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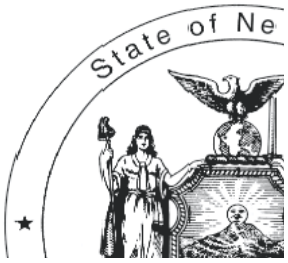
Rethinking the Revolving Door

A Look at Mental Illness in the Courts



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A Look at Mental Illness in the Courts

Introduction

Each day, a disturbingly large number of people with mental illness cycle through the criminal justice system across the nation. While it is difficult to get an accurate read of exact numbers — many defendants are never properly diagnosed — a recent study found that about 16 percent of the national prison and jail population suffer from some form of mental illness (U.S. Department of Justice, 1999). Before arriving in the criminal justice system, these individuals have frequently fallen through the "safety net" of families, hospitals and community-based treatment providers.

Once they reach the courts, defendants with mental illness pose significant challenges for judges. Judges typically lack both the tools necessary to perform meaningful assessments and the connections with mental health service providers necessary to know what kinds of treatment options are available. Given these realities — and given concerns for public safety — judges find that in many cases the safest choice is to sentence mentally ill offenders to jail or prison. The calculus is simple: while incarcerated, there's at least a chance that an offender will receive some form of medication and assistance.

Incarceration may in fact be the right outcome for some mentally ill offenders who pose a serious threat to individual victims or the public welfare. But for many others, particularly those without violent histories, incarceration makes little sense. The drawbacks are obvious. It's expensive both on the front end and the back end. State and local governments incur significant costs when they incarcerate people. Just as significantly, prisons and jails are not designed to be therapeutic environments. All too often, the condition of mentally ill individuals seriously deteriorates in custody. They are then released to the streets with little or no discharge planning. No one links them to needed treatment, housing and other services. And no one checks to make sure they take advantage of these services. Unsurprisingly, many mentally ill defendants find themselves back before the courts in short order, repeating the same process. Everyone loses in this scenario. Defendants with mental illness fail to receive the help they need. The justice system fails to deploy resources either efficiently or effectively. And the community at large fails to address a serious public safety problem.

This study takes a closer look at these challenges. Along the way, it seeks to answer a set of basic questions about defendants with mental illness. How big is the problem? What do judges, attorneys, service providers and other stakeholders

think about the ways that courts currently handle cases involving defendants with mental illness? What efforts have been made to improve the situation? And what kinds of obstacles have these efforts confronted? In answering these questions, this study seeks to provide judges, attorneys and court administrators across the country with new ideas, new tools and new strategies as they grapple with some of the most difficult cases that ever appear in court.

"Rethinking the Revolving Door" is the product of a year-long study performed by the New York State Unified Court System in conjunction with its independent research and development arm, the Center for Court Innovation. The methodology for this research effort was fairly straightforward; it included reviewing the current literature in the field, attending relevant conferences and workshops, making site visits to promising programs and conducting dozens of stakeholder interviews.

The purpose of the study, which was underwritten by a grant from the State Justice Institute, was not to create a work of original scholarship. Nor was it to determine whether specialized "mental health courts" are a good thing or a bad thing. The aspirations for the feasibility study were rather more modest: to provide practitioners with an overview of mental health and the courts, a description of the model projects currently being tested in a number of jurisdictions and an outline of some of the concerns that have been raised by various stakeholders. The findings in this report have already served as the foundation for a proposed mental health court in Brooklyn, providing the planning team with a sense of context and a guide to issues that are worthy of deeper exploration. With any luck, in the days ahead it will continue to provide helpful background information to those with an interest in this field.

Scope of the Problem

Over the last few years, the number of people with mental illness in the criminal justice system has increased steadily. This phenomenon can be traced to various intersecting causes, including law enforcement strategies targeting drugs and low-level, "quality-of-life" offenses and the long-term effects of de-institutionalization (Marasso & Pepper, 2001; Health Foundation of Greater Cincinnati, 2000).

"De-institutionalization" is a term that describes a systematic shift in resources for treating people with mental illness — from large, residential, state-run psychiatric hospitals to community-based treatment (Department of Health & Human Services, 1999). Advances in the effectiveness of psychiatric medications since the 1950s have allowed even the most severe mental disorders to be treated on an outpatient basis, decreasing the need for inpatient institutionalization. And starting in the 1970s, civil libertarians and legislative reformers sought changes in civil commitment statutes and regulations to make it more difficult to place a person with mental illness in a psychiatric hospital involuntarily. In general, the guiding principle of de-institutionalization reformers was to offer appropriate treatment in the least restrictive environment possible (Torrey & Zdanowicz, 1998).

One unintended consequence of this shift in public policy has been that it has become far more difficult for many people with mental illness to access the mental health system. Many states closed or shrank their state psychiatric hospitals without adequately funding community treatment (Kupers, 1999). Accordingly, all too many people with mental illness live in the community, but they do so without adequate support services or medication.

While the number of people with mental illness in state psychiatric hospitals has decreased precipitously over the last thirty years, the number of mentally-ill people in jails and prisons has steadily increased. In 1955, there were 560,000 individuals hospitalized with mental illness in the United States. By 1999, there were less than 80,000 (Kupers, 1999). By contrast, since 1970, the U.S. jail and prison populations have increased fivefold to a total of about 1.6 million people (Bureau of Justice Statistics, 1999). And a recent Department of Justice survey found that 16 percent of the inmates in United States prisons and jails reported having a mental condition or mental health hospitalization. That translates to about a quarter-of-a-million inmates with mental illness (Ditton, 1999). Some critics, drawing a causal link between the rise of incarcerated mentally ill individuals and the decline in mental health hospitals, have labeled this phenomenon "transinstitutionalization" (Torrey & Zdanowicz, 2000; Massaro & Pepper, 2001).

Treatment in the Criminal Justice System

So if jails and prisons have become — de facto — "hospitals of last resort" for people with mental illness, the next question is: What kind of treatment do they receive while they are there?

Jails and prisons offer 24-hour, 7-day-a-week supervision and housing, but they were never intended to be psychiatric hospitals. And they are not typically institutionally equipped, trained or staffed to address the treatment needs of people with mental illness. Of the inmates who report mental illness, only 17 percent of state prisoners and 11 percent of jail inmates receive treatment for mental illness while incarcerated (Ditton, 1999). [A similar story can be told for substance abuse treatment in jail and prison. Of the estimated 70-85 percent of all state inmates who need substance abuse treatment, only 12 percent of them receive some form of treatment (CASA, 1998).]

These statistics are just the tip of the iceberg. The bottom line is that there is a severe shortage of treatment for people with mental illness while they are incarcerated. Even when treatment programs are available, their effectiveness is limited by long waiting lists, lack of incentives to participate, a dearth of trained counselors and the stigmatization of those who participate (CASA, 1998).

The inadequacy of treatment for mental illness and substance abuse in jails and prisons is exacerbated by the lack of adequate discharge planning and aftercare services. (This is a problem that has been the subject of litigation by advocates seeking to improve conditions for the mentally ill — see, for example, the "Brad H." lawsuit in New York City.) The result is that many offenders with mental illnesses

leave jail and prison no better — and sometimes quite worse — than when they were first incarcerated.

Revolving Doors

It comes as little surprise that many ex-offenders with mental illness find themselves back in the criminal justice system again in short order (Barr, 1999). Forty-nine percent of federal prisoners with mental illnesses have three or more prior probations, incarcerations or arrests, compared to 28 percent without mental illnesses (Ditton, 1999). Family members report that the average number of arrests for their relative with mental illness is more than three (McFarland, Faulkner, Bloom & Hallaux, 1989).

Mentally ill individuals with a criminal record are often placed in a lose-lose situation. While incarcerated, their condition tends to worsen (Belcher, 1988). And upon release, they are often unable to access available community treatment because of providers' reluctance to serve them (Lamb & Weinberger, 1998). Many community mental health centers are unprepared or unwilling to treat people who have criminal records (Jemelka, et al., 1989).

The results are painfully clear: many defendants with mental illness churn through the criminal justice again and again, going through a "revolving door" from street to court to cell and back again without ever receiving the support and structure they need (Finkelstein & Brawley, 1997). It is fair to say that no one wins when this happens — not defendants, not police, not courts, not victims and not communities.

Co-Occurring Disorders

One of the factors that complicates any effort to address the problems faced by criminal defendants with mental illness is the prevalence of co-occurring disorders among this population. A diagnosis of "co-occurring disorder" (also known as "dual diagnosis" or "dual recovery") describes the presence of both a mental disorder and a substance abuse disorder (American Psychiatric Association, 1994).

National research suggests that as many as three out of every four defendants in major cities test positive for drugs at the time of arrest (National Institute of Justice, 1998). Mental illness and substance abuse have a symbiotic relationship: people with substance abuse disorders are more likely to develop mental illness and people with mental illness are more likely to develop a substance abuse disorder (Peters & Hills, 1997; Massaro & Pepper, 1994). And people with mental illness who have significant criminal justice histories are more likely to have a co-occurring substance abuse problem than the general population of people with mental illness (Peters & Hills, 1997; GAINS Center, 1997).

Research indicates that people with co-occurring disorders have lower rates of treatment compliance, more severe symptoms and higher relapse rates than those treated for a single disorder (Peters & Hills, 1997). They are three times more likely to be arrested than others with mental disorders (Borum, et al., 1997). And without effective and appropriate treatment, they are more likely to be jailed again and again (Draine & Solomon, 1994).

Why is this? What exactly is the relationship between mental illness and substance abuse? People with mental illness often take alcohol or other drugs to temporarily reduce their symptoms (Peters & Hills, 1997). Using drugs and alcohol to alleviate psychiatric symptoms is at best a short-term solution. Alcohol and drugs can cause significant health consequences. They can also precipitate certain psychiatric symptoms, including anxiety, depression and confusion. Together, mental illness and substance abuse can lead to an ever-intensifying cycle of abuse as relief for symptoms is sought through consuming more and more drugs or alcohol (Pepper, 1992). This cycle is known as "self-medication."

There is a growing recognition among researchers and policymakers that the problem of co-occurring disorders is one that requires significant attention. One sign of this is the creation of a new federal partnership of mental health, substance abuse and justice agencies, called the National GAINS Center for Persons with Co-Occurring Disorders in the Justice System.

Among the issues that the GAINS Center has examined is how to assess people with co-occurring disorders. The reality is that co-occurring disorders are not easy to identify. The residual effects of substance abuse may "mask or mimic psychiatric symptoms such as depression" (Peters & Hills, 1997). And acute psychiatric symptoms may interfere with substance abuse treatment (ibid.). Another complicating factor is the reality that people with co-occurring disorders tend to suffer from a whole host of collateral problems including homelessness, HIV, violent behavior, trauma, and difficulties with employment, social and family relationships (Peters & Hills, 1997; Broner, et al., 2000).

But assessment is far from the only obstacle. More significant is the lack of effective treatment designed to address both mental health and substance abuse disorders in one therapeutic setting. Traditionally, services for mental health and substance abuse have been kept separate (Peters & Hills, 1997). Most programs treat co-occurring disorders sequentially, which means that patients must complete one form of treatment before engaging in another. There is a good deal of evidence that suggests that sequential treatment has proven ineffective for people with co-occurring disorders. Another approach is "parallel" treatment, in which a patient attends mental health and substance abuse treatment simultaneously but with different providers. While parallel treatment is an improvement over sequential treatment, it is far from perfect (Peters & Hills, 1997; GAINS Center, 2001).

In recent years, "integrated" treatment services for co-occurring disorders that address both substance abuse and mental health simultaneously in a continuous and comprehensive fashion have been developed, evaluated, and found to be more effective than nonintegrated programs (Drake, et al., 2001). For example, the New Hampshire-Dartmouth Research Center has created a model for integrated treatment that emphasizes the following elements: case management, group interventions, assertive outreach, education, development of long-term perspective, relapse prevention, family support, and progressive levels of treatment (Mueser, et al., 1997).

Effective integrated treatment must also incorporate a vast array of other supportive services such as health, financial aid and housing (Pepper & Hendrickson, 1996).

While many experts argue that integrated treatment is a promising approach to treating co-occurring disorders, it is rarely used by treatment providers. (Peters & Hills, 1997, GAINS Center, 2001). Why? State and local governments often have separate and inconsistent structures for licensing, regulating and financing mental health and substance abuse treatment services. Service standards, administrative guidelines and quality assurance procedures for integrated treatment have not yet been widely incorporated by public mental health and substance abuse authorities or adopted by service providers, so that many treatment providers are simply not up-to-date on the methodology and potential benefits of this approach. Even where clinicians are interested in moving beyond the traditions of their separate mental health and substance abuse systems, opportunities for cross-training and credentialing have been limited (Drake, et al., 2001; Quadrant IV Task Force, 2001). The result is that there is a genuine scarcity of the kind of treatment most needed by a substantial number of offenders with mental illness.

Mental Health and the Courts

It is difficult to get an accurate read on exactly how many people with mental illness come before the courts each day. The recent Department of Justice survey of inmates with mental illness was based on self-reporting rather than the diagnoses of mental health professionals. And studies of the mentally ill in jails and prisons miss defendants with mental illness who make their way through the court system but whose cases are ultimately dismissed or who receive sentences other than incarceration. Preliminary results from a recent study in Brooklyn suggest that as many as 30 percent of all arraigned defendants may have a serious mental illness (Broner, Owen, Lamon & Karopkin, 2000).

How have courts dealt with mental illness in the past? Not particularly well. Historically, courts have a handful of methods to address problems associated with defendants who appear to be mentally ill. These include pleas of "not guilty by reason of insanity" and "guilty but mentally ill" as well as rulings that a defendant is not competent to stand trial (Parry, et al., 1998). These tools are used very infrequently. For instance, an eight-state study showed that the insanity defense was used in less than 1 percent of all cases and was successful only 26 percent of the time despite the fact that 90 percent of those invoking the defense had been diagnosed with a mental illness (American Psychiatric Association, 2001). On the civil side, judges may order involuntary treatment for people with severe mental illness who are found to be a danger to themselves or others. However, the impact of civil commitment proceedings is sharply limited by the tiny numbers of inpatient beds available and the many procedural safeguards that permit patients to obtain their own release after a short time.

More often than not, defendants with mental illness receive no special treatment whatsoever from the court — they are treated just like any other defendant. In fact, many are treated worse, because they are stigmatized by criminal justice officials

with little experience dealing with mental illness. It should come as no surprise that the existing approaches have not been effective in reducing recidivism, improving the health of defendants with mental illness or protecting communities.

New Directions

In recent years, many state courts have come to realize that business as usual isn't working. Out of this recognition has come a wave of new criminal justice interventions for defendants with mental illness, including post-booking diversion programs, enhanced mental health services in jails and programs that link participants to intensive treatment after release (Watson, et. al., 2001).

One judicial experiment in particular has attracted a great deal of attention: the development of specialized "mental health courts" that seek to link defendants to long-term treatment as an alternative to incarceration. The goal of these new model courts — which, along with drug courts, community courts, domestic violence courts and re-entry courts, are often called "problem-solving courts" — is to move beyond standard case processing to address the underlying problems that bring people to court. In the process, they seek to shift the focus of the courtroom from weighing past facts to changing the future behavior of defendants (Feinblatt, et al., 2000-A).

In many respects, mental health courts are built on the foundation of an earlier problem-solving court model: drug courts. In 1989, Dade County, Florida created the first drug court in the country. The drug court sentences addicted defendants to long-term, judicially-supervised drug treatment instead of incarceration. Participation in treatment is closely monitored by the drug court judge, who responds to progress or failure with a system of graduated rewards and sanctions, including short-term jail sentences. If a participant successfully completes treatment, the judge will reduce the charges or dismiss the case (Drug Courts Program Office, 1997).

The results of the Dade County experiment have attracted national attention — and for good reason. A study by the National Institute of Justice revealed that Dade County drug court defendants had fewer re-arrests than comparable non-drug court defendants (U.S. Department of Justice, 1993). Based on these kinds of results, drug courts have become an increasingly standard feature of the judicial landscape across the country (Feinblatt, et al., 2000-B). At last count, there were more than a thousand drug courts nationwide, including ones in operation or being planned in every state (Drug Court Clearinghouse and Technical Assistance Project, 2001). In addition, several states, including New York and California, have begun to look at how some of the principles of drug courts might be institutionalized throughout a state court system (New York State Commission on Drugs and the Courts, 2000; Kaye, 2001; Feinblatt, et al., 2000-B).

Based on the success of the drug court model, a handful of jurisdictions across the country have developed specialized courts to address mental illness. Like drug courts, the central goal of mental health courts is to reduce the recidivism of defendants by providing them with court-monitored treatment. The first of these courts opened in June 1997 in Broward County, Florida.

There are many points of entry into the Broward County Mental Health Court, but primarily candidates are identified during intake by jail staff within 24 hours of arrest. Jail psychiatrists evaluate each defendant's mental health. If a defendant is found to pose a danger to himself or others, the psychiatrist will seek a judge's order to transport the defendant to a crisis center for symptom stabilization. Defendants charged with misdemeanor offenses who are found to have mental health problems and who are deemed stable are referred to clinicians from the public defender's office who perform an additional screening. If symptoms of mental illness are again found during this second screening, the defense attorney informs a magistrate presiding over the bail hearing, who refers the case to Mental Health Court.

At the Mental Health Court, the judge will recommend pre-adjudication diversion into treatment. The judge will monitor defendants in treatment for up to one year. The length of judicial supervision and level of treatment vary depending on the treatment needs of the individual defendant. For defendants who agree to participate in treatment diversion, the State's Attorney may either dismiss charges immediately or hold prosecution in abeyance, depending on the seriousness of the offense. Upon completion of the treatment, the charges held in abeyance will be dismissed or reduced. However, certain defendants with serious criminal histories may be required to plead guilty and get credit for time served in treatment in lieu of incarceration.

Proliferation of Mental Health Courts

Shortly after Broward opened its doors, several other municipalities began to plan mental health courts. Today, there are mental health courts in Seattle and Vancouver, Washington; San Bernardino, Santa Barbara and Santa Clara, California; Anchorage, Alaska; Marion County, Indiana; St. Louis, Missouri; Akron, Ohio; and Jefferson County, Alabama. A number of other mental health courts are in the planning stages. A recent study by the Crime and Justice Research Institute documented the practices of the first four mental health courts — Broward, King County (Seattle), San Bernardino and Anchorage (Goldkamp & Irons-Guynn, 2000). While each mental health court is unique, this study — and independent research on the other mental health courts — highlighted a set of common procedures and goals that typify the mental health court approach:

Problem-Solving Mental health courts mark an attempt by court systems to address a systemic problem, taking a critical look at the issues that defendants with mental illness pose for the courts and crafting a new set of responses. Put simply, these courts are not satisfied with continuing with business as usual — standard case processing or out-sourcing the solution to some other agency. (Finkelstein & Brawley, 1997).

Public Safety By responding to widespread concerns about how courts deal with defendants with mental illness, mental health courts attempt to shore up public trust and confidence in the justice system. Indeed, many mental health courts have been created in response to a specific local crisis involving mentally ill defendants — for

instance, the murder of a retired firefighter in Seattle, Washington by a person with mental illness (Goldkamp & Irons-Guynn, 2000).

Therapeutic Jurisprudence In linking defendants with mental illness to treatment alternatives, many mental health courts see themselves as practicing "therapeutic jurisprudence" (Lurigio et al., 2001; Lerner-Wren, 2001; Wexler & Winnick, 1996). In one way or another, mental health courts are testing the extent to which the law can be a therapeutic agent — a social force producing positive life changes for defendants.

Identification Mental health courts develop new systems to identify defendants with mental illness. The point in the criminal justice process at which this intervention occurs varies by jurisdiction. Usually, identification takes place within 24 hours of arrest while defendants are still in custody. The primary sources of identification are jail staff, family members and defense attorneys.

Targeting After identification, each court has created eligibility criteria that target a certain type of defendant. Almost all programs require that defendants have symptoms of severe mental illness and face non-violent, misdemeanor charges. San Bernardino's court has handled some non-violent felonies on a case-by-case basis. In general, mental health courts specify that the defendants' mental illnesses must be "Axis I disorders" as designated in the Diagnostic Statistics Manual IV (American Psychiatric Association, 1994).

Dedicated Staff Each mental health court has a dedicated judge and some additional specialized staff. The specialized staff are usually mental health clinicians who screen cases for eligibility, prepare treatment plans, and report to the judge on defendants' progress in treatment. In some cases, this staff is hired by the court system using new funding sources. In other cases, this staff is assigned from a collaborative government agency or from a local treatment provider. In general, mental health courts have been planned and overseen by interdisciplinary teams composed of a variety of criminal justice and behavioral health stakeholders. For instance, the Santa Clara Mental Health Court "team" includes the judge, district attorney, public defender, and mental health caseworkers (Santa Clara Bar Association, 2001). The team meets to discuss every case, with each representative providing input from their unique institutional perspective.

Non-Traditional Roles Mental health courts — like drug courts before them — have altered the dynamics of the courtroom, including, at times, certain features of the adversarial process. For example, in some courts defenders and prosecutors come together to discuss their common goals for each defendant. Mental health courts may engage judges in unfamiliar roles as well, asking them to convene meetings and broker relationships with service providers.

Voluntariness Participation in mental health court is voluntary — defendants must affirmatively "opt-in" to receive treatment. For instance, the King County Mental Health Court in Washington gives defendants two weeks in a treatment placement to help them decide whether to participate in the program or not (during this time, their attorneys can also investigate the strength of the case against their client) (Goldkamp & Irons-Guynn, 2000).

Plea Structure Once a defendant opts into a mental health court, one of two things happens: either prosecution is "frozen" and charges are dropped after the defendant successfully completes treatment, or a plea is taken and later vacated (or charges reduced) after treatment is completed. All of the mental health courts require a longer period of time in treatment than the defendant would have served in jail or prison if they had plead guilty to the crime charged, and most courts require participating defendants to spend a minimum of one year in treatment. The rationale behind this is two-fold. First, mandated treatment involves many fewer restrictions than being incarcerated (many defendants are even released to their own residences). Second, mental health courts are willing to invest in treatment only if there is real promise of reducing symptom severity (and thereby reducing recidivism). Experience indicates that it takes at least a year to successfully engage people with mental illness in treatment. Accordingly, many mental health courts reserve the right to extend offenders' period of treatment in the event of non-compliance.

Judicial Monitoring Mental health courts require participants to return frequently to court to enable the judge to monitor the progress of treatment. Court appearances are made less frequently as participants demonstrate consistent compliance over a sustained period of time.

System Integration Mental health courts seek to promote reform with partners outside of the courthouse as well as within. For instance, mental health courts have encouraged mental health and drug treatment providers to come together to improve service delivery for offenders.

Results

What does the record show about mental health courts? Are they working? The short answer is that it is too early in the development of mental health courts to say whether they are achieving their goal of reducing the recidivism of participating defendants — there's simply not enough evidence to make the case one way or another.

At this point, most of the available evidence about mental health courts comes from a University of South Florida evaluation of the Broward County Mental Health Court and an evaluation of the first two years of the King County Mental Health Court performed by the University of Washington.

From July 1997 to June 2000, the Broward Mental Health Court evaluated 1,530 defendants for participation, 652 of whom were found to be eligible. While long-

term treatment results are not yet available, researchers have documented some basic information about participants:

- Fifty-four percent of defendants presented with mental illness only, 16 percent with co-occurring disorders, 2 percent with substance abuse disorders alone, 2 percent with development disabilities and 26 percent with an undetermined diagnosis (but still believed to be mentally ill).
- Thirty-six percent of defendants reported one or more psychiatric hospitalizations in the past.
- About 26 percent of defendants were homeless.
- Sixty-nine percent of defendants were male. The average age was about 40 years old. Fifty-five percent of defendants were white, 3 percent Black, 5 percent Hispanic, less than 1 percent Asian and 6 percent unspecified (Broward County 2000-A).

Meanwhile, an evaluation of the 236 defendants who have been referred to the King County Mental Health Court over the last two years revealed that:

- Forty-one percent of defendants referred to the King County Mental Health Court opted to participate.
- Eighty-five percent of those referred were diagnosed with severe mental disorders such as psychotic disorders, bipolar disorder, major depression, and organic brain dysfunction.
- Those defendants who opted into the King County Mental Health Court received more hours of treatment per month after contact with the court than they had received in the past.
- Participants in the program spent fewer days in detention than those who did not participate.
- Most significantly, researchers found that there was a sharp drop in the rate of new arrests for opt-in defendants compared to those who chose not to participate (Trupin, et al., 2001).

More substantial information from the independent evaluations of King County and Broward should become available in the months ahead. In the meantime, it is possible to look at the self-reported results from the first wave of mental health courts. Perhaps predictably, these results are almost uniformly encouraging. For example, the Santa Clara Mental Health Court had graduated 56 participants as of January 1, 2001. During the 2 years prior to their entry into the Santa Clara Mental Health Court, these 56 graduates were held in custody for a total of 19,040 days, at a cost of approximately $1,252,832. Court officials estimate that the effect of moving these 56 clients from jail custody into community treatment over a one-year period saved 6,013 jail days, for a cost savings of approximately $395,655. And during the

period of involvement with the court, there were no new arrests for this first group of graduates (Santa Clara Bar Association, 2001).

While these results are promising, there is a need for more rigorous research about the impacts of mental health courts. This is especially true given that the proliferation of these experiments shows no sign of slowing down any time soon.

Challenges, Questions and Tensions

Perhaps because they offer a provocative new approach to defendants with mental illness, mental health courts have attracted a fair amount of scrutiny from judges, prosecutors, defenders, mental health advocates and others with an interest in what happens to mentally-ill offenders. What follows is a brief overview of some of the concerns and questions these experiments have generated:

Defining Success How do you define success in a mental health court? How realistic are the goals of reduced recidivism and stable community living when working with offenders who are severely ill? Some offenders with serious mental illnesses will need treatment throughout their lives. At what point can the court say that treatment has been successful? When should the involvement of the court begin and end?

Proportionality Traditionally, the gravity of an offender's crime determines how much leverage the court has to impose conditions for release or probation. This poses a dilemma for mental health courts, which tend to focus on low-level cases involving defendants who require long-term therapeutic interventions. How do mental health courts determine the right proportion between charge severity and the length of mandated treatment? Finding this balance is crucial to winning the support of both prosecutors and defenders.

Case Targeting Mental health courts have used various criteria for determining eligibility. Some exclude offenders with histories of violence. Others exclude offenders with co-occurring disorders. Still others exclude defendants charged with felonies or violent crimes. Targeting misdemeanors may make political sense, particularly during a project's pilot phase, but this approach does little to address the problem of "transinstitutionalization" for the more serious offenders who are headed for longer stays in jails and prisons. And it runs the risk of lower success rates due to proportionality problems. What approach to case targeting makes the most sense given the goals of mental health courts?

Sanctions and Rewards Building on the drug court model, some mental health courts apply a series of graduated sanctions and rewards to help improve compliance with treatment mandates. Does this structure work with mentally ill defendants? Do some mentally ill defendants lack the capacity for consequential thinking that is required for this approach to work? If so, what sanctions and rewards are most effective in promoting compliance?

Use of Jail Many mental health court practitioners struggle with the issue of whether it is ever appropriate to use jail as a sanction for defendants who fail to take their medications or participate in treatment. In drug court, there's a certain logic to sending offenders to jail for dirty urine because they're violating the law — there's a clear connection between the incarceration and the violation. When a mentally ill defendant stops taking his medications, he may have violated the court's order but no law has been broken. What kinds of sanctions are appropriate in this case? And apart from appropriateness, there are questions about the effectiveness of jail for offenders with mental illness. For instance, the King County Mental Health Court tries to avoid using jail sanctions because offenders' mental condition often deteriorates in jail, making it harder for them to re-engage in treatment upon release (Cayce, 2000). The San Bernardino Mental Health Court also seeks to avoid the use of jail, but for a different reason. Interestingly, they found that offenders with mental illness were simply not motivated by the threat of jail. Many regarded a stay in jail as a welcome relief from the difficulties of life in treatment or in the community (Morris, 2000). As a result, San Bernardino has aggressively employed community service sanctions instead.

Beyond Legal Competency Legal competency statutes and rulings set a very low standard for participation in criminal proceedings. Even if defendants meet the standard for legal competency to stand trial, their mental disorders may impair their abilities to make effective treatment decisions (Grisso & Applebaum, 1998). Given this, what expectations of competency should mental health courts adopt? One approach to this difficult question is offered by King County, which permits defendants to enter treatment for a short period of time pre-plea to stabilize their condition and maximize their ability to make competent decisions about their legal and treatment options.

Treatment Availability/Effectiveness Mental illnesses are various and complicated. Are certain mental illnesses less susceptible to treatment than others? How do you handle defendants for whom medication simply has no effect? Are there some illnesses for which treatment will have no impact on recidivism? Is there enough "integrated" treatment available for defendants with co-occurring disorders?

Public Safety A single sensational story about a participant committing a violent act could be enough to sink the entire mental health court movement. Courts must always balance the desire to rehabilitate with the need to preserve public safety. How can mental health courts quickly and effectively assess the public safety risks posed by defendants with mental illness? How reliable are the available risk assessment instruments? How should they be used?

Stigma and Confidentiality Do mental health courts run the danger of stigmatizing defendants with mental illness? What happens if a defendant decides not to opt in

to mental health court and the case is transferred to a conventional court? What information should the new judge and prosecutor receive about that defendant's mental illness, if any? And would this information have the potential to prejudice the way that the prosecutor and judge treated the defendant in subsequent proceedings? More generally, what kinds of confidentiality protections are appropriate for the information that defendants reveal as part of their involvement with mental health court?

Housing Many defendants with mental illness are homeless — they need housing in addition to treatment. And the effectiveness of treatment may be seriously compromised without adequate housing (Ades, 2001). How will mental health courts ensure access to housing for those defendants who require it?

Public Benefits The vast majority of participants in mental health courts will require public benefits — Medicaid, Social Security Insurance or Social Security Disability Insurance — for their subsistence and treatment. These federal benefits are often terminated or suspended when a person is jailed. As a result, when defendants are released, they must re-apply for benefits. It often takes several weeks before benefits applications are processed and payments begin. This leaves many defendants with mental illness in limbo, unable to meet their basic support and health needs (GAINS Center, 1999). What, if anything, can mental health courts do to address this problem?

The Role of the Courts Many individuals who end up in mental health courts have already been in the mental health system at some point in their lives. What evidence is there that courts can bring about different results? What do they bring to the table that's unique? Is it simply coercion? Or is it something else? Can courts promote enhanced system integration, bringing together criminal justice, mental health and drug treatment agencies?

Answering these questions will go a long way toward coming to terms with a more fundamental question: Are mental health courts a good thing or a bad thing? This is a question that can only be answered over time, with the help of solid, independent research and more practice on the ground.

While mental health courts have raised difficult legal, ethical, practical and therapeutic concerns, it is important to note that many of these issues are not entirely new. Drug courts, community courts, domestic violence courts and other problem-solving courts have been grappling with these issues for years. And the record has shown that on a local level, many problem-solving courts have managed to figure out answers to thorny issues of confidentiality, proportionality, case targeting and public safety. Mental health courts must figure out how to build on the best of the existing problem-solving courts while formulating new responses to issues that are unique to the mental health field.

Stakeholders

Mental health courts have not emerged in a vacuum, of course. To forge a new response to mentally-ill offenders inevitably requires the active engagement of a variety of stakeholders — judges, defenders, prosecutors, mental health advocacy groups and others. What do each of these groups think about the way that courts have traditionally handled cases involving mentally ill defendants? What would they do differently if they could? What do they think of the mental health court experiment? What are their primary concerns with this new model?

The following pages sketch out answers to these questions based on the results of dozens of interviews with each of these stakeholder groups. It is important to note that these sections are not intended to provide a definitive look at what these groups think about mental illness in the courts. Rather, the goal is to take a snapshot of a moment in time, offering impressions gleaned from months of interviews and focus group research.

Judges

Interviews with criminal court judges around the country reveal a consistent theme: defendants with mental illness pose special problems.

In general, judges feel that the standard options available in the criminal justice system are not a good fit for the majority of cases involving people with mental illness (Karopkin, 2000; Cayce, 2000). Judges in arraignment parts and courts that deal with misdemeanors and violations say that a substantial portion of their core business involves repeat offenders who appear to have mental illness (Broward County, 2000-B; Karopkin, 2000; Cayce, 2000; Norko, 2000; Rosenberg, 2001). The same holds true in lesser volume in courts that deal with felonies (Ferdinand, 2000; Morris, 2000; Leventhal, 2000). For this reason, one judge dubbed defendants who appeared to have mental illness as "frequent flyers" (Cayce, 2000).

Judges say that defendants "appear" to have mental illness because, in most circumstances, they do not really know for sure (Karopkin, 2000; Landsberg et al., 2000). Judges report that they usually lack the capacity to identify whether defendants have mental illness in any kind of systematic way (Anderson, 2000). More often than not, a judge will receive information from jail staff, defense attorneys or prosecutors about the possibility of a defendant's mental illness based on signs of strange behavior. According to James Cayce, the first presiding judge at the King County Mental Health Court: "This ad hoc approach certainly misses many defendants who suffer from mental illnesses but who do not have florid and obvious symptoms" (Cayce, 2000).

Even if judges in conventional courts could identify defendants with mental illness, they still lack the kinds of connections with community-based service providers that are necessary to place people in appropriate treatment programs (Broward County, 2000-B). According to Martin G. Karopkin, a judge in Brooklyn's criminal court, "Without a mental health professional they can turn to for reliable information, judges don't have any confidence that treatment is going to be effective for any

given defendant, so they won't risk it. Simply put, it's a frustrating situation that makes sense to no one" (Karopkin, 2000).

Problem-Solving Judges

In contrast, judges in problem-solving courts report that they have more time and resources to address the underlying problems of defendants. This includes staff to perform meaningful assessments, connections with treatment providers, and procedures for monitoring defendants in treatment. Despite these advantages, problem-solving judges say that defendants with mental illness often don't fit the mold. Some drug courts have simply excluded defendants with co-occurring disorders from program participation (Anderson, 2000). For drug courts that do accept defendants with co-occurring mental illness, it is estimated that these cases account for about one-third of their total caseload (Ferdinand, 2000). Domestic violence courts judges estimate that about one in ten defendants suffer from a mental illness (Leventhal, 2000). And much of the core business of community courts involves defendants with mental illness and substance abuse problems who are homeless (Koretz, 2000; Norko, 2000). In all of these settings, judges have noticed that defendants with mental illnesses tend to fail to satisfy the court's requirements at a higher rate than those without such problems.

In drug courts, judges have found that "defendants with co-occurring disorders are harder to place in treatment than defendants with a single disorder" (Ferdinand, 2000). Choosing the appropriate mode of treatment is also difficult for judges, even when relying on expert advice. First of all, co-occurring disorders are not easy to diagnose properly. Especially at or near the time of arrest, identifying a co-occurring disorder often requires a subtle differential diagnosis that is capable of separating out symptoms (Broner, et al., 2000). And mental illness is not a one-size-fits-all problem — not all mentally ill defendants are alike. Some have thought disorders like schizophrenia that can cause delusions. Others suffer from mood disorders like severe depression. Making an accurate diagnosis for placement in treatment requires a highly-trained mental health professional that even most drug courts do not have on staff and could not afford to retain.

In domestic violence courts, defendants with mental illness are often involved in crimes against their parents with whom they reside (Leventhal, 2000). Usually, parents do not want to cooperate with prosecution of the case, fearing it will result in punishment of their child (ibid.). But they have been scared by their child's violent behavior. They often implore the judge to use his or her powers to leverage and mandate treatment. The problem for domestic violence courts is that linking defendants to mental health treatment is not part of their core business (ibid.). Diagnosing a defendant, finding appropriate treatment and monitoring his or her progress is time-consuming, requires additional expertise and reduces the number of cases a judge can handle. Judges in domestic violence courts expressed a desire to be able to refer these defendants to a court that specializes in addressing mental health issues (ibid.).

Community courts handle a steady stream of low-level, quality-of-life offenses. Defendants are often repeat offenders who have co-occurring disorders (Koretz, 2000; Norko, 2000). Community courts emphasize neighborhood restoration through community service while helping defendants access basic services to address their underlying problems. This program design does not work very well with defendants suffering from serious mental illnesses (Koretz, 2000). Many defendants with mental illness are disorganized and confused, especially after being arrested and jailed pending arraignment. "They tend to miss court appointments to perform community service or to attend short-term treatment readiness programs" says Eileen Koretz, the presiding judge of the Midtown Community Court in New York. As a result, many community courts are searching for new approaches to defendants with mental illness.

By contrast, judges presiding in mental health courts feel like they have finally gotten a chance to address the issues of defendants with mental illness in an appropriate manner (Cayce, 2000; Anderson, 2000). Judge Ginger Lerner-Wren of the Broward County Mental Health Court has described her experience this way: "We view the Mental Health Court as a 'strategy' to bring fairness to the administration of justice for persons being arrested on minor offenses who suffer from major mental disability. We have seen time and time again true successes. Persons with major psychiatric disorders and/or mental disabilities can live and thrive in the community with individualized care, treatment and community support" (Lerner-Wren, 2001). Similarly, Judge Cayce has written about the King County Mental Health Court: "We see a positive difference in the defendants' personal level of satisfaction with their role in the system, the use of our limited jail resources, and in protecting public safety" (Cayce & Burrell, 1999).

Defense Attorneys

In many cases, defense attorneys are the first to discover that a client suffers from mental illness when they interview them after arrest (Saucedo, 2001). Defenders report a variety of challenges that accompany these clients. For instance, impaired mental functioning may make it much more difficult for clients to understand their attorneys' advice or for attorneys to clearly discern their clients' wishes (Bock, 2000).

Many defenders believe that their clients' mental illness drives their criminal conduct (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000; Finkelstein & Brawley, 1997). Some defenders believe that the system "criminalizes" mental illness — arresting people with mental illness for quality-of-life crimes, like disorderly conduct, that are the direct result of symptoms of their untreated illness (Schreibersdorf, 2001). "If they're acting 'weird' in the opinion of the police, then they get arrested. That 'weird' is a symptom of mental illness not criminal conduct," explains Lisa Schreibersdorf of Brooklyn Defender Service. And in the past, many people with mental illness would have been taken by the police for inpatient hospitalization rather than being arrested, booked and jailed (Finkelstein & Brawley, 1997). As a result, defenders tend to think that charges against their mentally ill clients are unfair and should be dismissed (Saucedo, 2001; Schreibersdorf, 2001).

What happens when a defender believes that his or her client with mental illness would benefit from treatment? Defenders talk about some daunting obstacles that they must then face. Their clients may not be "clean" enough or rational enough to accept that they are suffering from a mental illness. In this state, clients often won't accept the necessity of treatment (Bock, 2000). Or even if clients accept that they are ill, they may not want to engage in treatment, having become so used to serving short terms in jail or prison and so averse to treatment with its medications and their potentially negative side effects (Saucedo, 2001). Clients' resistance to treatment complicates defenders' ability to act in those clients' best interest. Finally, defenders worry about setting their clients up for failure by entrusting them to a behavioral health system that has failed to adequately treat and monitor people with mental illness who end up in the criminal justice system (Finkelstein & Brawley, 1997; Schreibersdorf, 2001).

In addition, defenders are not satisfied with the standard plea options available to their clients with mental illness. For instance, defenders almost never recommend the defense of "not guilty by reason of insanity" (Bock, 2000). They only recommend seeking this verdict in serious felonies, usually murders, which make up a minute amount of their overall caseload (Schreibersdorf, 2001). Defense attorneys explain that defendants will serve less time behind bars in most cases than they would spend hospitalized under an insanity defense, except when facing a sentence of death or life in prison (ibid.).

The same logic usually applies to seeking a ruling of incompetency. In misdemeanors, defense attorneys may raise incompetency if the charges will be dropped (ibid.). But not in all cases. Defendants found guilty of misdemeanors are usually given time served, probation or very short jail sentences, all of which may be shorter than the hospitalization required under competency regimes. In felony cases, defenders may seek a ruling of incompetency as a strategic device to buy time or to improve their ability to communicate with a difficult client (ibid.). For a felony charge, incompetency usually means staying in a hospital until the defendant stabilizes enough to return to court and face trial. Finally, defense attorneys are mixed on the defense of guilty but mentally ill because it often requires inpatient treatment only. This leads defenders to recommend this plea only in cases involving serious charges.

Across the board, defense attorneys expressed reluctance to employ these traditional judicial solutions out of concern over the intense negative stigma placed upon criminal defendants with mental illness (Schreibersdorf, 2001; Saucedo, 2001). This fear of stigma extended to their perceptions about mental health courts as well. Defense attorneys believe that prosecutors, judges, juries and some of their own colleagues need to become better educated about mental illness. They point to the fact that prosecutors may seek and judges may agree to withhold bail, increase sentences and extend probation for defendants with mental illness (Schreibersdorf, 2001; Finkelstein & Brawley, 1997). Some defenders may even see this reaction as understandable and fail to protest. Some defenders have expressed concern that the deci-

sions by these system actors are often based on myths about mental illness rather than any individualized assessment of the defendant in front of them. This concern leads many defendants to keep their client's mental illness to themselves whenever possible (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000).

Defenders expressed a cautious optimism about mental health courts and mental health treatment diversion. After all, obtaining treatment as an alternative to incarceration is something that many defenders have wanted for years (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000) Some defenders hope mental health courts will act as a kind of catalyst "to spotlight the paucity of treatment in the community and... spark an interest in creating the treatment programs for the mentally ill that the law mandates as a matter of right, which up until now have been denied them" (Finkelstein & Brawley, 1997).

In assessing the mental health court model, defenders' opinions vary based on whether participation takes place pre- or post-plea. Defenders are concerned that courts mandating treatment prior to adjudicating guilt could be too coercive. Some feel that the charges should be dropped after a client is diverted into treatment, in recognition of the fact that a client lacks culpability for an offense fueled by symptoms of an untreated mental illness. In addition, some defenders contend that holding the threat of prosecution over a client's head while in treatment is unfair and potentially a violation of due process principles (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000).

Many of these arguments drop away in the post-plea context. Once the issue of guilt has been adjudicated, defenders agree that the court may exercise broad sentencing authority and mandate defendants into treatment (Schreibersdorf, 2001; Feinblatt & Denckla, 2001). Some mental health court pleas explicitly lay out the defendants' potential exposure to jail in the event of consistently failing to comply with program requirements. While defenders think this approach is fair in the post-plea context, they are concerned about how much jail time would be faced by their clients (Schreibersdorf, 2001). For instance, defenders think it is unfair to make offenders who fail out of a treatment program serve a longer sentence than they would have served under a standard plea agreement (Feinblatt & Denckla, 2001). Other defenders believe that the "back-up time" for failure should decrease as the offenders' time in treatment increases, giving them credit for time served.

A general concern voiced by defenders about problem-solving courts involves how much authority judges will exercise over treatment decisions (Feinblatt & Denckla, 2001). Defenders like the idea that judges are becoming more educated about mental illness, but they fear that judges might be tempted to become "psychologists with black robes" (ibid.).

Prosecutors

Chief among prosecutors' concerns about defendants with mental illness is public safety. Mentally ill offenders tend to be repeat offenders. Consequently, some prosecutors have been attracted to alternatives in these cases, hoping that new solutions

might help reduce recidivism (Newman, 2001; Schrunk, 2001; Hynes, 2001; Clark, 2000; Raybon, 1997).

Unfortunately, many prosecutors who support alternatives to incarceration are often frustrated with the limits of treatment providers' capacity and willingness to treat defendants with mental illness. Some prosecutors complain that admissions standards are used to reject more defendants than they include. (Swern, 2000; Landsberg, et al., 2000). Given their mission to protect the public, prosecutors are particularly interested in residential treatment for offenders with mental illness. Many express concern about the dearth of residential treatment slots (Clark, 2000; Swern, 2000; Landsberg, et al., 2000).

Put simply, prosecutors want mental health courts to ensure the accountability of defendants linked to treatment. Prosecutors fear that a defendant with mental illness who is released for treatment will commit a violent crime (Clark, 2000). "Not only would this be tragic for potential victims but it could attract negative media attention that might be used to shut down alternative programs like the mental health court," says Daniel Clark, a prosecutor from King County (Clark, 2000). Given this concern, prosecutors focus a great deal of attention on risk assessment and case targeting (Swern, 2000, Monahan, 2001). "We have a responsibility to the public to assess the risk of violence and assure ourselves that the risk is as little as possible," says Anne Swern of the Brooklyn District Attorney's Office. "We are making an investment in treatment in order to prevent the re-occurrence of crime — particularly violent crime — by offenders with mental illness." Defining who is and is not eligible for a mental health court based on the risk of violence may be crucial to addressing prosecutorial priorities.

Defendants and Ex-Offenders with Mental Illness

In general, ex-offenders and defendants with mental illness who were interviewed at Howie the Harp Advocacy Center, Pathways to Housing, Odyssey House, Harbor House and the Brooklyn Arraignment Part in New York City Criminal Court thought that they had not been served well by the standard case processing of the criminal justice system. Ex-offenders baldly state that their mental illness (and, in many cases, their substance abuse) helped drive their criminal activity. Many reported that they committed their crimes under the influence of drugs or alcohol during a period in which they also failed to take prescribed psychiatric medications. Most had been arrested more than once. Many had served time in jail or prison.

Interestingly, ex-offenders expressed a good deal of ambivalence about their defense attorneys. While many had positive things to say about the legal counsel they had received, others felt that their attorneys were more focused on pursuing short-term strategies necessary to close the case than in preventing their return to the criminal justice system. One ex-offender put it this way: "Defense attorneys aren't thinking about me as an individual who has a mental illness. They're not thinking about my best interests, my need for long-term treatment or how to keep me from coming back to court tomorrow. They are thinking about the short-term of this case. If they knew more about mental illness, they would do things differently." This criti-

cism was fueled by the fact that the ex-offenders interviewed for this study had managed to stay out of the criminal justice system once they obtained treatment. (Many admitted that they had to try a number of different treatment modalities — and get arrested again — before they were able to stabilize.)

None of the ex-offenders interviewed had ever sought a verdict of "not guilty by reason of insanity" or "guilty but mentally ill." Some of them had been referred by their defense attorneys for a competency hearing. Some had also taken advantage of substance abuse treatment as an alternative to incarceration. It had worked for only a few of them because the treatment offered failed to address their mental illness as well.

While none of the ex-offenders interviewed had participated in a mental health court, most of them thought that this type of program was a good way to prevent recidivism. While many said that they would be willing to accept services at the time of arrest, there were some who, even with the benefit of hindsight, stated that would not avail themselves of treatment. Clearly, overcoming resistance to treatment is an issue that any mental health court must take seriously.

Ex-offenders thought that any treatment alternative should be mandated for a period of time longer than what a defendant would face in jail or prison. They repeated stories about how they and others like them didn't realize their own need for treatment even after they were arrested or incarcerated. They would resist treatment, especially if it involved psychiatric medications which carried negative side effects. And repeat offenders stressed that even several months in jail was considered a "skid bid" that was easier to serve rather than enter unwanted treatment.

As to case targeting, some ex-offenders thought that misdemeanor charges did not carry enough of a threat of incarceration to deliver long-term engagement in treatment. One ex-offender explained it in the following fashion:

> *Look, misdemeanors aren't going to be enough to get these guys [with mental illness] into treatment. If you're facing a misdemeanor, you're not going to do more than a year. Now, for most guys who've been through the system, they can do [that time] standing on their head. It's nothing. It's a 'skid bid' — fast and smooth. So they are not going to take treatment unless it is less than [a year], especially if they don't think they have a mental illness. And your program isn't going to want them to go to three months or six months or even a year of treatment. It takes a minimum of two years — maybe three — for treatment to work. So, I think you've got to take felons only. If you're facing a [sentence of] three-to-five [years in prison], two years in treatment is going to sound good.*

Ex-offenders offered suggestions about how to engage defendants with mental illness in treatment: "They are not going to listen to anybody except someone who has been through what they've been through and changed. That's why you need peer educators. It's the only way you'll get through to them." When asked about their experiences with judges, court officers, clerks and district attorneys, ex-offenders reported that these court personnel could benefit from training in the the mental

health recovery process ("relapse is part of recovery"). The ex-offenders also pointed to the need for training about the dangers of free time: "If I'm just sitting around in my house, watching the TV, that's when I start to get into trouble. My thoughts wander to the drugs, to the street, to whatever. Really, I'm just bored. But when I'm doing something all day — volunteering, working, even sightseeing — I'm not going to get into trouble."

What sanctions and rewards would be effective with defendants with mental illness? Interviewees stated that treatment plans should be re-evaluated to see if non-compliance is due to either an inappropriate treatment modality or truly willful behavior. One consumer put it this way: "You want [defendants] to think about the consequences — stay on track, you get a reward; mess up, you get punished. But what if they're confused and can't think straight because their medication is wrong? That's not their fault. It's not right to punish them then." They expressed the need to separate legal issues from treatment issues. The ex-offenders also suggested that a defendant's failure to comply should trigger the court to review whether the provider delivered the agreed upon services. And one consumer urged courts to use privacy as a sanction and reward: "Take away their [defendants'] privacy or give them more privacy. Everyone wants to be left alone. Reward them with more privacy."

The ex-offenders suggested various ways to reward/sanction with privacy. The consumers believed that increasing monitoring visits and calls, particularly at home, would be more effective than increased office visits, which can be easily ignored. They noted that privacy can be increased or decreased within a treatment facility (e.g., sharing a room with one person versus ten). However, they did not think short terms in jail would be effective as a sanction. Why? "In jail you lose the progress you made in treatment. Your self-esteem goes down. You think you can't get well. And you're afraid for your life. You don't want to go to the MO [Mental Observation Unit]. They dope you up on the wrong drugs. You fall apart." The consumers also proposed taking control of a defendant's income as another sanction. "Without spending money, you can't get into much more trouble."

Families

What about the families of criminal defendants with mental illness? In many cases, family members have been victimized by mentally ill offenders, suffering abuse, theft and harassment. Nevertheless, many families are extremely concerned over the incarceration of their relatives (Finkelstein, 2001; Saler, 2001). Organizations such as the National Alliance for the Mentally Ill (NAMI) have begun to explore solutions to this problem (Honberg, 2000; Corliss, 2000; Flynn, 1999). Family members feel trapped by unappealing alternatives. On the one hand, there is the mental health treatment system, which has failed to engage their relative in effective treatment. And on the other hand, there is the criminal justice system, which is certain to punish their relative for behavior that stems from their untreated illness (Corliss, 2000). But at least in jail or prison, their relative will be restrained from hurting themselves or others. And many offenders with mental illness have long, complex histories of resisting treatment, including failing to take their prescribed psychiatric

medications (Saler, 2001). Families want their mentally-ill relatives to get help, but in many cases they don't know how to do it (ibid.).

Families of mentally ill defendants are divided over the use of coercion to engage their relatives in treatment. Many lean towards the use of coercion because they have often been victimized by their relatives' criminal activity and their failure to remain in treatment (Saler, 2001; Corliss, 2000; Landsberg, et al., 2000). As a result, many families support outpatient civil commitment statutes, such as "Kendra's Law" in New York State, as a way to promote treatment compliance (Corliss, 2000). Similarly, many families have reacted positively to mental health courts (Finkelstein, 2001; Saler, 2001; Honberg, 2000; Corliss, 2000). They see these new experiments as providing their relative with a powerful incentive to remain engaged in treatment (Honberg, 2000; Corliss, 2000).

Mental Health Advocacy Groups

Mental health advocacy groups such as the Urban Justice Center's Mental Health Project in New York City and the Bazelon Center for Mental Health Law in Washington, D.C., engage in lobbying, public education and litigation on behalf of people with mental illness. Similar to defense attorneys, these advocacy groups believe that over the last decade or so law enforcement priorities combined with the effects of significant gaps in community mental health services have resulted in a "criminalization" of people with mental illness. (Barr, 2001; Bernstein, 2000).

Mental health advocates believe many defendants with mental illness commit crimes because their illness has not been effectively treated (Barr, 2001; Bernstein, 2000). Accordingly, advocates argue that defendants with mental illness should be diverted out of the criminal justice system and into treatment as early as possible. They believe that prosecuting most defendants with mental illness is fundamentally unfair. These advocates favor pre-booking diversion programs (sometimes called Crisis Intervention Teams) like the one employed with the police in Memphis, Tennessee (Barr, 2001). "The mental health system needs to develop more appropriate responses to people in psychological crises that will help avoid any criminal justice involvement," says Heather Barr, a staff attorney at the Urban Justice Center. If a defendant must go to court, they favor a diversion to treatment at arraignment and a dismissal of charges (Barr, 2001; Bernstein, 2000).

Mental health advocates are not very favorably inclined towards certain attributes of mental health courts. They share many of the same concerns voiced by defense attorneys. They see court-mandated treatment as an invasion of defendant's liberty and privacy (Barr, 2001; Bernstein, 2000). "Coercion by the courts," explains Barr, "is only appropriate when a defendant chooses that option freely and the offense is one that would lead to a substantial period of incarceration in the normal sentencing marketplace of the criminal justice system" (Barr, 2001). As a matter of principle, advocates tend to believe that individuals with mental illness should access treatment voluntarily on their own after charges against them have been dismissed.

In addition, mental health advocates are concerned about the use of confidential treatment information by prosecutors and judges in mental health courts (Bernstein,

2000). They describe occasions when prosecutors and judges have used psychiatric information disclosed in the course of advocating for a treatment disposition to justify a greater period of incarceration (Barr, 2001). They also fear that prosecutors (or other government agencies) will collaterally prosecute or impeach a witness on cross-examination using information obtained by the court during its mental health evaluation of the defendant (ibid.).

The Treatment Community

The behavioral health "treatment community" consists of state and county agencies of mental health, mental retardation and substance abuse and the programs they fund, including psychiatric hospitals and community-based service providers. Historically, the treatment community has been reluctant to address the issue of people with mental illness who have repeated contacts with the criminal justice system (Osher, 2001). Recently, that has begun to change. For one thing, research has documented that a significant number of people with mental illness cycle back and forth from treatment to incarceration. Even though the treatment community is starting to come to grips with this issue, the solutions are not easy ones. Addressing the needs of defendants with mental illness requires intricate cooperation among government agencies not used to collaboration with each other (ibid.).

Even though many of their clients have had criminal justice contacts in the past, many treatment providers do not have an expertise in treating these clients (often known as "forensic" clients). In general, where treatment providers are able to choose their clients, they tend to select clients who do not pose the kinds of treatment challenges associated with forensic clients (McCormick, 2000). Treatment providers often associate forensic clients with disruptive or violent behavior (Tsemberis, 2000; McCormick, 2000). As a result, many treatment providers will not treat people coming directly from the criminal justice system, fearing for the safety of their own staff and other clients (Tsemberis 2000). Further, some treatment providers also express concern about the complexity of forensic cases, explaining that clients from the criminal justice system usually have a host of very severe problems that are very difficult to treat effectively (Wertheimer, 2000).

In addition, many community treatment providers are concerned that forensic clients may require more frequent hospitalizations because of the severity of their mental health issues, thus impairing the provider's overall treatment performance statistics (there is even the potential that the failures of forensic clients will jeopardize funding from government sources that require performance-based contracts). "Evaluations of mental health services often regard hospitalization as a negative outcome when it may actually be a positive outcome when compared to being inappropriately placed in jail or prison," says C. Terence McCormick of the New York State Office of Mental Health (McCormick, 2000).

Hospitalization is a tricky problem. In jurisdictions that use a managed care system to deliver mental health services, psychiatric hospitalization initiated by community treatment providers is sometimes discouraged because of its expense (McCormick, 2000). Hospitals have an impact on the front end as well. Many

refuse to admit forensic patients, which makes it more likely that a police or parole officer will exercise his discretion to detain that person in the criminal justice system (Landsberg, et al. 2000).

Treatment providers share the view of many defenders and mental health advocates that mental illness has been "criminalized" in recent years, resulting in more and more criminal justice contacts for their clients (Wertheimer, 2000; Tsemberis, 2000). They also report that people with mental illness do not respond well to the stresses associated with arrest, courtroom appearances and incarceration (Tsemberis, 2000).

Treatment providers have mixed responses to the mental health court model. Some like it because it guarantees on-going court involvement with difficult clients. It gives them a greater sense of assurance that they can call upon the court to help engage forensic clients in treatment (Unterbach, 2001; Wertheimer, 2000). "Treatment outcomes are usually much better when the client, case managers and treatment staff maintain a close relationship with the court" explains Arnold Unterbach, director of mental health services at Odyssey House in New York City (Unterbach, 2001). Indeed, despite their concerns with forensic clients, treatment providers tend to believe that treatment works or can be made to work for just about any person with mental illness. Moreover, many believe that effective treatment can prevent recidivism (Wertheimer, 2000).

Some mental health service providers are encouraged that the courts have begun to realize that their conventional responses to defendants with mental illness are not working. Some believe that the courts may be taking the lead — ahead of the treatment community — in pushing for integrated treatment for co-occurring disorders (Osher, 2001). Other treatment providers express doubts. They worry that courts will intrude into the treatment process without developing a real understanding of either the day-to-day realities of providers' work or the challenges that people face in treatment (Stoller, 2000). And they fear that their need to report confidential information to the court could jeopardize their ability to gain clients' trust, reducing the chances that treatment will be successful (Tsemberis, 2000). "Our concern is that mental health courts may perpetuate the public's unrealistic expectation that when a court mandates someone to do something they actually do it. In reality, when people are told that they have to do something, paradoxically, they often do the opposite. That's human nature — whether you have a mental illness or not," says Ellen Stoller of FEGS, the largest community mental health treatment provider in New York City (Stoller, 2000). Finally treatment providers worry that without specific relationships with treatment providers and priority access to services, mental health courts will face difficulties placing forensic clients in treatment (McCormick, 2000).

Conclusion

While judges, attorneys, service providers and defendants with mental illness come at the issue from different perspectives, there is a consensus that criminal defendants with mental illness pose a major problem for courts in the United States. Standard case processing methods have proven to be neither efficient nor effective in dealing

with these defendants. Given this reality, state court systems have begun to test new approaches in an effort to protect communities and prevent defendants with mental illness from returning to court over and over again at great cost. Most notable among these approaches are mental health courts.

Mental health courts are creating a great deal of discussion around the country. They have provoked a surprising variety of responses from stakeholders in the criminal justice system and the mental health system. For instance, offenders with mental illness and their families appear to differ from defense attorneys and mental health advocates about whether or not coerced treatment is ever appropriate. Further, offenders with mental illness report that their attorneys sometimes fail to pursue case outcomes (e.g., treatment alternatives) that might involve the short-term loss of liberty but might also keep them out of the criminal justice system over the long haul. Defenders and mental health advocates have responded with ambivalence to mental health courts — worrying over the possibility of increased state coercion while applauding the system's interest in expanding access to treatment.

Meanwhile, many prosecutors and judges seem willing to risk the possibility of failure to test whether treating symptoms of mental illness will reduce recidivism and improve public safety. Strikingly, they have encountered some of the most solid resistance from treatment providers, who lack the capacity (and, in many cases, the knowledge about effective treatment regimes) to serve this difficult population. Courts are not an institution known for innovation. But if mental health courts are to succeed, it is clear that they will have to take a leadership role, both in building public support for treatment an alternative to incarceration and in encouraging treatment providers to work with forensic clients.

As mental health courts move forward, they will test three ideas. Primarily, mental health courts explore the connection between defendants' symptoms of mental illness and their criminal conduct, asking whether intensively monitored treatment can reduce recidivism. They also aim to evaluate whether coercion helps improve accountability by engaging defendants with mental illness in long-term treatment. And they tackle the question of system integration: Can the systems of mental health and criminal justice craft collaborative approaches to mental illness and in the process improve the delivery of services to defendants with mental illness and co-occurring disorders? In the years ahead, the answers to these questions will go a long way towards determining both the course of mental health treatment and the future of individuals with mental illness in the criminal justice system.

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