Mental Health Court: Promises and Limitations

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On November 5, 1999, the University of Chicago Center for Public Mental Health Services Research, the Isaac Ray Center/Rush Medical College, and the Loyola University Department of Criminal Justice jointly sponsored the first public symposium to address the issue of mental health courts. Experts from the legal, psychiatric, and public mental health communities were brought together with academic researchers and judges to discuss the promises and limitations of such courts. Presenters included Collie Brown from the National GAINS (Gather, Assess, Interpret, Network, Stimulate) Center for People with Co-occurring Disorders in the Justice System; Norman Poythress, PhD, from the University of South Florida; the Honorable Ginger Lerner-Wren from Broward County, FL; the Honorable Steven Eichholtz from Marion County, IN; the Honorable Stephanie Rhoades from Anchorage, AK; and the Honorable Marjan Staniec (Ret.) from Cook County, IL. Following the presentations, a discussion panel was convened, consisting of Mark Heyrman, JD, from the University of Chicago Law School; Arthur Lurigio, PhD, From Loyola University; James Cavanaugh, MD, from the Isaac Ray Center; James Zartman, JD, from the National Association for the Mentally Ill (NAMI)-Illinois; and Leigh Steiner, PhD, from the Illinois Office of Mental Health. Daniel Luchins, MD, from the University of Chicago and Illinois Office of Mental Health moderated the day's proceedings. The following article summarizes the forum presentations and discussion.

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Therapeutic Jurisprudence and Treatment Courts

The term "therapeutic jurisprudence" first appeared in the law literature in the late 1980s and was used in the context of mental health law.[1] Therapeutic jurisprudence is "the study of the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences for individuals involved in the legal process."[1] Since the late 1980s, therapeutic jurisprudence has emerged as an approach for examining a wide array of legal subjects, including the criminal court system. This new "lens" allows us to examine how legal arrangements may affect therapeutic outcomes.

At about the same time, another movement was forming, separate, but consistent with, the scholarly emergence of therapeutic jurisprudence. Beginning in 1989, the first Drug Treatment Court (DTC) introduced drug treatment principles into the criminal justice process for addicted criminal defendants. By 1997, 325 DTCs were running in 48 states nationwide. This innovative movement reflected the growing recognition and frustration among all parties in the system that traditional methods had failed to significantly reduce drug use among criminals.

The DTC concept synthesizes therapeutic treatment and judicial process; drug possession is viewed as both a criminal justice and a public health problem. Treatment is provided instead of incarceration or probation, and relapse is considered a stumbling block rather than a failure. While a variety of models have been developed, there are five common elements of DTCs: intervention is immediate; the process is non-adversarial; the judge plays a hands-on role; the treatment program has clearly defined rules and goals; and a team approach is used.[1]

Drug court evaluations have shown promising results, including reductions in drug use, criminal behavior, and costs.[1,2] Drug court conferences have been held and professional associations formed. Some jurisdictions have obtained state and federal support; in 1995, the Department of Justice formed the Office of Drug Court Programs. Given the success of DTCs and the frustration with existing methods, several jurisdictions have applied therapeutic jurisprudence concepts and DTC models to their work with offenders with mental illness.

Collie Brown, Associate Director of the National GAINS Center, Policy Research Inc., Delmar, NY, spoke of the context in which the mental health court movement has emerged. As the drug courts spread, these courts have seen an influx of individuals with mental health problems. In response, several jurisdictions have developed mental health tracks within the drug treatment court itself, for example, in Honolulu, HI and Ithaca, NY. The DTC in Lane County, OR has developed two mental health tracks, one for persons with serious mental illness and another for individuals with personality disorders. San Bernardino County, CA has separate drug treatment and mental health courts with the same judge presiding over both.

The first mental health court in the country was established in Broward County, FL in 1997 by administrative order. The goal of the specialized docket is to centralize most criminal misdemeanor cases involving defendants with mental illnesses or developmental disabilities into one court to facilitate quick review and treatment as an alternative to entrance into the criminal justice system. Since the inception of this court, there has been increased interest in mental health courts. Other jurisdictions have begun implementing their own versions, such as the mental health tracks in drug courts, mentioned previously, and separate mental health courts in Santa Barbara, CA, King County, Seattle, WA, and Anchorage, AK. Additionally, federal legislation to fund pilot mental health courts has been introduced in both houses of Congress.

There is no single mental health court model; all of the existing courts have distinct features. An infrastructure is needed to examine this innovation and its potential for success and to create a national locus for dissemination of information and to provide technical and financial support. Brown further recommended that the potential for increased fragmentation caused by specialization be addressed by system collaboration that ensures appropriate services are available to respond to clients' multiple service needs.

Broward County, Florida

Judge Ginger Lerner-Wren has served in the Criminal Division of the Seventeenth Judicial Circuit, Fort Lauderdale, FL since 1996 and as the presiding judge of the Broward County Mental Health Court since it began in 1997.

Credited as the first in the country, the Broward County Mental Health Court was established in 1997 by administrative order. In 1994, Circuit Court Judge Mark Speiser and Public Defender Howard Finkelstein moved to create a Mental Health and Criminal Justice Task Force to address the issues of jail overcrowding and inadequate treatment for offenders with mental illnesses. The task force included representatives from the public defender's office, state's attorney's office, the Broward County Sheriff's Office, community treatment providers, and the local hospital district. Out of this task force, the idea for the mental health court was born. The court has operated on the assumption that the mental health system has failed. It works to marshal and coordinate scarce resources as well as develop new community resources.

The court is a pretrial model that diverts offenders immediately into treatment rather than into the traditional criminal justice system. Currently, nonviolent misdemeanants are eligible to have their cases transferred to the mental health court, with the exception of domestic violence and driving under the influence cases. Simple battery cases are eligible with the victims' consent. In the future, eligibility may be expanded to nonviolent felony cases. Participation in the mental health court is voluntary. Defendants may opt out and go back to traditional criminal court at any time. The process is therapeutically based,

respectful, and deals with the needs of each person individually. Treatment and compliance are monitored internally by the court. When individuals show signs of stability (i.e., housing, social adjustment, etc.), they are released from supervision.

To date, more than 1,700 individuals have passed through Broward's Mental Health Court. Since its doors opened, the court has received national attention and numerous awards. Jurisdictions from across the country and even Europe have visited to gather information.

Broward County Evaluation

The McArthur Foundation has funded an evaluation of the Broward County Mental Health Court to be completed by investigators from the Florida Mental Health Institute at the University of South Florida. Norman Poythress, PhD, Professor and Research Director in the Department of Mental Health Law & Policy, discussed the evaluation design. Dr. Poythress indicated that data collection would begin in December of 1999.

The study will include key informant interviews with individuals from various mental health and criminal justice agencies whose collaborative efforts gave rise to the mental health court. A court process evaluation will compare transcripts from both the mental health court and a conventional misdemeanor court. Initial observations suggest that interactions among participants in the mental health court are considerably less formal than those that occur in traditional courts. Defendants' perceptions of both types of court will also be compared. System and mental health outcomes will be measured in terms of current mental status, community adjustment, mental health services utilization, risky behavior, and system data.

The evaluation will not answer the question "Does mental health court work?" Rather, it is a descriptive study to determine how the Broward County Mental Health Court works. The judgment of whether it works really depends on the values of the policymakers. A decrease in jail days and increases in treatment utilization are expected, which may or may not result in a net cost savings.

Anchorage District Court

Judge Stephanie Rhoades is the administrative judge of the mental health court in Anchorage, AK. She gave an overview of their model, issues they have encountered in implementing the court, and strategies they have adopted for addressing problems.

The Anchorage District Court operates the Court Coordinated Resources Project (CCRP). This mental health court consists of a collaboration of designated corrections, judicial, prosecution, and defense staff who quickly identify nonviolent, low risk, mentally disabled misdemeanants for diversion from expensive jail beds and into community-based behavioral health treatment on bail or as a condition of probation. The court works in tandem with the Jail Alternative Services (JAS) project, a post-booking, jail diversion program operated by the Department of Corrections.

On a sample day in 1997, 37 percent of Anchorage's incarcerated population were Alaska Mental Health Trust beneficiaries.[3] The Department of Corrections, Alaska's largest provider of hospital-based mental health services, is under court order to reduce jail crowding. The tandem projects are the result of a judicial and Department of Corrections-led effort to address these issues. Judge Rhoades chairs a multidisciplinary task force that developed the projects with technical assistance from the National GAINS Center.

The CCRP Mental Health Court is an adjudication court, not a trial court. Individuals who, with the assistance of counsel, choose to participate waive their right to a trial based on the merits of their case and enter a plea of guilty. Because of the local culture in Anchorage, a pretrial diversion model was not feasible. Individuals with mental disabilities who are charged with nonviolent misdemeanors are eligible, and participation is voluntary. Most participants have co-occurring substance abuse or dependence disorders. Because there is no misdemeanor probation in Alaska, the mental health court is the only active monitoring available for these defendants.

In its first year, the CCRP and the JAS project have addressed the lack of probation for misdemeanants and relieved some of the pressure on the Department of Corrections. The 36 offenders who passed through the JAS program and the court were compared against themselves. In the year prior to participation, this group spent a total of 652 days in the hospital and 3,062 in jail. During the year of participation, the same 36 totaled 112 days in the hospital and 585 in jail.

Collaboration among agencies is crucial to implementing the CCRP and similar programs. Players

must be willing to shift out of traditional roles; for example, public defenders must consider the long-term benefit to their client of participating in treatment rather than simply the fastest way to dispose of the criminal case. Judge Rhoades also stressed the importance of a respectful process that does not turn service providers into snitches. For example, she asks defendants if it is okay to ask their treatment providers how they are doing.

One problem in Anchorage is a lack of community resources. There are shortages of housing, integrated mental health and substance abuse treatment programs, and services for individuals with multiple treatment issues. Often, treatment providers will accept only the most well-behaved individuals, rejecting many court clients. Judge Rhoades, careful not to misuse her role as judge, has also suggested that the court should be involved in ensuring that the community takes responsibility so that people are not inappropriately entering the justice system for treatment purposes. Leadership from the judiciary is necessary and appropriate for successful implementation of mental health courts.

Marion County, Indiana

The Honorable Steven Eichholtz is an associate presiding judge of the Marion Superior Court, Indianapolis, IN. A judge since 1991, he has served in both criminal and civil court divisions. He presented an overview of their program and commented on the need for the judiciary to take a leadership role in this area.

The Psychiatric Assertive Identification and Response (PAIR) Mental Health Diversion Project is a cooperative effort of the Marion County Superior Court, the Marion County Prosecutor, the Mental Health Association in Marion County, and mental health services providers, which was begun in September 1996. The project's goals are to reduce rearrests and rehospitalizations of mentally ill offenders and to open up court dockets and jail beds by identifying mentally ill criminal defendants in jail within 72 hours of arrest. Diversion of these defendants to the most appropriate community services follows, with monitoring for compliance with diversion plans.

To be eligible for the program, an individual must have an AXIS I diagnosis of schizophrenia, bipolar disorder, or major depression; be charged with a misdemeanor; and sign an agreement to participate in the program. Potential participants may be identified from jail screening or referred by their attorney, the court, or family members. The local mental health association operates a 24-hour hotline to take referrals from concerned parties. The PAIR program consists of seven steps: referral, assessment and screening, meeting of the Roundtable, service delivery, compliance monitoring, compliance hearings, and dismissal of charges.

The Roundtable is a weekly meeting of the public defender, state's attorney, jail mental health screener, service providers, and a volunteer compliance officer from the mental health association. These meetings do not include members of the judiciary. Participants of the Roundtable discuss which offenders are eligible for the program and develop treatment plans which are then presented to the court for approval. An order is signed by the judge requiring the defendant to take his or her medication, cooperate with treatment, and stay out of trouble for one year. Defendants are required to appear before a magistrate biweekly for compliance hearing. Because providers are involved in selecting who is eligible, there have been very few problems in getting them to accept clients for services. The court recognizes that defendants will relapse, and it tries to work with the individual to achieve the best outcome. If a defendant refuses to comply, or chooses to opt out of the program, he or she is returned to the original court for traditional adjudication. Only 15 percent of participants have failed to complete the program in the past three years.

The PAIR project is more of a pretrial diversion program than a separate mental health court. Legislation expanding the program to nonviolent felony cases was attempted but was unsuccessful; this effort, however, will continue. Additionally, program supporters are considering implementing post-trial programming for mentally ill offenders on probation and parole, training in mental health issues for police officers, and mental health oversight committees for each community, to ensure appropriate services are available and provided.

Unlike his colleagues' informal approaches in Broward and Anchorage counties, Judge Eichholtz takes a more formal approach with mentally ill offenders in the courtroom. He is simply more comfortable with this style, and it seems to be working. Regardless of the particular style or approach, it is important that judges take a leadership role and address the many

issues related to mentally ill offenders in the criminal justice system.

Issues and Concerns

Following the presentations by the presiding mental health court judges, a number of issues and concerns were raised for discussion. Mark Heyrman, Clinical Professor of Law at the University of Chicago, reviewed several reasons why developing a mental health court might be considered and why this might not be appropriate for large metropolitan jurisdictions such as Cook County, IL. First, mental health court models have been presented as a method for dealing with the issue of mentally ill individuals charged with minor crimes and languishing in jails. Although this may be a problem in other jurisdictions, it is not occurring in large urban systems such as Cook County Jail, where 98 percent of the incarcerated population face felony charges.

Second, while implementation of a mental health court may attract resources, Heyrman questioned whether it was worth increasing the stigma of mental illness by locating services within the criminal justice system. Focusing resources here may actually increase the criminalization of the mentally ill, as more charges are filed in an attempt to get people to services. Instead, Heyrman suggested that it is better to direct the resources to provide services to people before they become involved in the criminal justice system. For example, initiatives focused on enhancing community resources and training police to divert individuals to treatment are showing promise.

Third, the mental health court concept has proven effective in bringing various stakeholders together to more effectively address the issues related to offenders with mental illness, as evidenced by the efforts discussed above. In Illinois, people from different systems are already coming together for this purpose. Heyrman pointed to the Metropolitan Planning Council, which consists of representatives from police agencies, consumers, advocates, and providers. He predicts this group will be successful in implementing change using existing mechanisms.

Finally, mental health courts have been suggested as one way to deal with individuals who cycle in and out of hospitals and the criminal justice system, continually failing to comply with treatment. According to Heyrman, there are less stigmatizing mechanisms available in civil court to coerce treatment when necessary. The existing outpatient commitment laws, which have rarely been used in the past, are currently the focus of experiment. If used creatively, Heyrman believes these laws can effectively keep "recyclers" out of the criminal justice system.

In contrast to Heyrman's position, Art Lurigio, Chair of the Criminal Justice Department at Loyola University, Chicago, indicated that some type of mental health court might be a useful tool in large metropolitan jurisdictions as well suburban and rural jurisdictions. He commented on the importance of addressing the issue of co-morbid mental illness and substance abuse that is so prevalent in the criminal justice system. To gain resources for this purpose, Lurigio suggested that it might make sense to emphasize the evidence provided by the McArthur Foundation study that co-morbidity greatly increases the risk of violent behavior. He acknowledged that this approach may not be palatable to those concerned about the stigma of mental illness, but it may be necessary to generate adequate resources. Lurigio also mentioned the potential of specialized probation programs for working with mentally ill offenders.

James Zartman, treasurer of NAMI-Illinois, registered disagreement with Heyrman's view that resources should not be focused on the criminal justice system. Zartman indicated that mentally ill individuals are already in the criminal justice system and need to be provided with services. Resources have not been forthcoming from the community. He supported using the power of the court to obtain and use resources more effectively.

James Cavanaugh, MD, Professor of Psychiatry at Rush Medical College and President of the Isaac Ray Foundation, indicated that a mental health court should be considered as one of many possible interventions. In large urban jurisdictions such as Cook County, where the jail population is primarily felony offenders, it would make the most sense to start with nonviolent felony cases. This approach could work only with the cooperation of various stakeholders, while considering local political realities.

Retired Cook County Judge Marjan Staniec expressed concerns about due process rights and the individual's right to self-determination. He expressed concern that because of their illnesses, some individuals may lack the capacity to make the decision to participate in a mental health court. It is crucial that representation be provided to ensure that mentally ill defendants fully understand the consequences of their options. Finally, he and several oth-

ers emphasized the need to insure that appropriate community services are provided by state and community mental health agencies.

Illinois Office of Mental Health Associate Director Leigh Steiner shared others' concerns about inadequate resources for services. She indicated that Illinois, like many states, has spent much of the last decade establishing linkages from hospital to community and vice versa. It is now time to focus on the development of those linkages into and out of other places where people with mental illnesses are found; these include the criminal justice system, and a mental health court is one potential point of intervention. She questioned how the public's "lock 'em up" sentiment could be overcome. Judge Eichholtz, from Indiana, responded that in developing their program, they included all of the major stakeholders in the process from the beginning. Furthermore, they did not take the concept to the public prior to implementing the PAIR project. Judge Rhoades, from Alaska, indicated that documenting the cost savings from reduced incarceration has helped gain public support in Anchorage, and Judge Wren, from Florida, suggested starting with misdemeanor offenders.

Legal Considerations

Several legal issues must be addressed when conceptualizing and implementing a mental health court. First, state law specifies and limits which crimes may be the basis for an order of probation or supervision imposed without a conviction. Similarly, in most states there are limits on what crimes may be punished by probation following a conviction. Some crimes require mandatory terms of imprisonment.

Additionally, probation and supervision are generally considered lesser sentences than imprisonment. They are, therefore, in some sense "chosen" by a defendant who prefers these sanctions to imprisonment. Nevertheless, due process may prohibit the imposition of treatment as a condition of probation or supervision without a determination that the defendant is mentally ill and that the treatment is appropriate to the defendant's illness; this is particularly true if the treatment is psychotropic medication. Courts have consistently held that even convicted felons retain a qualified right under the due process clause of the Constitution to refuse psychotropic medication and thatthere must be adequate procedural safeguards in place to insure that the treatment is appropriate.

Conclusion

In addition to the legal considerations, several issues became apparent during the forum's presentations and discussion. First, for any type of mental health court model to work, the players involved must be willing to shift roles and work together. Without such collaboration, implementation is unlikely to be successful. Second, there is no single mental health court model that will fit all jurisdictions. The programs discussed varied in terms of origin, population served (types of charges, diagnostic criteria), whether the intervention took place pre- or post-adjudication, and the services and monitoring provided. As indicated by the discussion, some models may be more appropriate for rural or suburban areas or smaller cities than for major metropolitan areas. Perhaps most important, the resources to support the services provided to offenders come from different sources. In Broward County, FL, the mental health court has made use of the existing resources and recently purchased its own transitional residential treatment facility. In Anchorage, AK, the mental health court must utilize existing community resources and often plays the role of encouraging local agencies to provide services to mentally ill offenders. According to Judge Rhoades, lack of resources such as housing and integrated substance abuse treatment remains a major problem in Anchorage. Judge Eichholtz indicated that they have been relatively successful in bringing together existing resources to serve Marion County's (IN) Mental Health Court clients. Other mental health courts, such as the one in King County, Seattle, WA, rely on funds from various sources, including leveraged existing funds, additional new county funds, and externally funded grants.[4]

Who controls the resources has important implications for services to mentally ill offenders and to others with mental illnesses. Whether it is the state, the county, or the court itself that funds services will determine who gets what from whom. Will mental health courts bring new resources to the table, or simply shift existing resources to a new "priority" population? What is the most efficient and effective use of the available resources? If the court controls the resources, who makes treatment decisions? All of

these questions must be considered before implementation of a mental health courts begins.

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