavior and subsequent arrest or incarceration. There is evidence, however, that only a small fraction of individuals with serious mental illness are at a higher risk of being violent.⁶⁸ Further, the idea that psychiatric disorders as a class of illness, independent of substance use disorders, are a primary driver of criminal behavior has been proven false.^{69–72} Instead, it appears that most criminal behavior among individuals with serious mental illness is a result of the same problems that drive criminal behavior in people without serious mental illness: age, comorbid substance use, poverty, unemployment, and homelessness.^{26,70,73,74} By attempting to reduce criminal recidivism through psychiatric

treatment, MHCs may perpetuate the disproven notion that serious mental illness is a primary cause of criminal behavior. This has the potential to obscure the socioeconomic sources of that behavior, rooted in systemically racist and ableist policies in law enforcement^{27,75-77} and therefore limit momentum for reform related to race, wealth, health care, housing, employment, and education equity.

Linking the benefits and harm reduction that accompany MHCs only to individuals with serious mental illness, even though the same drivers of criminal behavior affect those without serious mental illness, deprives those without an eligible psychiatric diagnosis of those benefits despite needing similar resources and equally deserving humane treatment. As many as 500,000 Americans are held in jail because of an inability to pay bail for a low-level offense: 75 percent of them have been charged with drug or property crimes⁷⁸ and many of them are Black or Latinx. The harmful and traumatic effects of poverty and racism on physical and emotional health are well-documented⁷⁹⁻⁸¹ and profoundly influence decision-making and subsequent behavior. As articulated by criminal law professor Dr. Allegra McLeod, “It may be profoundly unfair to allow some criminal law breakers access to specialized criminal courts because we perceive them to be more worthy of our understanding, when others are really no more blameworthy” (Ref. 82, p 1646).

The removal from traditional courts of individuals viewed as more vulnerable, such as individuals with mental illness, may directly or indirectly legitimize the continued punishment of those individuals left behind. As Ruth Wilson Gilmore writes, this “foregrounding of the relatively innocent” serves to “reinforce the assumption that others are relatively or absolutely guilty and do not deserve political or policy intervention” (Ref. 83, section 3).

Additional analysis related to racial equity reveals that white people are overrepresented in MHCs, especially older women, while racial minorities, particularly Black and Latinx populations, are overrepresented in correctional settings.^{54,84-86} Racial minorities are more likely to be seen as noncompliant and are terminated from MHCs at a significantly higher rate than white defendants.⁸⁷⁻⁸⁹ Though more research is needed, the implication is that beneficial resources are being distributed preferentially to a disproportionately white group within a disproportionately black and brown population.

Another concern prominent in the analysis of MHCs with respect to the PIC is that MHCs were created as an extension of a criminal justice system that relies heavily on threatened or actual incarceration to shape behavior. For example, MHCs that require a plea to a lesser charge in exchange for participation and diversion out of incarceration cannot exist unless there are guilty people to populate them. By operating within the current criminal court structure, MHCs extend from and may further legitimize a judicial system that defines itself largely by who will be incarcerated, for what, and for how long. Although MHCs may prevent select groups of individuals from further incarceration, they may deepen our beliefs as a society that incarceration is appropriate for those without serious mental illness or those who do not comply with MHC mandates.

Critics have also raised concerns about the potential of MHCs to expand the PIC’s net of power and jurisdiction by increasing the reach and scope of policing and surveillance.^{82,90} They argue that this is done by dispensing mental health and social services through criminal-legal means, such as mandated treatment, and by sometimes keeping participants under MHC monitoring longer than they would have been in jail.^{44,90,91} MHCs also give judges the power to mandate interventions related to mental illness, albeit aided by assessments from mental health professionals, for which they are not the most appropriate or qualified arbiters.

While MHC operations may not actively destabilize the PIC, following Spade and Kaba’s guidance,^{18,64,65} we ask whether MHCs build power among those harmed by the PIC and enable them to work toward its abolition. One can reasonably argue that MHCs build power, materially and socially, for individuals with serious mental illness by assisting them with social supports and therapeutic interventions and by encouraging their voices in MHC proceedings. Unlike defendants in traditional criminal courts, MHC participants are routinely able to speak directly with the judge and share their point of view.⁵² MHCs still retain a paternalistic approach: judges mandate mental health interventions, surveil participants through regular court hearings and drug screening, and enforce these mandates via the threat of incarceration. MHCs keep power in the hands of judges, court actors, and service providers and maintain traditional power relations between the court and its participants. Although MHCs are designed to

be voluntary, and there are numerous studies indicating that participants subjectively experience their participation in MHCs as such,^{45,92} we argue that they remain at least coercive and, in some cases, unnecessarily threaten autonomy.^{44,93} According to Collins,³⁴ MHCs have the appearance of progressive reform that confers benefits upon ambitious judges, but do nothing to address the root causes of inequality, structural racism, and ableism that leave individuals with serious mental illness marginalized in the first place.

Next Steps

MHCs were founded on important concepts that remain critical today: therapeutic jurisprudence, the risk-needs-responsivity model, the decriminalization of serious mental illness, and resource allocation geared toward optimal benefit. We advocate for these principles to be examined from an abolitionist perspective. As advocates for the mental and physical well-being of all people, psychiatrists should take a closer look at practices that we have historically hailed as healthy and progressive. Though this article has begun to critically reassess the role of MHCs from an abolitionist perspective, much more research, analysis, and discussion among psychiatrists, criminal justice professionals, community members, and advocates are needed. If during these discussions we find that MHCs do not help advance society past reliance on imprisonment of its most marginalized members, we should advocate for policy changes and interventions that will. While the root causes of community violence and harm may take generations to address, the “carceral state is a product of policies that can be undone over a few years, even if the structural determinants of crime remain” (Ref. 94, para 23). By carefully assessing the broader implications of our work for incarcerated people, psychiatrists can help bolster grassroots efforts to dismantle the carceral state and build better futures for our communities.

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