Editor:

We read with interest Zhou and Ford's article "Analyzing the Relationship Between Mental Health Courts and the Prison Industrial Complex."[1] This important article is relevant to a problem that many have sought to address: the over-representation of people with severe mental illness within our criminal justice system. In discussing mental health court (MHC) outcomes, the authors note both the general effectiveness of MHCs at promoting decarceration as well as the variability that detracts from MHC outcomes. Examining MHCs through an abolitionist lens, Zhou and Ford's timely article compels us to examine whether MHC efforts at preventing incarceration may unwittingly serve to perpetuate it.

We commend the authors for drawing attention to MHC's under-representation of Black and Latinx populations, a problem we and other researchers have encountered. We respectfully challenge, however, the authors' suggestion that attempting to reduce criminal recidivism through psychiatric treatment perpetuates a "disproven notion" about mental illness. The authors' view of psychiatric disorders as "a class of illness" overlooks evidence that psychosis and mania can directly or indirectly lead to criminal justice involvement and that treatment of these conditions can reduce such involvement. We recently addressed this subject in a review including 12 studies that examined the effect of pharmacotherapy for psychosis or mania on criminal justice system involvement. Eleven studies (92%) reported significantly reduced criminal recidivism as evidenced by fewer arrests, fewer convictions, delayed time to first arrest, or fewer days incarcerated.[2]

Most people with schizophrenia spectrum disorders or bipolar disorder can be engaged in treatment by consistently offering care that is person centered, trauma informed, and culturally attuned. Some will remain unwilling or unable to accept such care, however, particularly those who are unaware they are ill. These individuals are at risk for cycling through jail, where they experience longer stays with higher rates of disciplinary problems, victimization, and suicide compared with those without psychosis or mania.[3] MHCs provide an opportunity to break this cycle by using legal authority to promote engagement in necessary treatments and services. Coercion is a risk of MHC intervention, but patient perceptions of coercion can be minimized by applying legal authority in ways that support personal autonomy.[4]

The authors expressed concern that MHCs may operate as extensions of the criminal justice system, relying heavily on threats of incarceration while increasing the prison industrial complex's surveillance power. While some courts may operate in this manner, such operation is highly inconsistent with "what works" to prevent criminal recidivism.[5] In addition to using both rewards and graduated sanctions, effective MHCs utilize mental health and criminal justice collaboration with shared problem solving rather than relegating mental health professionals to a surveillance role.

MHCs are only as effective as the treatments and services provided; they should not be expected to replace policy-level efforts to address root causes of incarceration, including poverty and structural racism. We believe that MHC effectiveness should encourage the use of problem-solving courts with other marginalized groups rather than discouraging it, as suggested by the authors.

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