

HALTING THE REVOLVING DOOR OF RECIDIVISM: THE SOCIETAL VALUE OF THE MENTAL HEALTH COURTS AND THE MEANS OF THEIR AMELIORATION

INTRODUCTION

Over the past several years, Mental Health Courts have become more prevalent in criminal justice systems throughout the United States in an effort to halt the revolving door of mentally ill individuals through the courts, hospitals, and prisons, by providing them with effective treatment.¹ The nation's movement toward alternative treatment culminated with President Clinton's signing of Senate bill S. 1865 in November of 2000, which authorized the creation of up to one hundred mental health courts and \$10 million a year for a period of four years for their maintenance.² Over the next several years, mental health courts remained at the political forefront, as Congress continued to pass legislation to aid in their creation and operation. In 2004, Congress authorized the implementation of the Justice and Mental Health Collaboration Program, which strived to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems; since its inception, this program has provided funding for several mental health courts, among other services.³ Due to heightened awareness about the effectiveness of this alternative treatment option, there have been many state grants for such programs as well.⁴ As of 2008, there were about 175 mental health courts nationwide.⁵

¹ Henry J. Steadman et al., *Mental Health Courts: Their Promise and Unanswered Questions*, 52 J.L. & PSYCHIATRY, 457, 457 (2001).

² *Id.*

³ DEP'T OF JUSTICE, MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS, 18 (2008).

⁴ *Id.* at 19.

⁵ Emma Schwartz, *Mental Health Courts: How Special Courts Can Serve Justice and Help Mentally Ill Offenders*, US NEWS AND WORLD REPORT, Feb. 7, 2008, <http://www.usnews.com/articles/news/national/2008/02/07/mental-health-courts.html>.

These developments are a direct result of the renewed focus on therapeutic jurisprudence, which emphasizes the promotion of the psychological well-being of those who are subject to legal proceedings.⁶ In the same vein, the guiding principle of the Mental Health Court programs is that jail and formal adjudication will do little to address the reasons for mentally ill individuals' involvement in the criminal justice system in the first place, will likely exacerbate their conditions, and will probably result in their repeated recycling through the criminal court.⁷ As such, this alternative treatment option emphasizes decreased recidivism through increased mental health services and support for mentally ill offenders.

However, research on mental health courts has demonstrated that there is a lack of any common model or framework other than a hybrid of drug court principles and existing community-based services for people with mental illnesses, making it difficult for other jurisdictions to replicate those that are already in existence.⁸ Further, socioeconomic differences among jurisdictions also make the replication of a paradigmatic model nearly impossible. Generally speaking, the premise is as follows: instead of being sentenced to jail or standard probation, offenders in mental health court are diverted to treatment programs and remain under regular supervision for a fixed length of time until they have stabilized.⁹ However, each court uses a different treatment plan and applies different sanctioning methods.

Any similarities that exist between the mental health courts are simply a result of mirror-imaging by new jurisdictions seeking to replicate their predecessors. However, such copy cat behavior can be problematic due to the major differences between communities, which are not always translatable. Instead of searching for a single paradigmatic model among the existing

⁶ Steadman, *supra* note 1, at 457.

⁷ BUREAU OF JUSTICE ASSISTANCE, MENTAL HEALTH COURTS 11 (2000) (on file with author).

⁸ Steadman, *supra* note 1, at 457.

⁹ Schwartz, *supra* note 5.

mental health courts, program facilitators should create a general framework, which each community could then tailor to accommodate its individual differences. Unfortunately, a universally applicable model of a mental health court has yet to be created despite the fact that it would serve as a cost effective tool to guide interested communities in the implementation of alternative treatment programs.

Today, thousands of mentally ill individuals lack access to proper treatment. Unable to stabilize their condition, many find themselves in prison. In fact, approximately a quarter million individuals with severe mental illnesses are incarcerated at any given moment; about half of them were arrested for non-violent offenses, such as trespassing or disorderly conduct, many of which are an extension of their uncontrolled illnesses.¹⁰ This statistic does not account for the more than half million probationers with serious mental illnesses.¹¹ Considering the extent of the problem, we must explore how the mental health courts have addressed it, determine whether they have been successful at providing much needed resources for mentally ill offenders, and analyze reformative measures to improve the current system.

Part I of this Article addresses the deinstitutionalization of asylums in the United States, resulting in a drastic spike in mentally ill criminals. Part II traces the history of mental health courts and their development nationwide, using the Schenectady County Mental Health Court as a case study. Part III overviews four prominent mental health courts, assessing their successes and failures. Part IV analyzes the success of the mental health court system in decreasing recidivism and provides suggestions for improvement through the implementation of a more centralized and comprehensive program model. Finally, Part V applauds the qualified success of

¹⁰ Lake County Ohio Sheriff, *What is a Mental Health Court?*, <http://www.lakecountyohio.org/sheriff/MENTALHEALTHCOURT.htm> (last visited May 24, 2010).

¹¹ *Id.*

the mental health courts, yet also proposes widespread system reform as the ultimate solution to the mental health crisis in the United States.

I. THE UNFORESEEN BACKLASH OF DEINSTITUTIONALIZATION

To frame the discussion, it is logical to begin with some statistics that elucidate the extent of this nation's mass exodus from the mental health system. At the beginning of the twentieth century, there were approximately 145,000 patients in state mental hospitals.¹² By 1955, that number reached its highest point in the United States, with 559,000 individuals institutionalized in state hospitals.¹³ From 1960 to 1980 this number plunged to less than 100,000; some suggest that that number today may be as low as 40,000 people being housed in state psychiatric hospitals.¹⁴ Instead, many of those who might have been hospitalized in an earlier era have made their homes in local prisons.

Problems with the federal government's deinstitutionalization program arose almost immediately. The centers that were established in response to this legislation were substantially under-funded, leading to a mediocre implementation of the facets of the program.¹⁵ Also, as to be expected, individuals within the community fell prey to NIMBY ("Not In My Back Yard") syndrome, and were consequently resistant to facilities in their neighborhoods, further complicating and slowing the implementation process.¹⁶ As a result of political pressures, plans for the establishment of half-way houses, community residences, outpatient clinics, in-home psychiatric providers, and other alternatives to mental hospitals simply never materialized.¹⁷

Although some mentally ill individuals did receive community housing through Medicare and

¹² RISDON N. SLATE, *THE CRIMINALIZATION OF MENTAL ILLNESS: CRISIS & OPPORTUNITY FOR THE JUSTICE SYSTEM* 28 (2008).

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.* at 33.

¹⁶ *Id.*

¹⁷ *Id.*

Medicaid, these facilities, many of which were nursing homes, were not equipped to care for their mentally ill patients nor were they the proper location to house them.

Although the intent of deinstitutionalization was generally positive, as it aimed to establish specialized community treatment services for people with mental illnesses, such development has lagged far behind the transference of mentally ill people from psychiatric hospitals to the community.¹⁸ As a result of this virtual abandonment of mentally ill individuals, studies have shown that more than twice as many people with mental illness live in prisons than in state mental hospitals.¹⁹ The closure of mental hospitals in the United States during the late 1960s and early 1970s without the implementation of more programs to provide services for these stranded and unstable individuals has created a broken system in desperate need of repair.²⁰ Those that were either turned out of mental hospitals, or simply never allowed to enter in the first place, were forced into the streets, where they were arrested and incarcerated, or died.²¹ Not surprisingly, many of their crimes were manifestations of their untreated mental illnesses.

As a result, prisons became the insufficient replacement for mental hospitals, as they lacked the resources to provide the proper treatment that these individuals needed. In June of 2000, the Department of Justice released a study concluding that an astounding sixteen percent or approximately one in six of all inmates in state adult correctional facilities is identified as mentally ill.²² This statistic is in stark contrast to the two percent incidence of mental illness in

¹⁸ *Id.* at 28.

¹⁹ Schwartz, *supra* note 5.

²⁰ Lisa Rabasca, *A Court that Sentences Psychological Care rather than Jail Time*, 31 *MONITOR ON PSYCHOL.* 58, 58 (2000), available at <http://www.apa.org/monitor/julaug00/court.html>.

²¹ SLATE, *supra* note 12, at 33.

²² CNN, *Report: 16% of State Prison Inmates Mentally Ill*, <http://archives.cnn.com/2001/US/07/15/prisons.mental.health/> (last visited May 24, 2010). (rule 18.2.3.c)

the general population.²³ Furthermore, according to the American Jail Association, between 600,000 and 700,000 mentally ill people are committed to prison annually.²⁴ These statistics reaffirm the growing necessity for treatment, rather than punishment of these offenders, especially since studies have also shown that incarceration can actually exacerbate their illnesses and lead to further decompensation due to the extreme stress of detention.

Considering the nationwide success of specialized drug courts, Mental Health Courts appeared to have substantial promise as a solution to this dilemma. In many respects, their success is of the utmost importance for this society, since, according to the National Alliance for the Mentally Ill, between twenty-five and forty percent of America's mentally ill will have contact with the criminal justice system at least once during their lives.²⁵

II. SCHENECTADY COUNTY MENTAL HEALTH COURT AS A CASE STUDY

The Alternative Treatment Court program, also known as the Mental Health Court, is a relatively new addition to the criminal justice system in Schenectady County, as it was first implemented in June of 2004. The following information about the program draws from my own exposure to it as an intern at the Schenectady Probation Department during the fall of 2006. Utilizing this particular program as a case study is helpful because it demonstrates a somewhat formally structured, multidisciplinary approach to a mental health court program. The following information traces a mentally ill offender's journey through this particular system, starting with initial intake and continuing through graduation.

In Schenectady County, a judge, a probation officer, a social worker, a public defender, a prosecutor from the District Attorney's Office, and several other treatment providers form the

²³ Amy Watson, et al., *Mental Health Courts and the Complex Issue of Mentally Ill Offenders*, 52 *PSYCHIATRIC SERVS.* 477, 477 (2001).

²⁴ Mark Berg, *Mental Health Courts: A New Solution to an Old Problem*, 25 *BEHAV. HEALTH MGMT.* 16, 16 (2005).

²⁵ Rabasca, *supra* note 20, at 58.

team that facilitates the operation of the entire Alternative Treatment Court system. Unlike the typical criminal justice system, where such a team would operate as the adversary, in this setting, the team actually collaborates with the mentally ill offender to develop a functional treatment plan. The typical procedure that a potential candidate must undergo in order to be accepted as a participant in this court begins with a referral and a release of information from his lawyer after his voluntary agreement to participate. The program is not compulsion based, but rather is completely dependent on the individual's free will and desire for assistance. However, the extent to which this participation can honestly be characterized as voluntary will be scrutinized later.

The only offenders that are currently eligible for this program are those that have committed a non-violent felony, the majority of which are drug-related charges. Some of the participants were initially placed in the specialized Drug Court system in the County, but were transferred to the Alternative Treatment Court when substantial mental health issues arose, signifying that they suffered from co-occurring disorders, both mental health and substance abuse. Incredibly, sixty percent of all mentally ill state prison inmates were under the influence of alcohol or drugs at the time that they committed their offenses, elucidating the extent of the problem and highlighting the importance of addressing behavioral issues in conjunction with substance dependencies.²⁶

Since this program receives no outside funding, misdemeanants are unable to participate in this Court due to the lack of sufficient resources to accommodate them. Further, violent criminals are not potential candidates because they pose an immense liability for the Court, which can threaten to undermine the very integrity of the entire program. While this program

²⁶ Berg, *supra* note 24, at 16.

encourages vigilant oversight of the offenders, it is not designed to be a service that guarantees twenty-four hour surveillance, nor does the lack of resources make such a scenario feasible.

If the candidate fits the aforementioned criteria, the District Attorney is likely to accept the referral. However, like many other elements of this particular Court, every case is viewed on an individual, flexible basis, and there is always a possibility for exceptions to be made in extenuating circumstances. The probation officer then legally screens the offender to assess his level of cooperativeness based on his past history and other personal factors. The social worker also clinically screens the offender to determine if he or she can create a suitable program that serves the offender's needs. If both of the screenings yield positive results, the findings are then presented to the entire team who must arrive at a decision regarding his admission into the program. However, under the Schenectady County system, the judge has the ultimate control over all of the decisions and actions that concern the Court. At this phase, acceptance into the program results in the team's almost immediate supervision and care of the participant. The team members admit the individual into specific treatment agencies, do a formal mental health evaluation to properly diagnose him, and form a cohesive treatment plan that suits his needs.

Thus, the typically eighteen to twenty-four month long process of rehabilitation begins. During this time, the participants must meticulously follow their treatment plans, which include taking their medications, attending all appointments with their probation officer, attending counseling sessions, as well as going to court once a month to address the judge about their progress. However, it is not uncommon for the participants to relapse during this intense process, resulting in non-compliance with their conditions. Unlike normal criminal proceedings, the immediate response is not simply to find that the person is violating the terms of his probation, meaning that he would be sent to jail, but rather to provide other forms of punishment

that seek to rehabilitate rather than penalize. For instance, different forms of redirection include: intensified screening, extra supervision, and essay writing. Although some may argue that essay writing is a seemingly juvenile sanction that evokes childlike, academic punishments, the team believes that this tactic is an effective way of expression for such individuals, who sometimes have difficulty explaining their feelings verbally.

If none of these techniques seem to be effective tools for compliance, the team occasionally resorts to a brief jail sentence in order to reinforce the importance of adherence to the program. Graduated sanctions are also utilized on an individualized basis, meaning that there is not a rigid structure of specific, universal punishments that are applicable to everyone. If the offender is continually missing appointments or treatment, the probation officer will typically contact the court and have the participant placed on the calendar immediately. This technique is another form of sanctioning that dissuades non-compliance, as the individual must show up at the court and accept his sentence, usually of community service, or face a bench warrant. On the other hand, if the non-compliance is due to a re-arrest on felony charges, the person is almost undoubtedly going to be completely removed from the program without a chance of reintegration and will be immediately incarcerated, initiating the participant's journey through the traditional criminal justice system. However, if the re-arrest is for a misdemeanor offense, the participant will usually face sanctioning rather than dismissal from the program. In this respect, the Alternative Treatment Court system functions as a coercive agent that compels and encourages the participants to comply at the risk of repercussions for failure to do so.

When the team believes that a participant has stabilized for an extended period of time with no indications of relapse, it instates a six month trial period, in which the offender no longer attends the monthly court sessions, but continues his meetings with both his probation officer

and clinician. If the process is successful and the individual does not deteriorate, he will be eligible for graduation from the program. If he falters during this time, however, the participant must return to the previous conditions, including monthly court appearances.

Prior to the court proceedings, there is a team preparatory meeting. During the meeting, the team discusses the progress and conditions of the participants in the program, and the group decides what issues need to be addressed by the judge. In this sense, the entire court proceeding is a staged event, in which the judge already knows what issues he or she needs to address with each participant. The Alternative Treatment Court is an open court, meaning not only that the public is allowed to sit in on the proceedings, but also that other individuals who are not part of the program will be on the docket and may be waiting in the courtroom for their cases to be heard before the judge. The proceedings are extremely informal in nature and far more personal than the typically sterile court room environment, as the judge and the offender basically engage in a conversation about his needs and progress. Despite the informalities, a closed court setting would be more conducive to the precariousness of these individuals' situations because it would provide them with more privacy and anonymity.

Upon graduation from the program, the graduates are able to speak about their experiences in front of the entire courtroom and receive certificates of achievement from the team. Further, the graduates have their charges dropped (an opportunity that serves as an overarching incentive to not only join, but to complete the program) and are able to reintegrate into society with a clean slate and tools to thrive.

Once these participants are released from the program, there is no follow up procedure. This lack of continuing support ultimately creates a program that provides participants with tools for temporary rehabilitation rather than a permanent lifestyle change, which is not the purpose it

was intended to serve. A monthly or bi-monthly follow up meeting for the first few months after graduation would help to prevent and combat future relapses and be a strong indicator of the success of the program in permanently rehabilitating such offenders. Such information would legitimize any future request for increased funding for the program and would incentivize state leaders to support the program's development. Generally speaking though, despite its flaws and obstacles, the Alternative Treatment Court system in Schenectady is on the right path to becoming a successful and lasting program.

III. NATIONAL SUCCESS OF THE MENTAL HEALTH COURT SYSTEM

Taking the Alternative Treatment Court in Schenectady County as a sample case study, it can then be analyzed in relation to other more developed programs of therapeutic jurisprudence throughout the nation in order to evaluate the mental health court program's effectiveness as well as its shortcomings. Most of the prominent mental health courts across the nation, including those in Broward County, Marion County, King County, and Anchorage, have enjoyed only qualified successes due to vast under-funding and their inability to provide continuing resources and support to the program graduates. Although the following examples illustrate that the differences between these mental health courts are not drastic, it also demonstrates the need for a universally applicable framework to guide the formation of future mental health courts. Such a model must be flexible in order to accommodate the unique cultural and financial needs of different jurisdictions. If all mental health courts across jurisdictions abided by a somewhat uniform model, they would be able to work cooperatively to further develop and improve the mental health court system. This collaborative relationship would operate in stark contrast to the mental health courts' current inability to provide support and advice to one another due to their individual complexities and structural differences.

Although around 175 of these specialized courts exist in the United States today with many more in the process of being established, there is an unequal distribution throughout the states, as Ohio alone is home to thirty of these courts.²⁷ Unfortunately, some communities have been unable to either acquire adequate funding or garner sufficient interest and support for the program, or both. Typically, these programs develop due to the interest of an innovative judge who supports and oversees their implementation. However, as some states continue to invest in such alternative treatment options, awareness of their beneficial impact will hopefully continue to spread, and with it, their popularity.

The first mental health court in the country was established in 1997 in Broward County, Florida by administrative order. The creation of this Court was prompted by the case of Aaron Wynn.²⁸ In 1993, while shopping at a Broward County grocery store, Wynn, with a history of violent schizophrenic episodes, had a psychotic break, running outside and knocking an elderly woman to the ground; she hit her head and died.²⁹ He was charged with manslaughter, was eventually found incompetent to stand trial, and was sent to a psychiatric hospital.³⁰ His case prompted a scathing grand jury report on the state of the county's disorganized mental health system.³¹ Further, a mental health task force that year found that the county was regularly locking up the mentally ill for minor offenses.³² Desperate for a solution to this widespread problem, the county decided to take a leap of faith and implement the first mental health court.

²⁷Ari Shapiro, *States Try Out Courts Tailored for the Mentally Ill*, <http://www.npr.org/templates/story/story.php?storyId=5685265> (last visited May 24, 2010).

²⁸ PBS, *A New Justice System for the Mentally Ill*, <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/courts.html> (last visited May 24, 2010).

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

Only nonviolent misdemeanants are eligible for this alternative treatment program, with the exception of those charged with domestic violence or driving under the influence of alcohol or drugs because separate court programs are already in place to handle these types of offenses.³³ The decision to intervene in misdemeanor cases was intended as an early prevention strategy to target defendants who, with proper treatment and support, could avoid committing more serious crimes in the future.³⁴ With the victim's consent, individuals that are charged with misdemeanor battery are also eligible, making this court one of a handful in the nation that accepts any type of violent criminal.³⁵ With the accumulation of more resources, facilitators intend to extend this program to include nonviolent felons as well. Other successor courts have taken different approaches; Brooklyn Mental Health Court, for example, handles only felonies to avoid becoming the point of entry for people abandoned by the mental health system.³⁶

Like the Schenectady County court, participation is entirely voluntary, and release from the program is concluded on an individual finding of stability.³⁷ In order to be referred as a participant, a clinician from the public defender's office must screen the offender. If the clinician detects symptoms of mental illness, he or she informs the presiding magistrate, who then refers the offender to the Mental Health Court.³⁸ However, before entering the program, the offender must enter a plea of guilty with the understanding that adjudication will be withheld.³⁹ The Broward County program includes a task force that is similar to that of Schenectady County, consisting of representatives from the public defender's office, the prosecutor's office, the

³³ BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at 10.

³⁴ *Id.*

³⁵ *Id.*

³⁶ Carol, Fisler, *Building Trust and Managing Risk: A Look At A Felony Mental Health Court*, 11 PSYCHOLOGY, PUB. POL'Y & LAW 587, 587 (2005).

³⁷ BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at 15.

³⁸ Berg, *supra* note 24, at 19.

³⁹ Patricia A. Griffin, et al., *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVS. 1285, 1287 (2002).

sheriff's office, the local hospital, and the community treatment providers, key stakeholders in the success of the participants.⁴⁰ This group provides services like short and long term residential treatment, community treatment, and substance abuse treatment.⁴¹ Florida's innovative efforts have proven to be a loose model for other mental health courts throughout the nation. Only four years after its inception, 1,200 offenders had passed through Florida's program, a staggeringly higher number than in Schenectady.⁴² However, as the caseloads continue to expand, resources become a concern for the program's facilitators who hope to develop the program without being stymied by under-funding.⁴³

Only a few years later, following Broward County's lead, the judicial system in King County, Washington launched its own mental health court after a similarly disturbing crime occurred within its borders.⁴⁴ A mentally ill misdemeanant brutally murdered the Captain of the Fire Department.⁴⁵ Prior to the murder, the defendant had been released into the community after being found incompetent by the court.⁴⁶ This random attack prompted leaders to search for proper treatment options for such offenders. Unlike the Schenectady County program, these cases are heard on a separate calendar. Initially, in order to be accepted into the program, individuals had to enter a plea of guilty or no contest to their charges with the understanding that they would be convicted with either probation or a suspended jail sentence.⁴⁷ However, now, defendants can choose to go to trial, get convicted and then seek to enter the mental health court, or they may enter the mental health court through a statutory petition for deferred prosecution or

⁴⁰ BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at 17.

⁴¹ *Id.* at 18.

⁴² BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at 10–11.

⁴³ Watson, *supra* note 23, at 479.

⁴⁴ Steadman, *supra* note 1, 457.

⁴⁵ BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at 21.

⁴⁶ *Id.*

⁴⁷ BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at IX.

an agreement with the prosecution for a deferred sentence.⁴⁸ Similar to both Broward County and Schenectady County, this mental health court system is structured as a team approach, with court representatives from justice agencies as well as treatment providers collaborating to create individualized plans for the participants, which include living arrangements, supervision, and treatment.⁴⁹ It is also equipped to support the rehabilitation of participants that range from misdemeanor offenders to violent felons.⁵⁰ Similar to the Schenectady Mental Health Court, when participants fail to comply with the stipulations of their individualized plans, the judge can sanction them with incarceration.

Several public agencies provide funding for the program and sufficient resources for its operation, including the requisite staff. Further, several county funds have been offered on a temporary basis, and the federal government has provided an eighteen month grant of \$150,000 to help support the operation of the court.⁵¹ However, in order to ensure the successful continuation of the program, the state or other governmental entity will need to allocate permanent resources.⁵² Unsurprisingly, like all of the aforementioned mental health court programs, this one also seems to suffer from the dilemma of under-funding.

Another challenge that the King County Mental Health Court program faces is its size; there are seventeen treatment facilities at locations throughout the county, making it difficult to ensure effective oversight of the participants.⁵³ At the same time, further complicating the treatment system, the King County Mental Health Courts have “wrap around” services, whereby the participants engage in some sort of structured treatment or activity from morning to night

⁴⁸ *Id.* at IX, 23.

⁴⁹ *Id.* at 22–26.

⁵⁰ *Id.*

⁵¹ Watson, *supra* note 23, at 479.

⁵² *Id.*

⁵³ BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at 31.

each day, with specialized case managers who visit the participant daily to monitor compliance with day treatment and medication and try to respond to problems as they arise.⁵⁴ This special feature, although certainly beneficial to the participants, requires extensive supervision and therefore also requires increased expenses to ensure that it functions properly, creating a constant balancing act between overextension of the budget and under-utilization of the court's program offerings. Overall, the King County mental health court system has proven relatively successful thus far. However, the program facilitators will need to address its financial and logistical challenges if they want to ensure its continued improvement.

Anchorage, Alaska is the third trailblazing community in the mental health court regime. It is home to one of the most prominent Mental Health Courts in the United States. In 1998, the Criminal Justice Assessment Commission, which had been formed to examine jail overcrowding problems in Anchorage, identified the mentally ill and disabled as a special population presenting difficult problems for the jail and local justice system. One of the recommendations of the Decriminalizing the Mentally Ill Subcommittee was to explore means of "identifying mentally disabled offenders for diversion away from the justice system into coordinated community treatment services," potentially through the development of a mental health court.⁵⁵ This report was the catalyst for its implementation. Interestingly, though, the court chose not to call itself a "mental health court" to avoid the stigma that might be attached to such a title, thus encouraging participation by maintaining the participants' anonymity and privacy.⁵⁶ The Court is divided into two separate systems: the Jail Alternative Services Pilot Program (JAS) and the Court Coordinated Resources Project (CCRP). JAS is a specialized jail based program that

⁵⁴ *Id.* at 33.

⁵⁵ *Id.* at 35.

⁵⁶ *Id.* at 36.

provides placement in community mental health treatment programs for inmates, while CCRP is the actual mental health court program.⁵⁷

The task force staff consists of individuals from the corrections, judiciary, prosecution, and criminal defense arenas. These staff members work together to identify nonviolent, low risk mentally disabled misdemeanants that could be potential participants in the program.⁵⁸ As in the Schenectady County program, the participants must waive their right to a trial and plead guilty to their crimes in order to become involved in the program.⁵⁹ They are then convicted with a term of probation and a suspended jail sentence.⁶⁰ This process is used as an effective means of leverage in encouraging the participants' compliance, as non-adherence with the conditions of the program would then result in traditional court proceedings and sentencing with resulting incarceration for their already confessed offenses. However, like the aforementioned Courts, participation functions on a completely voluntary basis, and cannot be compelled or forced.⁶¹

Many of the offenders that engage in this program, similar to those in Schenectady County, suffer from a co-occurring disorder of mental instability and substance dependency and abuse; in fact, some statistics indicate that nearly half of all participants in this program have a co-occurring disorder.⁶² Although the program in Schenectady is still relatively new, statistics for the success rate of those in the Anchorage program show compelling evidence and indications of its productivity, as there were substantial reductions in the amount of days spent in the hospital and in jail once the participants entered the program.⁶³ However, like King County

⁵⁷ *Id.* at 35.

⁵⁸ *Id.* at 36.

⁵⁹ Griffin, *supra* note 39, at 1287.

⁶⁰ *Id.*

⁶¹ BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at 39.

⁶² *Id.* at 24.

⁶³ Watson, *supra* note 23, at 480.

and Schenectady County, the Anchorage Mental Health Court faces the same problems with securing sufficient funding to ensure the continued availability of services.⁶⁴

The final model for Mental Health Courts in the United States resides in Marion County, Indiana. Participation in this program requires that an individual has an Axis I diagnosis of schizophrenia, bipolar disorder, or major depression, be charged with a misdemeanor offense, and sign an agreement to comply with the conditions of the program.⁶⁵ It is fascinating, yet frustrating that the founders of the program decided to extend eligibility for the program only to misdemeanants with specific mental illnesses at the exclusion of a major cross section of the mentally ill community. Although targeting a large part of the population, these three mental illnesses certainly do not account for all of the mentally ill criminals in the County. In this respect, it seems to be a somewhat random eligibility requirement that disadvantages many individuals who could be potentially excellent candidates for an alternative treatment option. This decision unfortunately perpetuates the misconception that the sickest individuals are those that have one of the three aforementioned illnesses. Awareness of the complexities and types of mental disorders has increased drastically over the recent decades; this development should be acknowledged by providing all mentally ill offenders with alternative treatment options.

As in Schenectady County, attorneys can refer possible participants. However, in Marion County, courts and family members also have the jurisdiction to refer individuals to the program, with a local twenty-four hour hotline overseeing such requests.⁶⁶ This program also follows the near identical process of that in Schenectady County: referral, assessment and screening, meeting of the roundtable (task force/team), service delivery, compliance monitoring, compliance

⁶⁴ BUREAU OF JUSTICE ASSISTANCE, *supra* note 7, at 41.

⁶⁵ Watson, *supra* note 23, at 480.

⁶⁶ *Id.*

hearings (court), and dismissal of the initial charges.⁶⁷ While the roundtable meetings in Marion County are weekly with biweekly compliance hearings, they do not include members of the judiciary.⁶⁸ On the other hand, the meetings in Schenectady County are monthly with monthly compliance hearings and require the presence of the presiding judge. As pertains to the majority of the mental health courts, if the participant continually refuses to comply with the program or opts out at any time, he returns to the original court for the normal proceedings of his conviction. Statistics have indicated that this program has been extremely successful; over the last few years, only fifteen percent of participants have failed to complete the program.⁶⁹

Another more recent success story is the mental health court located in Pittsburgh, which began in 2001. It boasts a recidivism rate of only ten percent compared to the national average of sixty-eight percent, proving that mental health courts might just be the answer to halting the revolving door of recidivism.⁷⁰ Participation in this program is completely voluntary. However, only a handful of eligible defendants turn it down every year, typically because of the possibility of longer court supervision. While the program accepts those facing misdemeanor and felony charges, it bars sex offenders and most violent criminals from participating.⁷¹ In exchange for their guilty pleas, the defendants are put on probation and given an individualized treatment plan. They also receive two months' rent and \$200 for new clothing.⁷² In this respect, the program creates a stable environment for the mentally ill defendants, giving them a better opportunity to assimilate into mainstream society, a transition with which many of the unsupported mentally ill struggle. However, this program faces the problem of retention; of the 481 people who have

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ Schwartz, *supra* note 5.

⁷¹ *Id.*

⁷² *Id.*

enrolled in the court, forty-seven have been thrown out for non-compliance or simply left, a failure rate of nearly ten percent.⁷³

The most recent development in Pennsylvania was the opening of a Mental Health Court in Philadelphia. It began on July 8, 2009 with a pilot group of fifteen non-violent inmates on the verge of completing their jail terms.⁷⁴ The system aims at ensuring that the participants have the necessary therapy and supervision to facilitate their successful reintegration into mainstream society.⁷⁵ The start-up costs for this new court have been funded by a state grant, while personnel have been drawn from existing probation and mental health agencies to keep costs relatively manageable in the hope that it will continue to grow without maintenance costs impeding its development. Pennsylvania's participation in the expansion of the mental health court system will hopefully encourage other states to utilize their resources for the same cause.⁷⁶

IV. SUGGESTIONS FOR IMPROVEMENT

The mental health courts throughout the nation have been fairly effective at rehabilitating their mentally ill participants, making many of them productive members of society rather than recurrent visitors at correctional facilities. Statistics have indicated that not only have the majority of participants successfully completed their alternative treatment plans, but also that the

⁷³ *Id.*

⁷⁴ Joseph A. Slobodzian, *Philadelphia Opens Mental Health Court*, PHILADELPHIA INQUIRER, July 8 2009.

⁷⁵ *Id.*

⁷⁶ Last year, a Mental Health Court also opened in Billings, Montana with the support of a Bureau of Justice Assistance grant for \$249,000. It began with only 14 participants.

To participate in the new Billings court, those facing one or more misdemeanors must plead guilty or agree to a pre-trial diversion, giving the mental-health court at least one year of jurisdiction over their lives. They must also be diagnosed with a clinical mental disorder, such as schizophrenia, bipolar disorder or major depression, and they cannot have a history of sexual or violent offenses.

Kahrin Deines, *Adult Mental Health Court Sees Modest Successes*, BILLINGS GAZETTE, Feb. 28, 2010, available at http://billingsgazette.com/news/local/article_81e7a616-2425-11df-9391-001cc4c03286.html.

recidivism rates of these participants have decreased significantly, demonstrating that there is a strong correlation between mental health treatment and decreased criminality among mentally ill offenders. In this respect, both the mental health court program and the criminal justice system have achieved their desired results by addressing the root cause of these offenders' criminal behavior: uncontrolled mental illness.

However, these programs have only experienced qualified successes. There is certainly room for improvement, especially considering the fact that the entire system is only a little over a decade old and is still considerably undeveloped. The non-exhaustive list of dilemmas that continue to plague the mental health system include: widespread under-funding, impermanent resources, which ultimately result in diminished resources for the mainstream population, the arguably coercive nature of participation, the lack of privacy and anonymity for participants, the use of incarceration as punishment for non-compliance, the extensive length of the program, the use of coerced medication, and the lack of post-graduation support or oversight of the participants. The following paragraphs will analyze these issues and provide potential solutions.

Although, as the following text indicates, the program facilitators can certainly tackle each of these problems in an effort to improve the mental health courts, these changes will only serve as a small bandage for a much larger wound, one that can only be healed through widespread reform of the entire mental health system. The true solution to the continuing mental health crisis would require a system overhaul, which would provide the mentally ill with access to readily available, inexpensive treatment options prior to incarceration. The likelihood that such a reformation will occur is minimal due to its unimaginable complexity and extensity. Since this idealistic rectification is unlikely, mental health courts currently serve as the best alternative for providing much needed support and treatment to the mentally ill. As such, we

should strive to address its current problems rather than lamenting and belaboring the failure of the mental health system generally.

One dilemma that plagues all of the programs is the lack of permanent resources and funds that are available for discretionary use. Schenectady County, for example, definitely needs consistent funding in order to advance its Alternative Treatment Court program. Although the program facilitators are applying for grants from the federal government to procure funding for psychiatrist and psychologist time as well as compensation for a program services coordinator, this money is not guaranteed and is only a temporary provision. In this respect, most grants are nothing more than fleeting solutions.

While the programs benefit from the leadership of innovative judges looking for creative alternatives for the participants and the community, they still have limited access to new resources or the reallocation of current community-based resources for the treatment of mental illness, including housing and health services.⁷⁷ All of the programs are in desperate need of a reliable and permanent source of funding to provide the proper professional assistance that the participants need. While some local governments may be hesitant about allocating funds for this program, as its benefits are not entirely visible yet, without continual support, the programs cannot develop and thus remain a part-time project with few participants. To ameliorate this fiscal dilemma, program facilitators and the community at large must rally support for the mental health court system in hopes of garnering political attention on the issue of under-funding.

Another major concern is the effect of diminished resources on the law abiding population. These prison diversion programs expend resources to provide treatment for mentally ill offenders which could have been used to provide treatment for non-criminal mentally ill citizens. Therefore, if the state is diverting its resources to the alternative treatment programs, it

⁷⁷ Steadman, *supra* note 1, at 458.

may be forced to delay or even deny treatment for its law abiding citizens. As such, new services must be provided for the community in conjunction with the establishment of mental health courts; otherwise, the net benefit of the mental health court program will be skewed, as assistance for those already incarcerated will be offset by the disproportionate increase in detention of the mentally ill who did not receive the proper treatment when they needed it, and thus committed crimes simply because they were unable to stabilize themselves.⁷⁸ The only way to truly halt the revolving door of recidivism is to provide proper resources for all individuals that are in need regardless of their criminal history.

Another dilemma that Schenectady County in particular faces is the lack of privacy and anonymity for its participants. Although many of the other mental health courts throughout the nation function on separate calendar schedules for their programs, Schenectady County does not engage in these closed court proceedings.⁷⁹ Instead, the Alternative Treatment Court is simply an element of the daily docket. However, the Court would probably function more effectively if it were in a closed setting because participants would feel more comfortable discussing their problems in a setting that was exclusively dedicated to participants in the program and their support networks. Implementing such a change would require minimal effort, as it would only mean that the normal daily proceedings would begin an hour later than usual once a month, allowing for a more intimate environment for these emotionally fragile individuals.

One positive aspect of the mental health courts generally is that the participants have all voluntarily engaged in their process. Some argue that a compulsory program would violate the Equal Protection Clause of the 14th Amendment, as well as the 6th Amendment right to a trial by

⁷⁸ Stephan Haimowitz, *Can Mental Health Courts End the Criminalization of Persons with Mental Illnesses?*, 53 L. & PSYCHIATRY, 1226, 1227 (2002).

⁷⁹ John Monahan et al., *Mandated Treatment in the Community for People with Mental Disorders*, 22 HEALTH AFFAIRS 5, 33 (2003).

jury.⁸⁰ Others believe that a mandatory system would violate the prohibition against discrimination under the Americans with Disabilities Act.⁸¹ Therefore, not only does participation on a voluntary basis guarantee the constitutionality of the program, but it also increases the likelihood that the participants will comply with their individualized treatment plans, successfully graduate from the program, and assimilate into mainstream society.

On the other hand, realistically speaking, although the program is labeled as “voluntary,” one cannot deny its inherently coercive nature. First, family and friends can refer an offender for participation in the program. This familial involvement serves as a major pressure point for the offender and greatly influences what is supposed to be a “voluntary” decision. Second, the alternative to participation in the program is usually incarceration, meaning that a refusal to participate comes at a very high price, one that many are probably unwilling to pay. Therefore, it is somewhat misleading to refer to this program as voluntary when failure to participate can result in the harsh penalties of prison time and familial disappointment.

Again, even though the program is technically considered voluntary, some argue that the attorneys that represent mentally ill criminals are also placed in a compromising position. While it is their goal to move their clients through the criminal justice system as swiftly as possible, which may encourage them to counsel their clients into simply serving their sentence, they also have a duty to act in the best interest of their clients, which may translate into addressing their mental health needs through an alternative treatment program.⁸² Therefore, many attorneys may decide to encourage their clients to volunteer for the mental health court program even though it

⁸⁰ THE BAZELON CENTER FOR MENTAL HEALTH LAW, *THE ROLE OF MENTAL HEALTH COURTS IN SYSTEM REFORM* (2004) *available at* <http://www.bazelon.org/issues/criminalization/publications/mentalhealthcourts/> (on file with author).

⁸¹ *Id.*

⁸² *Id.*

conflicts with their obligation to move their clients through the system as quickly as possible. Further complicating this decision is the fact that such elections are made when the defendant is likely to be under considerable stress, exacerbating his mental illness, and thereby decreasing his ability to truly consent.⁸³ In this respect, the attorney's position in relation to his client is further evidence that the "voluntary" nature of entry is actually quite coercive.

If the program facilitators have a true interest in maintaining a purely voluntary system, they must make changes to ensure that the decision to enter the program is entirely based on the offender's free will and desire. First, they should remove the option of familial referrals. On one hand, these recommendations are useful because the offender's family members presumably have a more intimate knowledge of his needs and can identify an offender that will benefit from the program. On the other hand, these nominations place immense pressure on the offender's decision and can ultimately compel his participation. Therefore, although familial referrals are beneficial, if the goal is to create an entirely voluntary system, they must be removed. Second, the program facilitators should instate several options other than incarceration for an offender who refuses to participate in the program. These options could include indefinite house arrest, and in-patient treatment, among others. Although making a finite list of less than ideal options would still create an element of coercion, the fact that the offender would be given more than a choice between compliance and incarceration would make his decision to enter the mental health court program a bit more voluntary.

The program facilitators should also reassess the fact that participants can be incarcerated for non-compliance with their individualized treatment plans. If the goal is to lessen the incarceration rate of people with mental illnesses, then using jail time as a punishment seems somewhat counterintuitive and counterproductive. This tactic demonstrates either the failure of

⁸³ *Id.*

all prior intervention efforts or the inexistence of alternative punishments, both of which are disappointing scenarios. Since the participants are suffering from mental illness, certain setbacks in their individualized treatment plans may have no relation to their desire to adhere to the court orders. It is possible that the first treatment plan was not properly tailored to suit all of the unique needs of the participant, thereby making compliance more difficult. The courts should instead work cooperatively with the participants to decipher the root of the problem, “whether any noncompliance with diversion conditions. . . was willful, was a symptom of the mental health illness or was an indication of the need to change the treatment plan.”⁸⁴ Typically, a more appropriate response is modification of the treatment plan, rather than revocation of the alternative treatment option entirely or incarceration.

Another major dilemma that the mental health court faces is the extended and sometimes indeterminate length of the program. This uncertainty is often a deterrent to many potential participants who want to serve their time and return to their lives as soon as possible. According to a study by the Bazelon Center for Mental Health Law, in at least forty percent of the jurisdictions surveyed, the length of court supervision significantly exceeded the possible length of incarceration and probation for the offense, with the treatment even requiring indeterminate supervision in some instances.⁸⁵ As a result, there exists a constant balancing act between ensuring that the participants are psychologically stabilized before reintegrating into society while also incentivizing involvement in the program by maintaining fairly equivalent supervisory periods. The difficulty in maintaining reciprocity between the two treatment options (jail time and the mental health court program) arises when one considers that many of the participants were arrested for misdemeanors, which require minimal retributive punishment, usually only

⁸⁴ COUNCIL OF STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 88–89 (2002), http://consensusproject.org/downloads/Entire_report.pdf.

⁸⁵ BAZELON CENTER FOR MENTAL HEALTH, *supra* note 79.

amounting to incarceration for a few months. Meanwhile, if they volunteer for the mental health court program, the participants could face an indefinite period of supervision and a far more extensive period of compliance, which could potentially last for years. Since the program is designed as a rehabilitative measure, it can require more time to accomplish its purpose than retributive measures require. However, this extensive commitment creates a disincentive for people to even enter the program.

Another related issue is the highly controversial use of the somewhat coerced medication of participants in the mental health court programs. Although the participants voluntarily enter the program aware of the mental health court's process and requirements, failure to take one's medication becomes a violation of the stipulations of their individualized plans, and therefore, in many programs that utilize the carrot and stick method, can result in jail time.⁸⁶ As a result, the participants must make a Hobson's choice between medication and incarceration. If the participants decide not to take their medication, they inevitably find themselves in the exact place that the program was designed to avoid. This desire to prevent using jail time as punishment not only arises from the ineffectiveness of incarceration at treating the root of the participants' problems and of preventing recidivism, but also because of the undeniable national epidemic of jail overcrowding.

A crucial element of the mental health court program that is completely non-existent is post-graduation support. There is no follow-up procedure to ensure that the individual continues to be successful and lead a healthy life. It would be extremely beneficial if the program extended to include occasional contact with the participant for the next few months in order to continue to

⁸⁶ Some Mental Health Courts require their participants to sign contracts. Among the stipulated compliance measures includes an agreement that they will take their medication and a failure to do so will result in punishment. *See, e.g.*, Plattsburgh Mental Health Court, Participant Contract, *available at* http://nycourts.gov/courts/4jd/plattsburgh_city/mh_participantcontract.pdf.

provide the necessary support and encouragement. This continued contact would help to prevent the offender from recycling through the system due to post-release deterioration. It would also give the program facilitators a better understanding of the overall and ultimate productivity of the program, information that would incentivize future government funding.

Lastly, program facilitators should encourage the creation of more mental health courts, as there are less than two hundred in operation with unequal distribution nationwide. Since the mental health courts only begin through the advocacy of innovative judges, the program should focus on fostering judicial interest by organizing regional workshops that would educate judges about the mental health court program and serve as training sessions that would give judges the necessary tools and information to establish mental health courts within their jurisdictions. It is likely that many judges have an interest in working to solve the growing mental health crisis but they simply do not know how to effectuate that interest. These workshops, although they would not obligate judges to initiate mental health court programs, would provide them with the knowledge and support to do so.

V. CONCLUDING THOUGHTS

The Council of State and Local Governments has found that “people with mental illness are falling through the cracks of this country’s social safety net and are landing in the criminal justice system at an alarming rate.”⁸⁷ The mental health court programs throughout the United States serve as a system reform that will hopefully counteract this growing problem. They strive to reduce incarceration and recidivism rates of the mentally ill by linking them to the mental health services and support that they need to become stabilized individuals who are prepared for reintegration into mainstream society. However, these programs are still very much works in

⁸⁷ BAZELON CENTER FOR MENTAL HEALTH, *supra* note 79.

progress and are going to require more resources and extensive funding in order to ensure their continued success and development over the coming years.

Despite their shortcomings and challenges, the mental health court programs have still been successful. Since their inception, many studies have yielded favorable statistics supporting the assertion that mental health courts have been a positive addition to criminal justice systems nationwide. These studies have shown that mental health court participants were significantly less likely to incur new charges or to be arrested after graduation from the programs, thereby accomplishing one of the program's most important goals of decreasing recidivism.⁸⁸ Mental health court participants also reported more positive interactions with judges and a perception that they were treated with greater fairness and respect than in traditional court, potentially accounting for their successful completion of the program.⁸⁹ Lastly, these studies have indicated that participants improved their independent functioning and decreased their substance abuse, allowing them to operate more productively in society without repeated destabilization.⁹⁰

In the end, the best intervention and prevention plans would provide mental health care to these individuals before they even entered the criminal justice system. There are underlying systemic problems that must be addressed to prevent the arrest and incarceration of mentally ill people in disproportionate numbers. The cycle of worsening mental illness and criminal behavior can only be broken by working from the ground up, attacking the shortcomings of the community mental health system and the inadequacies of the treatment options in prison. The ultimate goal of the mental health court system is to prevent the continued use of the criminal and juvenile justice systems as the front door to access mental health care by addressing both the causes and the symptoms of inadequate mental health care in the United States.

⁸⁸ DEP'T OF JUSTICE, *supra* note 3, at 14 (2008).

⁸⁹ *Id.*

⁹⁰ *Id.*

By tackling this growing problem from the roots and encouraging widespread system reform, the mental health court programs serve to create a safer society by providing mentally ill criminals with a better quality of life through stabilization and reintegration into mainstream society. In closing, the long-term solution to the mental health crisis is system-wide reform, which would provide all citizens with readily available and cost effective mental health treatment. However, while the nation anxiously awaits such a drastic change, properly funded mental health courts will offer a fairly successful temporary option.