Mental Health Courts: What are the Best Practices, Structures, and how can we Modify the Courts to be More Effective in Reducing Recidivism Among Mentally Ill Offenders

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Jordan Zarka

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Abstract

Since deinstitutionalization took place in the 1970s, the amount of mentally ill offenders in United States jails and prisons has been on the rise. One of the solutions to this problem was mental health courts. The first mental health court was established in Broward County, Florida in 1997. A team approach to this alternative court allows mentally ill offenders the chance to participate in community based treatment. Much like drug court programs, mental health court programs use the application of sanctions and incentives in order to facilitate change among offenders. Mental health courts are still in their infancy and show promise when it comes to reducing recidivism among mentally ill offenders. The mental health court programs in Broward County, Florida, Hennepin County, Minnesota, San Francisco, California, and Brooklyn, New York., are evaluated to see consistencies among mental health court programs. With these evaluations recommendations to the structure, treatment team, and funding are made to be used toward a universal mental health court model.
INTRODUCTION

The introduction of psychiatric medications along with reports of mistreatment in state mental facilities began a movement to take the mentally ill out of state mental facilities and put them back into communities. The thoughts behind this move was to treat the mentally ill in a less restrictive matter. Community-based treatments were to take over the treatment process and this is referred to as “deinstitutionalization” (Odegaard, 2007). There were unintended consequences from that movement including the rise of mentally ill individuals in jails and prisons. In response to this consequence, Mental Health Courts were established as another alternative to prison.

Purpose of the Study

The purpose of this study explores the best practices, structures, and effectiveness among mental health court programs in the United States. The study examines mental health court models among different locations throughout the United States. An examination of variables such as practices that are the best basis for an effective model, the different mental health court structures, qualifications for being accepted into the different programs, and the application of sanctions. This study looks into what has been shown to be effective and ineffective among the different models to reduce recidivism among mentally ill offenders. By comparing and contrasting the components that work and do not work, would give a basis to design an effective universal mental health court program.

Significance or Implications of the Study

The significance of this study is to build a stronger design for mental health court programs. Studies have been mixed as far as the effectiveness of mental health court programs.
Many programs are not designed or ran the same way even within the same state. Mental health courts have been growing and were built off of the structure of drug courts. As mental health courts grow, and effective model will become increasingly needed. Developing an effective model through this study could have many future implications. An effective model that is evidence based could help toward a criminal justice system that breaks the “revolving door” cycle of the mentally ill.

**Methods of Approach**

The methodology for this paper first reviews the literature to explain the problem of the amount of mentally ill offenders in United States jails and prisons. An introduction of data on the issue will be discussed. Through this analysis the history of mental health courts and how the idea of them came from drug courts will be explained.

Also a summary will be done of the Mental Health Court programs that are currently active across the United States. Each court program is unique and tend to have differences in how they are implemented as well as ran. An analysis will be done on the data showing the effectiveness of these programs on recidivism among mentally ill offenders.

Lastly, using the information from the literature review as well as the analyses of the current Mental Health Courts, this study will provide recommendations for a universal and effective Mental Health Court model.

**Section II: Literature Review**

Deinstitutionalization played a big part in the development and establishing of mental health courts around the United Stated. With the mentally ill not having anywhere to go, they recycled through the criminal justice system at high rates. Many mentally ill offenders do not
have the option for the proper services to treat their mental illness. As a result, options were explored to fix the problem of the high numbers of mentally ill offenders in jails and prisons, and mental health court programs were developed. Mental health court programs are designed in a way to divert mentally ill offenders from re-entering the criminal justice program.

A. The Effects of Deinstitutionalization

With the introduction of psychiatric medications in the 1950s, the need for the institutionalization of the mentally ill decreased (Odegaard, 2007). Many in the Unites States population wanted this population to receive treatment within the community and outside of state institutions that had the reputation of treating mentally ill patients poorly. The 1970s brought the introduction of new civil commitment statutes which made it more difficult to commit mentally ill individuals. During *O’Connor v. Donaldson*, the United States Supreme Court ruled that a state cannot involuntarily confine a non-dangerous person (Linhorst & Dirks-Linhorst, 2015). The case of *Lessard v. Schmidt*, held a ruling from a federal district court that persons undergoing civil commitment had due procedural rights similar to those individuals in the criminal justice system because of the loss of liberty involved (Linhorst & Dirks-Linhorst, 2015). Due to these changes many of those who were displaced by deinstitutionalization would partake in the same behaviors that would have gotten them committed, but instead they were now being arrested and put into jails or prisons.

The thoughts behind this move was to treat the mentally ill in a less restrictive matter by using community based treatment. Originally the Community Mental Health Centers Construction Act of 1962 was to help fund these community centers for the mentally ill to obtain services (Dumont & Dumont, 2008). This legislation was eventually funded to an extent of $140 million annually and only a few Community Mental Health Centers (CMHCs) were built and
staffed with federal money, the original goal was designed as a $7 billion effort with a goal of 2,000 CMHCs across the country (Dumont & Dumont, 2008). However, with the economy weakening in the 1970s, the funding was not there for these centers to be funded. Slowly, these comprehensive programs were not available and more private practices relying on Medicare, Medicaid, and private insurances for funding emerged (Dumont & Dumont, 2008). In 1968, Richard Nixon suspended, and then terminated funding for mental health reforms. This resulted in mentally ill individuals returning to their communities to find no community-based treatments available. Many communities were not prepared to accommodate the mentally ill and did not foresee the repercussions of deinstitutionalization.

B. The Rise of Mentally Ill in Jails and Prisons

A repercussion of deinstitutionalization was what is referred to as the “revolving door”, which is referring to mentally ill offenders being repeatedly recycled through the criminal justice system (Odegaard, 2007). Brandt (2012) stated that an estimated 15-20 percent of people in criminal justice institutions suffer from a serious mental illness. Restrictions on the availability of community based mental health services, local law enforcement agencies as well as criminal justice systems have increasingly found themselves coming in contact with mentally ill persons. In 1955 there were about 559,000 state psychiatric beds available, which was about 339 beds per 100,000 people, however by 2000 the amount of beds went to 59,403, about 22 beds per 100,000 (Linhorst & Dirks-Linhorst, 2015). It is estimated that 7 percent of all police contacts is with a mentally ill person (Shafer, Arthur & Franczak, 2004). Studies have provided evidence that persons with mental illness represent a meaningful percentage of persons incarcerated (Christy, Poythress, Petrila & Mehra, 2005). MHCs allow for an alternative for mentally ill offenders that is different than the “revolving door” that has become so common for this population.
C. Exploring Solutions to the Problem

Problem-solving courts already existed before the development of mental health courts. In 1971, President Nixon declared the war on drugs in an attempt to address substance abuse and the negative impact on society (Fisher, 2014). In 1989, the first drug court was established in Miami as another solution to the negative effects of substance abuse on society (Bozza, 2007). Drug courts consist of a team including a judge, prosecutor, defense attorney, probation officer and a treatment liaison (Fisher, 2014). Drug court was a response to help those with substance abuse issues and also to help reduce recidivism among addicts. Drug courts rely on a graduated sanction and phase system. As a participant progresses through the drug court program they are expected to continue to follow the guidelines of the program, if they fail to comply, a sanction will be given and if they are compliant an incentive will be given (Fisher, 2014). Building off of this model, the mental health court concept grew.

In response to the large numbers of mentally ill in the criminal justice system, Mental Health Courts began. The first MHC was established in 1997, in Broward County, Florida (Christy et al., 2005). MHC’s were developed alongside other problem-solving courts such as drug court and domestic violence court. There is no one universal way to run MHC’s, so, “when one has seen one mental health court, one has seen one mental health court”. No two courts are alike. These courts are structured very similar to Drug Courts. There is a team that takes part in running the court. Often this team consists of the judge, defense attorney, treatment professional, prosecuting attorney, and a probation officer. Mental health courts also make use of sanctions and incentives. Courts in Broward County, Florida, Hennepin County, Minnesota, San Francisco, California, and Brooklyn, New York, will be compared and contrasted to find what is working in MHC’s today.
These courts have been developed to help those with mental illness break the cycle of the “revolving door”. These courts are still relatively new and with that comes trial and error. It is recommended that all of the team members are properly trained about mental illness and how to work with this population of people. It is also recommended there needs to be more support and funding for not only MHC’s, but for the mental health system in general. Mental Health Courts offer an alternative for the mentally ill population instead of jail or prison, while also offering the participants treatment.

**D. The Development of Mental Health Courts**

Not only did the introduction of psychotropic medications lead to deinstitutionalization, but there was also an increase in people wanting those suffering from mental illness to obtain services within the community. This psychiatric reform promised a more humane and effective treatment for the mentally ill by shifting this population from state institutions to community-based services (Dumont & Dumont, 2008). Once many of these mentally ill persons were released, there was a lack of follow-up and a lack of services available to this population. High numbers of this population could be found among the estimated 40 percent of homeless shelter and prison populations in the United States (Dumont & Dumont, 2008).

It is estimated that less than half of the mentally ill population in jails or prisons receive any treatment while incarcerated (Brandt 2012). An effective intervention for this would be to train staff on mental illness and how to properly deal with this population, however it is not used. Due to limited resources such as time, space and money, the most common form of treatment given to mentally ill inmates is the administration of medications (Brandt, 2012). In these situations it is hard to tell whether the medicines are being used to treat the mental illness itself or if they are just helping control the symptoms so these people are more manageable while
incarcerated. Most of the time correctional staff and mental health staff work independently. Sometimes the roles of correctional staff and mental health staff are conflicting (Brandt, 2012). The goal of MHCs is to build a “bridge” between the two entities and help solve the problem of high amounts of mentally ill in jails or prisons.

The new “bridge” between the criminal justice system and mental health professionals began in 1997 with the first MHC that was established in Broward County, Florida (D’Emic, 2015). Mental health courts are only one of 14 different types of problem-solving courts in the United States. Only a handful of MHCs were established by the late 1990s and by 2010 approximately 300 were operating in more than 40 states (Fisler, 2015). These courts were modeled after other problem solving court models.

E. The Structure of Mental Health Courts

MHCs have been modeled after drug courts and are built on the principle of therapeutic jurisprudence (Brandt, 2012). Therapeutic jurisprudence is an approach that both emphasizes and facilitates treatment or other practical change strategies (Redlich & Han, 2014). It is believed that criminal offenders are more likely to successfully address underlying problems and avoid further criminal contact with the use of problem-solving courts and therapeutic jurisprudence (Redlich & Han, 2014). MHC dockets consist of criminal defendants with typically severe psychiatric problems. It has been argued that the court’s failure to recognize mental disorders could contribute to crime and recidivism (Brandt, 2012). MHC’s help combine efforts from the criminal justice system along with mental health services to work toward a reduction in recidivism in mentally ill offenders. MHC’s allow for mentally ill offenders to participate in a court model that is set up to help this group of people receive the mental health
services that are needed, while at the same time deferring charges if the offender completes the program successfully.

There is no one universal way for a MHC to be structured and it has been stated that once one has seen one MHC, then they have only seen that one MHC because they tend to differ so much. Linhorst, Dirks-Linhorst, Stiffelman, Gianino, Bernsen, & Kelley (2010), broke down essential elements that should be a part of every MHC. Planning and administration is one element of MHCs, which includes a group of stakeholders that represent the criminal justice, mental health, substance abuse treatment, and other related systems of the community to guide and plan the administration of the court (Linhorst et al., 2010). The first element helps to form the court team that is another element of the MHC program. The court team consists of criminal justice and mental health staff who work together to run the court. These individuals are mental health professionals, prosecutors, defense attorneys, probation and a judge, the individuals may vary by court and other individuals may be added to help the specific court function.

A target population must be decided for a court to function and to have the main focus of the group of individuals that will be chosen to participate in the MHC program. The target population element includes eligibility criteria address public safety and consider a community’s treatment capacity, in addition to the availability of alternatives to pretrial detention for the mentally ill population (Linhorst et al., 2010). Eligibility will at times also take into account the relationship between the defendant’s offenses and their mental illness, each case should be considered for what they are and not compared to the other participants. Another key element would be timely participant identification as well as the linkage to services (Linhorst et al., 2010). It is important to make the participation terms clear, encourage participation by the
defendant, promote public safety, individualize the treatment plan for each participant and provide positive legal outcomes for those defendant’s that complete the program successfully (Linhorst et al., 2010).

Informed choices are important to the MHC process. It is important that the defendant has proper counsel to help inform the decision the defendant is making, it is important the defendant understands the program and all of the aspects of the program before making the decision to join (Bureau of Justice Assistance, 2005). Treatment supports and services are the heart of a MHC program. Without treatment supports and services within the community, the therapeutic jurisprudence aspect of this program would not be supported without the proper programs within the community (Linhorst et al., 2010). Health and legal information should always be kept confidential and it is the participant’s confidentiality rights as mental health consumers and constitutional rights as defendants (Linhorst et al., 2010). Another important element for MHC programs is sustainability. Data should be collected and analyzed to demonstrate the effectiveness/impact of the MHC, also its performance should be assessed periodically, and support for the court in the community would be cultivated as well as expanded (Linhorst, 2010). Lastly, MHCs are similar to drug courts in the way that monitoring adherence to the program is an important element. MHC programs should have a schedule in place to where the defendant’s meet in the courtroom with the judge to report their progress within the program and any concerns they may have. When it comes to monitoring adherence, these court appearances are also the time that the proper sanctions or incentives may be enacted (Linhorst, 2010).

F. The Application of Incentives and Sanctions
The broad goal of all problem-solving courts, including mental health courts, is to address the underlying issues that contribute to people’s repeat contacts with the criminal justice system (Bureau of Justice Assistance, 2005). On top of the broad goal, it is a goal of mental health courts to increase public safety as well as increase engagement in treatment. It is important to track the progress of the participants and to monitor their adherence to court conditions. Similar to drug court models, in mental health court programs there is also a use of incentives and sanctions.

Mental health courts use the same general stipulation as drug courts in the aspect that a participant must comply with treatment and program requirements or face increasingly difficult sanctions. In drug courts, failure to compete or comply may result in incarceration, while this may be more common in drug courts, it is less common within mental health court due to the possible detrimental effects on a person with mental illness (Bozza, 2007). Drug court models have a systematic use of behavioral consequences along with the requirement for the direct and consistent involvement of judges to dispense the sanctions (Bozza, 2007). Mental health courts mirror the same concepts, however the sanction process can be different. Overall, the procedures developed for both court systems are intended to facilitate the common goal of getting their participants into treatment.

With treatment being at the forefront of mental health court programs, it is important to reward behaviors that show participation in the program. Positive reinforcement is often used in this court model. Both small and large achievements should be recognized. The Bureau of Justice Assistance (2005) identified the following as forms of incentives:

- Priority position in the order of cases called
- Praise from the judge
• Applause in court
• Increased time between status hearings
• Certificates for completion of treatment
• Food items or gift certificates from local businesses

These are only a few of the incentives that are used by mental health programs. Incentives are used in order to reinforce positive behaviors. On the other side of incentives are sanctions. Sometimes during the mental health court program process a participant may have a positive drug test or may not be adhering to all of the court conditions and in this case. Responses to these violations should balance the court’s need for accountability with the recognition that relapse is an expected component of recovery (Bureau of Justice Assistance, 2005).

Sanctions are to be used for significant violations and those violations require an immediate response. It is up to the mental health court team to assess each violation as they happen and determine whether a sanction is appropriate in that situation. The Bureau of Justice Assistance (2005) identified the following sanctions as some that have been used by mental health court programs:

• Journal Assignments
• Increased frequency of status hearings
• Increased supervision
• Community Service
• Restriction of privileges (e.g., curfew, travel)
• Jail
• Termination from the program

It is important to maintain specific and swift responses to both positive adherence as well as lack of adherence to the program. While jail time is one sanction used by mental health courts, it is not one that is often used.

G. Concerns with Mental Health Courts

Mental health courts function on the premise that their participants choose to participate in the court program and that it is done on a voluntary basis. Many individuals against mental health courts argue that mentally ill offenders do not have the mental capacity to make an informed decision about participating in the court program. Several studies have shown that there is a correlation between schizophrenia and diminished decision-making capacity, this is especially true in regards to understanding conditions and consequences (Kelly, 2015). It has also been shown to be try in those with severe depression. This makes it difficult to know whether the individual has the ability to voluntarily carry out the decision to participate in the mental health court program. It is up to counsel to inform the defendant properly of their options and to make it clear to them that they have a choice to either participate or not. Many studies have shown that many mental health court participants are not even aware that participation is optional and are less aware of the consequences of not participating or complying (Kelly, 2015). Along with the defendants being competent to voluntarily make the choice to participate, it is expressed by many who are opposed to mental health courts that they feel the defendants’ rights are infringed upon.

Concern of constitutional rights come into play when some are discussing mental health courts. First, many have suggested that a defendants’ constitutional rights of a jury is conflicted
with when a person chooses to participate in mental health court (Kelly, 2015). This is especially true if a participant does not have the capacity to make the decision to participate in the program and it was not thoroughly explained to them. Laid out in the Sixth Amendment and extended in the Fourteenth, this right provides that “the accused shall enjoy the right to a speedy and public trial, by impartial jury” (Kelly, 2015). In order to not infringe on this right, it is important that the defendant must have the access to enough information and understanding regarding their right to jury that they are able to voluntarily and informatively waive this right. This, however, is not the only right the opposing side argues is being infringed upon.

It is argued that participants’ right to counsel may also be infringed upon if they take part in a mental health court program. While mental health court participants are not required to abandon this particular right, problems could potentially arise due to the different role a defense attorney may take on as a member of the treatment team (Kelly, 2015). While it is necessary for the treatment team to work together, it is often argued that this team approach could cause a conflict of interest for the defense attorney. It is important for the defense attorney to maintain the clients best interest in mind, but in this case the defense attorney looks at best interest instead of the best deal for their client (Kelly, 2015).

H. Evaluation of the Effectiveness of Mental Health Courts

Lowder, Desmarais and Baucom (2016), conducted an analysis of data tracking recidivism among mental health court participants. This analysis found that mental health court participants were less likely to face new convictions and that a greater percentage of their convictions were for probation violations. Studies generally showed positive effects on recidivism as well as a reduction in arrests along with longer periods of time without new
charges after participation (Lowder et al., 2016). Although the results from this analysis show a positive effect on recidivism, many studies have shown inconsistent data.

Honeggar (2015) analyzed 20 articles for their study. It was reported that fifteen out of the twenty articles reported significant positive results related to a reduction in recidivism rates, while one of the remaining found statistically significant results of poorer recidivism outcomes for the mental health court group, while the remaining found no significant differences (Honeggar, 2015). These inconsistencies have been common among studies, however, much of the data has been positive in terms of recidivism rates. Many of these inconsistencies could also be due to the fact there is no universal model for mental health courts and

Honeggar (2015) explored the limitations in research on mental health courts. It was stated that a limitation was the demographic that was represented. White males in their mid-thirties were the primary participants included despite the overrepresentation of racial and ethnic minorities in the criminal justice system (Honeggar, 2015). There are many different reasons there could be a disproportionate demographic. Possible expectations could be the studies were conducted in areas where the racial composition was largely white or ethnic and racial minorities declined to participate or were ineligible for the court program (Honeggar, 2015). Another major limitation to the studies done on mental health courts was the amount of time the studies took place. Honeggar (2015) stated that of the 20 studies that were analyzed, approximately one third of the studies followed the participants for less than a year. It would be important for future studies to observe for a longer period of time due to the fact mental illness is something that effects a person for a lifetime and circumstances could change for a participant as time passes.

A study by Canada and Epperson (2014), evaluated the effect of the working relationship between the treatment team and the participants can have on success in the mental health court
setting. Research has shown that therapeutic alliance is a major predictor of clinical outcomes among individuals with mental illnesses and substance use disorders. Canada and Epperson (2014), found that perceived conflict with caseworkers was higher among participants who were terminated or missing from the mental health court program. It was discovered that a perceived bond with caseworkers was associated with more service use, but was not associated with days spent in jail or program retention (Canada & Epperson, 2014). Literature has supported the idea that therapeutic encounters can promote change, but the study by Canada and Epperson broadened the scope of how these therapeutic relationships can influence client outcomes through just a perception of conflict. Within the study, probation officers were not significantly associated with any outcomes in the study. Overall, the conclusion of the study was that a more positive therapeutic relationship there was as well as less perceived conflict, the participant was more likely to complete the program successfully. However, it was important to note there will always be some form of perceived conflict when it comes to participants in the criminal justice system due to past experiences, but the general perceived conflict did not have any significant effect on the results.

With the development of mental health court programs, there have been positive effects on recidivism rates among mentally ill offenders. Broward County, Florida, Hennepin County, Minnesota, San Francisco, California, and Brooklyn, New York, have all established mental health court programs over the years. They are similar in some ways and different in others, each will be evaluated to compare the different components of their programs.

**Section III: Comparison of Existing Mental Health Courts**

Only a handful of MHCs were established by the late 1990s and by 2010 approximately 300 were operating in more than 40 states (Fisler, 2015). Broward County, Florida was the first
to establish a mental health court in 1997 and since then, many more have been established. For the purpose of this paper, four courts will be discussed; Broward County, Florida, Hennepin County, Minnesota, San Francisco, California, and Brooklyn, New York. The similarities and differences of the courts will be discussed in order to see trends on what may work as components for a universal mental health court program.

**Broward County, Florida**

The Broward County mental health court was developed in response to significant overcrowding of Broward County jails and the large amount of persons with mental illness residing in jails that were not receiving adequate mental health services (Christy et al., 2005). This mental health court was one of the first mental health courts in the United States. The general concept of the court was modeled after drug court programs that had started years before.

The Broward County mental health court program team consists of a judge, prosecuting attorney, a representative of the county jail, a public defender, court monitor, a forensic social worker and a case manager (Christy et al., 2005). Federal legislation and subsequent funding from the Department of Justice followed to further support and ongoing implementation of mental health courts (Christy et al., 2005). The objectives of this court are similar to those of other mental health courts. The first objective was to increase the efficiency of the court by reducing days in jail for misdemeanants with mental illness. Next to increase access to services and to not compromise public safety by creating this court.

Each court operates under its own, mostly unwritten rules and procedures with its own way of addressing service issues (Christy et al., 2005). The Broward County mental health court established in order to be eligible to participate in their mental health court program, the offender
must have an Axis I serious mental illness, brain impairment, or a developmental disability (Odegaard, 2007). The possible candidates are typically identified by jail staff or the individual doing the intake of the offender. Once an offenders eligibility requirements are met, the offender is offered the opportunity to participate in the mental health court program. Once the offender agrees, they enter a supervised treatment plan that takes place over the course of a year and charges are temporarily set aside (Odegaard, 2007). However, in serious cases, the offender may be required to enter a guilty plea and given credit for time served. Offenses that qualify for this program include all misdemeanors except DUI and domestic violence, more recently Broward County has included some felonies on a case by case basis, typically all of the cases enter pre-adjudication (Odegaard, 2007). If a participant in the Broward County mental health court program does not adhere to their treatment plan, sanctions are implemented including; incarceration, changes in treatment, and hearings before the judge (Odegaard, 2007).

Evaluations of the Broward County mental health court program have been done and have assessed the effectiveness of the court. It was found approximately 47% of the mental health court participants compared to 56% of the comparison group showed at least one arrest following their initial court appearance (Christy et al., 2005). Compared to the time before the Broward County mental health court existed, there has been a substantially lower amount of jail days for defendants with mental illness since the mental health court has been implemented (Christy et al., 2005). Overall there has been an appearance that the court has been succeeding toward achieving their core goals. Extremely low levels of perceived coercion and high levels of perceived fairness have been reported by participants of the Broward County mental health court program (Christy et al., 2005). Many of the participants also reported the court made them feel the court was an opportunity for their voices to be heard. While there have been successful
results with this court program, it was discussed by Christy (et al., 2005), that these results may not generalize to other settings, given the organizational and structural differences between courts.

**Hennepin County, Minnesota**

Hennepin County, Minnesota established their mental health court program in 2003. Hennepin County mental health court has approximately 100 participants a year and is funded by the county as well as the Bureau of Justice Assistance (Odegaard, 2007). The court team for this court consists of a judge, a mental health screener from the county human services agency, a probation officer, and two attorneys (prosecution and defense) (Odegaard, 2007). This program is done on a voluntary basis and is designed to help offenders suffering from mental illness and/or co-occurring disorders. The length of the program may vary depending on the participant, usually lasting from 12-18 months (Meyer & Holbrook, 2007).

The offender is first screened by the mental health screener from the county human services agency to determine the initial eligibility of the offender for the program. Participants must have an Axis I or Axis II mental illness in order to participate (Odegaard, 2007). This includes not only persistent mental illness, but also traumatic brain injury, or an intellectual development disorder. The defendant must be charged within Hennepin County and must be a Hennepin or Ramsey county resident (Meyer & Holbrook, 2007). The charges in this case are not limited to misdemeanors. The offenses must be non-violent, but can be a felony or misdemeanor (Odegaard, 2007). However, each prospect is evaluated on a case by case basis and may be included despite a possible disqualifier. Once an offender has been accepted and has decided to join the program, a judge will require a guilty plea and the offender will be placed on probation, as well as ordered to participate in the program (Odegaard, 2007).
The goals of the Hennepin county mental health court include but are not limited to; reducing criminal recidivism, increasing compliance with court ordered conditions, improvements of life stability and facilitating access to services (Meyer & Holbrook, 2007). If a participant successfully completes the program, the case may be dismissed or the sentence may be reduced. If the participant does not complete successfully, the case is returned to conventional criminal court and will be processed as a traditional criminal case (Odegaard, 2007).

San Francisco, California

The San Francisco mental health court was established in 2003 (McNeil & Binder, 2007). This court program is a collaboration of the Superior Court, Haight Ashbury free clinic’s jail psychiatry services, UCSF’s City wide case management and the department of Public Health (McNeil & Binder, 2007). This court, like others requires the defendant to meet the criteria for an Axis I mental disorder. This court also accepts individuals with co-occurring substance use disorders and also accepts clients with Axis II personality disorder when the mental illness is severely compromising the individuals’ ability to function (Behavioral Health Court, 2008). Individuals are assessed to see if they meet this criteria. Defendants must be charged with, convicted of, or on probation for a misdemeanor or felony offense where the behavior that left to the offense had to do with their mental illness (Behavioral Health Court, 2008). However, defendants charged with misdemeanor or felony domestic violence offenses, elder abuse felony weapon, or serious offenses are not eligible for the program.

The primary goals of this program are to connect criminal defendants who suffer from serious mental illness to treatment services, find appropriate dispositions to criminal charges, taking in consideration mental illness as well as prior criminal history, and decrease chances of
returning to the criminal justice system (McNeil & Binder, 2007). A study by McNeil and Binder (2007), found that mental health court participants showed a longer time without any new charges when compared with similar individuals who did not participate in the program. An analysis in the same study showed that mental health court participants being charged with new crimes was about 26% lower than that of comparable individuals who received treatment as usual and the likelihood of mental health court participants being charged with new violent crimes was about 55% lower than individuals who received treatment as usual (McNeil & Binder, 2007).

**Brooklyn, New York**

The Brooklyn, New York mental health court program was developed in early 2002 (O’Keefe, 2006). The mental health court team for this program includes a judge, prosecution, defense, clinical team and treatment providers (O’Keefe, 2006). This team works with the offenders once they enter the program. The defendant is referred by the Assistant District Attorney after a lengthy review and there is roughly 60-100 new participants per year (O’Keefe, 2006). In this program defendants enter the mental health court by agreeing to a guilty plea with a sentence that would be comparable to a traditional sentence, although they agreed to a sentence, formal sentencing is waited for until the successful or unsuccessful completion of the program (Rossman, Willison, Mallik-Kane, Kim, Debus-Sherill & Downey, 2012).

In order to be eligible, offenders must be diagnosed with an Axis I disorder, individuals with personality disorders, cognitive impairment, developmental disabilities, brain damage, and dementia are not eligible for this mental health court program (Rossman et al., 2012). When it comes to the legal side, this program takes each case and evaluates, while still having a baseline.
All misdemeanors are eligible, but not intended for offenders who would only have a short amount of time in jail, misdemeanor offenders must be willing to accept a 12 month treatment mandate and potential jail sentences up to one year for failure to comply with the rules of the program (Rossman et al., 2012). All non-violent felons are eligible (e.g., assault, robbery, and burglary), but must be reviewed by the clinical team and ADA before acceptance, while violent felonies are presumed ineligible, but are reviewed on a case by case basis (Rossman et al., 2012).

The ultimate goals of the Brooklyn mental health court are to reduce recidivism and stop the “revolving door”. An evaluation done by O’Keefe (2006) showed results that homelessness among participants decreased, but was not significant. Recidivism decreased as well, but the results were not statistically significant, however, there was a significant decrease in drug and alcohol use (O’Keefe, 2006). Another significant finding by O’Keefe (2006) was that hospitalizations among mental health court participants significantly decreased from 50% to 19%. Overall, participants reported they did not feel coerced and showed high levels of satisfaction on views of procedural justice (O’Keefe, 2006).

Similarities and Differences Among the Courts

These four courts all have a general goal of reducing recidivism. Each court showed decreases in recidivism, however, some of them did not show statistically significant changes. All of these courts had a team consisting of a judge, prosecution, defense and some form of treatment team aspect. Every court allowed misdemeanor offenders and had some form of incentive for successfully completing the program. Those incentives ranged from a reduced sentences to dropped charges, although they differed, the same general concept of an incentive was intact. Each program had the same general make up of a separate docket and more intensive monitoring of their participants for compliance. Just like the incentives for completing the program, each program
has their own versions of incentives and sanctions. Sanctions varied between courts, however, each were consistent in the fact they would deliver a sanction for non-compliance. All of the courts also required an Axis I diagnosis in order for the offender to qualify for the mental health court program.

There were also many differences among the four court models. The biggest difference was with the qualifications to participate in the court. Broward County would only take non-violent misdemeanants. Whereas Brooklyn would take any misdemeanor as long as their sentence was not too short and would even consider some violent felons within their program. Hennepin County and San Francisco would both allow non-violent misdemeanants as well as felons. Each one is taken on a case by case basis. Each court program has a team involved with running the court, but none of them have the same team players. However, there is always a judge, prosecutor, defense, and some form of treatment provider. Some of the court programs have private treatment providers, while others are able to use their public health departments for their treatment contacts.

**Section IV: Recommendations for a Successful and Universal Mental Health Court Model**

While each court program has its similarities and their differences, each program has common goals of reducing recidivism among mentally ill offenders. It is common to hear that once one has seen one mental health court program, they have only seen one mental health court program. By evaluating programs throughout the country can help to identify key components of a successful mental health court program model that can be universally applied.

**Structure**
For mental health court programs to be successful, structure is a key component. A program must have the involvement from the four main key players to make up the court team. These key players include a judge, prosecutor, defense, and treatment provider. However, it is also important to involve a case manager or a probation officer. The last two key players are important because supervision and tracking of compliance are important for a participant’s success in the program. Often times these offenders are not only suffering from mental illness, but they have a co-occurring substance abuse problem. In this case, it is not only important to track the defendant’s progress within treatment, but also their compliance in abstaining from drug or alcohol use.

Much like drug courts, it is recommended that mental health courts also have a phase program. The first phase would consist of the participants being required to participate in the maximum amount of services while also going to court every week for a status hearing. As a participant progresses through the program, services may be reduced in order to help facilitate the participant to become more independent and established within the community. One of the goals of the program is to reduce recidivism, participating in groups and learning the coping skills to maintain their mental illness, is one way to help reduce recidivism among this group of offenders. It is also recommended for the participants with a co-occurring substance abuse disorder, that the program should also adopt the concept of frequent drug testing to monitor compliance in abstinence from drugs or alcohol.

**Treatment Team**

The treatment team is the core of any mental health court program. The treatment team generally consists of a judge, attorneys, treatment providers, a case manager and sometimes a
probation officer. These team members play different parts in helping the participants through the mental health court program and help to facilitate change.

It is recommended for each team member to be properly trained about mental illness along with the treatments of different mental illnesses. The treatment provider will already know much of this information and should help support other team members as they are learning the best ways to work with the participants in order to facilitate the best possible results. One good way for team members to undergo proper training is to send them to a national conference. One conference each year is the National Mental Health Court Summit. Conferences such as this one offer numerous workshops for members to attend; these workshops may include what a mental health court program entails and how to successfully establish a new program (Mental Health Court Summit, 2015). This conference offers different tracks for the different members to take such as; the judicial/legal track, clinical/programmatic track, and policing/corrections track (Mental Health Court Summit, 2015). Each session can be tailored to the different team member and their place on the treatment team.

Being properly trained can help to minimize the concerns previously discussed. If a team member knows how to properly discuss and explain options to the perspective participants, then they can help the participants understand all of the aspects of the program and help them to be able to make an informed decision to join. By knowing the population a team member is working with, they will be better equipped to make sure the participant can make an informed decision on whether to join the program or not along with the possible consequences of not completing the program. Once a participant has entered the program, each team member will be more knowledgeable on how they can help each participant toward the programs goal. Having team members properly trained does not only help them know their part better, but it can also
help their impact on the participants’ success. As previously discussed, positive therapeutic alliances can help facilitate change with participants as well as help participants be successful. With positive bonds, a participant is more likely to buy into the treatment aspects of the program which in turn can help the participant learn coping mechanisms to maintain stability in their lives.

**Goals of Treatment**

In order for a mental health court program to be successful, there must be clear goals of treatment. It is recommended that when working with the mentally ill population to clearly lay out goals and expectations for the participants to work toward. Each week there should be a status hearing with a judge, the mental health court team, and the participants, in order to check in on the participant’s progress. Tracking the progress of each participant will help to identify if the court program is helping the individual. Each participant should be mandated to a certain amount of treatment groups or individual sessions in order to address the mental health or co-occurring substance abuse. As a participant progresses through the program and shows improvements, their amount of groups may be decreased and their court mandates may decrease in an attempt to avoid the participant becoming reliant on the services being provided.

One common goal in mental health court programs is to address the mental health issues in hopes to decrease hospitalizations as well as increase independence among the mentally ill. By maintaining a schedule for the participants and making the expectations clear, it is more likely they will be successful. Another main goal for mental health courts is for participants to maintain control of their mental illness in order to live their lives. While it is important to have overall goals for a mental health court program, it is important to focus on individuals as well.
An individualized treatment plan as well as goal making will help to tailor the program to each individual and make it even more relevant to their progression out of the “revolving door”.

**Funding**

Just like any other programs, it is recommended that there is a proper funding source for the mental health court program. Local governments can help to fund not only the court program, but also the public health services that help these mental health court participants. Without funding to help with the treatment side, mental health courts would not be able to achieve their goals and would not be able to provide the services necessary for the participants to make progress. Not only can programs look to local government for funding, but also private donations. Private donors often will help these programs because in turn it helps the community. When a treatment team is properly trained and knowledgeable about their program, they will be able to go and find private donors to help fund the program.

The funding of these programs may help to support the part of the salary of the treatment team members. Funding may be used in many other ways including helping to pay for medications a participant may not be able to afford. Some psychotropic medications can cost an individual thousands of dollars if they do not have the proper insurance. A part of some mental health court programs is to help the participants obtain insurance, but until they are properly insured, a participant may need help affording their needed medication and proper funding can help to purchase these medications. Another necessity may be to help pay for treatment facilities for those participants that need help being stabilized on medications or substance abuse treatment for those with co-occurring substance abuse issues.
When these offenders get the help they need and there is improvement in their behaviors, it could potentially reduce crime in the area and benefit the citizens of the area. Without the proper funding, mental health court programs cannot properly function as well as help support the participants in the program.

Conclusion

With deinstitutionalization came unintended consequences. Individuals with mental illnesses were released from facilities and were expected to take part in community treatment programs. When they returned home, there were no resources available for this population. As a result, the mentally ill started to recycle through the criminal justice program and the “revolving door” concept began. In response to the growing number of mentally ill offenders in jails and prisons, mental health courts were developed. Mental health court programs are still in their infancy and are making headway in reducing recidivism among mentally ill offenders.

Mental health court programs are structured in a way to help offenders become more independent and be less likely to re-offend. The treatment team collaborates together to construct a treatment plan for each offender to address their individual needs. The application of sanctions and incentives can help to reinforce or discourage certain behaviors as well as reward behaviors that are showing improvement within the participant. Broward County, Florida, , Hennepin County, Minnesota, San Francisco, California, and Brooklyn, New York, are just a few of the many of mental health courts programs operating in the United States. The early evaluations of mental health courts are looking promising, but it is becoming more evident that these courts are not always structured the same.
With proper funding and training, these courts will thrive as they exit their infancy and develop more concrete ways of running each program. Each team member plays a different role and work together to reach the main goals of reducing recidivism among mentally ill offenders, address the mental health issues in hopes to decrease hospitalizations as well as increase independence among the mentally ill. As more research is conducted, it will be important to evaluate what is working and the best practices when it comes to these special court programs in order to compile it together and come up with a stronger and more uniform court model. As these courts become more established, it may be possible to help reduce the amount of mentally ill offenders in United States jails and prisons.

Reference


