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Mental Health Court Practices

Harvard Law School Mississippi Delta Project

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Introduction[1]

This report aims to assist Hinds County in the development of a mental health court by outlining practices in other courts and the rationales behind them. It pays specific attention to the priorities of the Bureau of Justice Assistance (BJA), so as to facilitate the acquisition of a planning grant from this subsidiary of the Department of Justice. It begins with an overview of the goals, background, and efficacy of mental health courts.

Mental health courts not only improve treatment of mentally ill criminal offenders, but also reduce recidivism.[2] This is an important public health tool; by actively monitoring participants' progress, mental health courts maximize public safety.[3] By reducing recidivism rates and lowering the number of people in jail, over time mental health courts may save communities more money than they cost to implement and maintain, making them economically practical.[4]

In addition to realizing community benefits, mental health courts improve outcomes for mentally ill offenders, connecting them with necessary but often out of reach resources and treatments.[5] Mental illness and criminal behavior can be cyclical; connecting mentally ill offenders with mental health resources, rather than incarcerating them, is a way of breaking that cycle, helping mentally ill offenders get the help they need, ultimately improving their quality of life.[6] In other words, for offenders who commit crimes in large part because of their mental illnesses, the traditional criminal justice system is not effective and not appropriate as a deterrent or a punishment.[7] Mental health courts are a means of addressing the inadequacy of the traditional criminal justice system, treating mentally ill offenders in a more appropriate way, resulting in better outcomes for all.

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[1] This report was prepared by Stephanie Berger, member of the Harvard Law School Mississippi Delta Project under the supervision of Katherine Record, Harvard Health Law and Policy Clinic and Nathan Rosenberg, Delta Directions. The following students from the Harvard Mississippi Delta Project were involved in research and drafting of this report: Alice Cullina, Sudipta Devanath, Priyanka Gupta, Dave Hanyok, Alana Kirkland, Seth Packrone, Amanda Savage, Kathryn Schmidt, and Katherine Walecka. Special thanks to Dorothea Van Buren, Regan Downey, Rene Hardwicke, Kevin Golembiewski, Harvard Law School and Emily Broad Leib, Harvard Law School.

[2] Bureau of Justice Assistance, MENTAL HEALTH COURTS PROGRAM, https://www.bja.gov/ProgramDetails.aspx?Program_ID=68 (last visited October, 2013).

[3] Lauren Almquist & Elizabeth Dodd, Council of State Governments Justice Center, *Mental Health Courts: A Guide to Research-Informed Policy and Practice*, v, 2, 2.5, 5 (2009), *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/Mental_Health_Court_Research_Guide.pdf.

[4] Almquist & Dodd *supra* note 3, at vi, 2, 26.

[5] *Id.* at 25.

[6] Robert Berstein & Tammy Seltzer, *Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform*, 7 DCSL L. REV. 143, 148 (2003); Almquist & Dodd, *supra* note 3, at 2.

[7] Bernstein & Seltzer, *supra* note 6, at 148.

The development of these courts emerged from both prison overcrowding as well as the emergence of drug courts,[8] which proved insufficient to reduce recidivism among mentally ill drug offenders.[9] Mental health courts were designed specifically to reduce the frequency of contact between individuals with mental illness and the criminal justice system by providing courts with the resources to improve their social functioning.[10] Early mental health courts restricted participation to defendants charged with misdemeanors, in large part out of concern for public safety and sufficient deterrence of felonies.[11] As discussed below, however, courts can take steps to reduce the risk that mentally ill violent offenders will reoffend. Moreover, it is unlikely that admitting offenders to treatment programs rather than jail time would decrease the deterrence effect, since diversion programs often have a duration comparable to jail time for the offense.[12]

Since mental health courts are relatively new, research has not yet identified best practices or model courts.[13] However, the goals of mental health courts, along with preliminary efficacy reviews suggest that the specialized courts benefit both communities and mentally ill offenders.[14] Mentally ill offenders adjudicated in a mental health court are less likely to be charged with a new crime than those processed in traditional court.[15] In addition, recidivism rates decline with each year of participation in a mental health court.[16] There is empirical evidence that suggests that lower recidivism rates persist even once mentally ill offenders have completed the mental health court's treatment programs, suggesting long-term benefits from participation.[17] In 2000, Congress acknowledged the potential of mental health courts to reduce crime, enacting America's Law Enforcement and Mental Health Project Act, funding the development and implementation of mental health courts.[18]

This report is organized as follows:

1. Target Population
2. Timely Participant Identification
3. Informed and Voluntary Choice

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[8] John S. Goldkamp & Cheryl Irons-Guynn, Bureau of Justice Assistance, EMERGING JUDICIAL STRATEGIES FOR THE MENTALLY ILL IN THE CRIMINAL CASELOAD: MENTAL HEALTH COURTS IN FORT LAUDERDALE, SEATTLE, SAN BERNARDINO, AND ANCHORAGE, 3 (2003), *available at* https://www.ncjrs.gov/pdffiles1/bja/182504.pdf.

[9] Council of State Governments, A GUIDE TO MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION, 5 (2005) [hereinafter DESIGN AND IMPLEMENTATION], *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/Guide-MHC-Design.pdf (citing Goldkamp & Irons-Guynn, *supra* note 8).

[10] DESIGN AND IMPLEMENTATION, *supra* note 9, at 5; Goldkamp & Irons-Guynn, *supra* note 8, at 3.

[11] *Id.* at 29.

[12] Almquist et al., *supra* note 3, at 9.

[13] DESIGN AND IMPLEMENTATION, *supra* note 9, at 8; *see also*, Almquist & Dodd, *supra* note 3, at 6.

[14] *See, e.g.*, Almquist & Dodd, *supra* note 3, at vi, 23–26; Bernstein & Seltzer, *supra* note 6, at 148.

[15] Almquist & Dodd, *supra* note 3, at 23.

[16] *Id.* at 24.

[17] *Id.* at vi.

[18] Bernstein & Seltzer, *supra* note 6, at 144 (citing PUB. L. NO. 106-515, 114 STAT. 2399 (2000) (codified as amended in scattered sections of 42 U.S.C.)).

4. Terms of Participation
5. Treatment Services
6. Confidentiality
7. Linkage to Support Services
8. The Court Team
9. Monitoring Adherence to Court Requirements
10. Sustainability

Target Population

To ensure both effectiveness and efficient allocation of resources, mental health courts should target specific populations according to severity of illness, diagnosis, severity of criminal charge, and criminal history.

Severity of Illness

Most states prioritize access to public mental health services for defendants with a severe and persistent mental illness (SPMI) - conditions that significantly limit an individual's ability to function over an extended period of time (e.g., schizophrenia, schizoaffective disorder, bipolar disorder, and severe depressive or anxiety disorders).[19] However some mental health courts extend eligibility to individuals with other disabling conditions that influence behavior such as developmental disabilities, personality disorders, traumatic brain injuries, or dementia. These disorders often co-occur with an SPMI and can contribute to increased encounters with the criminal justice system.

Eligibility decisions are largely based on the partnerships each court maintains with community agencies and services providers.[20] Most mental health courts target populations that fall under state identified priority populations, as this affects the relative availability of treatment and financial support.[21] Because Mississippi's priority population is broadly defined (adults with serious mental illness), Hinds County has flexibility in choosing a target population.[22]

Because approximately seventy-five percent of people with SPMI who become involved with the criminal justice system have a co-occurring substance use disorder (SUD), mental health courts generally focus on this population. Some courts also accept defendants based solely on a

[19] Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus Project, MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS, 5 (2008) [hereinafter PRIMER], *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-primer.pdf.
[20] *Id.* at 5.
[21] Almquist & Dodd, *supra* note 3, at 11.
[22] *FY 2014 Mississippi State Health Plan: Chapter 3 Mental Health*, MISS. STATE DEP'T OF HEALTH, 1 (2014), *available at* http://msdh.ms.gov/msdhsite/_static/resources/5409.pdf.

SUD diagnosis. A mental health court in Hinds County should coordinate with the drug court when determining whether or not to accept such individuals into its program.[23]

Diagnostic Criteria

Most mental health courts require a DSM-IV axis I diagnosis (the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition). These are clinical syndromes (e.g., depression, bipolar disorder, schizophrenia, phobias). Some courts also allow participation by offenders with co-occurring axis II disorders (developmental and personality disorders).[24] The release of the 5th edition of the DSM eliminates the axis system in favor of seventeen separate diagnostic groupings, meaning threshold definitions for court participation will change slightly (e.g., certain disorders are re-categorized).[25] Hinds County should keep this change in mind and consult with mental health treatment providers when establishing diagnosis-related eligibility criteria.[26]

Mental health courts vary in specific diagnosis-related eligibility criteria. Of the 37 BJA grantee courts, more than half of these courts have very specific criteria, such as requiring an Axis I diagnosis (with or without a co-morbid SUD) or an SPMI diagnosis. Other courts expand eligibility to defendants with brain injuries, developmental disabilities, and less serious mental illnesses.[27]

In general courts primarily accept individuals with SPMI (schizophrenia, schizoaffective disorder, bipolar disorder, and depressive/mood disorders were the most common diagnoses accepted in a 2005 survey).[28]

Severity of Criminal Charge

Felonies - Identification and Availability of Appropriate Resources

Courts may experience difficulty and delay in finding appropriate services for defendants charged with felonies, who may require more intense supervision to ensure public safety. Indeed, such services may not even exist in the

Felonies: Monroe County Mental Health Court (New York)

The decision to focus on defendants charged with felonies ensured the buy-in of the public defender and allowed for the development of a longer program duration, which court planners felt would improve the likelihood of effective treatment.

Source: DESIGN AND IMPLEMENTATION, *supra* note 9, at 30.

[23] *Id.*

[24] Almquist & Dodd, *supra* note 3, at 11 (citing American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994)).

[25] Doug Bradley, THE PROPOSED DSM-5: ALTERATIONS AND ALTERCATIONS, (August, 2012), *available at* http://www.nami.org/Template.cfm?Section=Top_Story&template=/contentmanagement/contentdisplay.cfm&ContentID=143362&title=The%20Proposed%20DSM-5%3A%20Alterations%20and%20Altercations.

[26] PRIMER, *supra* note 19, at 33.

[27] *Id.*

[28] Almquist & Dodd, *supra* note 3, at 10.

community.[29] To maximize services available to mentally ill defendants charged with felonies, courts should reach out to and foster relationships with service providers capable of meeting these needs, expanding the quantity of available services.

Exposure of the Prosecutor

Prosecutors may be reluctant to allow felony charges to be handled in mental health courts due to the risk of re-offending. Prosecutors, however, can benefit from feeding participants into the mental health court system. In systems in which a guilty plea is required, prosecutors can secure felony convictions without having to conduct trials. In addition, when a participant successfully completes his/her treatment mandate, the office can claim the victory of having turned an offender into "a law-abiding member of society."[30]

Victim Involvement

Working with participants charged with felonies may raise additional issues related to victims' rights. Some mental health courts have begun to adopt victims' rights policies that might otherwise not be available, but which are afforded in traditional courts. For example, some mental health courts require the victim's consent before a potential participant is allowed to enter the program; other mental health courts collect contact information from all victims such that court staff may notify them of important court events and even connect them to needed resources.[31]

Relationship Between Illness and Criminal Charge

Ideally, mental health courts should focus on defendants whose mental illnesses are related to criminal charges, as this will offer the best opportunity for rehabilitation and recidivism prevention. There is no standard measure to assess the extent to which a defendant's alleged offense and mental illness are related. Courts vary widely in whether and how they apply this standard. Generally, courts that require an assessment of the connection rely on a mental health professional to determine whether the offense with which the defendant is charged could be related to his/her diagnosis.[32] The mental health professional can also take into account whether there is a known and effective treatment for the participant's disorder and

[29] Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus Project, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESS: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT, 3 (2008) [hereinafter ESSENTIAL ELEMENTS], *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-essential-elements.pdf.

[30] Carol Fisler, Center for Court Innovation, BUILDING TRUST AND MANAGING RISK: A LOOK AT A FELONY MENTAL HEALTH COURT, 6 (2005), *available at* http://www.courtinnovation.org/research/building-trust-and-managing-risk-look-felony-mental-health-court?url=research%2F889%2Fpublication&mode=889&type=publication.

[31] Almquist & Dodd, *supra* note 3, at 9.

[32] PRIMER, *supra* note 19, at 29.

whether that treatment is likely to help the participant return to the community without committing future offenses.[33]

Special Considerations for Violent Offenders

Most mental health courts limit participation to those charged with non-violent offenses because of the public safety risk associated with placing potentially violent individuals in the community. Seventy-five percent of mental health courts funded with BJA grants automatically deny admission to violent offenders. The remaining twenty-five percent consider violent offenders on a case-by-case basis.[34]

Consideration on a case-by-case basis allows mental health courts to accept individuals whose violent charge is not indicative of future behavior or a risk to the community. For example, police officers with insufficient training on how to interact with individuals who have SPMI can escalate tensions during a routine trespass stop, leading to physical contact, and assault charges, even in cases with no physical injury. Similarly, domestic violence charges can follow minimal acts of aggression such as pushing, shoving, and agitation, when a person with SPMI experiences difficulty communicating their frustration or may perceive nonexistent danger. Mental health diversionary programs are often ideal in such cases.[35]

As a result, mental health courts have increasingly expanded access to individuals charged with violent offenses under specific conditions. Many courts have developed their own criteria for admitting individuals charged with violent crimes, such as the victim's consent or a determination by a mental health court team member that the participant no longer poses a threat to others.[36]

Violent Offenders: The Brooklyn Mental Health Court (New York)

The court team agreed to consider admission of defendants charged with second-degree robbery, second-degree assault, and burglary on a case-by-case basis. The District Attorney's Office must consent to each case before the clinical team can evaluate.

Source: Fisler, *supra* note 30, at 6.

In addition to restricting eligibility and requiring prosecutorial approval, a court has several options for protecting public safety should it chose to accept violent offenders. It can use psychiatric evaluation, psychosocial assessments, and other actuarial methods during the initial screening process to determine risk of future violence.[37] A court might also tailor treatment plans to individuals with higher risks of violence by lengthening the period of treatment and considering family supports.[38]

Criminal History

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[33] Fisler, *supra* note 30, at 8.
[34] PRIMER, *supra* note 19, at 32-33.
[35] *Id.*
[36] Almquist & Dodd, *supra* note 3, at 8.
[37] Fisler, *supra* note 30, at 8.
[38] Roger H. Peters and Fred C. Osher, The National Gains Center, CO-OCCURRING DISORDERS AND SPECIALTY COURTS, 11 (2004), *available at* gainscenter.samhsa.gov/pdfs/courts/CoOccurringSpecialty04.pdf.

Mental health courts vary widely with respect to addressing criminal history. Some courts prefer to take defendants with prior criminal histories, while others disfavor it. There are a number of factors to consider in thinking about including criminal history in the eligibility criteria.

Excluding Participation Based on Criminal History

Many courts exclude defendants convicted of prior violent crimes, even if the defendant's current offense is nonviolent.[39] However, this trend has shifted and the majority of mental health courts no longer use blanket exclusions.[40] Mental health courts also maintain a general practice of screening out people previously convicted of sex offenses.[41] Beyond public safety issues, courts generally avoid mandatory exclusion based on an individual's criminal record because many issues in the record, such as repeated failure to appear in court, are related to a person's mental illness. Instead, courts often consider the criminal record on a case-by-case basis.[42] Mental health court planners will have to decide whether to accept cases involving graduates who have re-offended and post-sentence cases involving probation violations.[43]

Targeting Defendants with Criminal Histories: Eighth Judicial District Mental Health Court of Clark County (Nevada)

The Court admits defendants charged with both gross misdemeanors and felonies, but it targets defendants with at least five jail bookings in the previous five years.

Source: DESIGN AND IMPLEMENTATION, *supra* note 9, at 35.

Some courts actually target defendants with prior criminal histories. Mental health courts could be particularly helpful to "revolving door" defendants who have not been successfully rehabilitated by the traditional court system.[44] Individuals with a high likelihood of recidivating actually stand to gain the most from programs with intensive supervision like those offered by mental health courts. Intensive supervision of low-risk individuals, on the other hand, has actually been shown to increase recidivism.[45]

Criminal Histories in Felony Focused Courts: Jackson County Mental Health Court (Missouri)

First-time offenders are eligible for participation in mental health court, but many court participants have a history of multiple misdemeanor offenses.

Source: DESIGN AND IMPLEMENTATION, *supra* note 9, at 29.

The court may want to consider including defendants with prior criminal histories especially if it will focus on defendants charged with felonies. Prosecutors

[39] PRIMER, *supra* note 19, at 35.
[40] Almquist & Dodd, *supra* note 3, at 8-9.
[41] PRIMER, *supra* note 19, at 35.
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] The Council of State Governments Justice Center, PRESENTATION: MODULE 4, TARGET POPULATION, *available at* http://learning.justicecenter.csg.org/?page_id=294.

have considerable discretion, and can charge defendants differently for similar crimes depending on the circumstances of the case. Yet a misdemeanor defendant with schizophrenia versus one who commits a felony will likely have similar treatment needs.[46]

Unfortunately there is little comparative research to assist courts in determining which populations will benefit most from the program. A mental health court planning team must instead weigh the factors like the political climate, available resources, and specific court objectives when determining eligibility criteria. This process will necessarily involve a balance between inclusiveness and triage.[47] Courts have experienced success despite targeting significantly different populations.

Typical Post-Adjudication: San Bernardino Mental Health Court (California)

Mental Health Clinicians at the local detention center interview and screen inmates after arraignment. After they inform eligible individuals about the program, those candidates must actively request admission.[1] Restricting referral to this process better serves the court's goal of reducing the number of incarcerated mentally ill individuals. *Source:* Goldkamp & Irons-Guynn, *supra* note 8, at 49.

Timely Participant Identification

Mental health court participants are referred to the program through varying sources. Referral patterns, along with plea arrangements, primarily differ according to trial stage. In general, pre-adjudication models are associated with misdemeanors and post-adjudication models are associated with felonies, although there are exceptions to this pattern.[48]

Referrals

In a survey of 125 mental health courts across the country, researchers found that referrals commonly come from judges, mental health personnel, and attorneys.[49] A majority of courts also accept referrals from jailers and pre-trial service administrators,[50] and/or families, service providers, law enforcement personnel, community agencies, and parole officers.[51] These referral patterns primarily vary according to trial stage.

Trial Stage

Pre-Adjudication Referrals and Plea Agreements

A pre-adjudication system identifies prospective participants during the probable cause/bond hearing stage. These models have the advantage of early identification, generally within 24 hours of arrest, which minimizes the time defendants must spend in jail.

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[46] PRIMER, *supra* note 19, at 30.
[47] *Id.* at 35 – 37.
[48] This model will be discussed further in the terms of participation section.
[49] Julie Raines & Glenn Laws, MENTAL HEALTH COURT SURVEY, 8 (2008), *available at* http://ssrn.com/abstract=1121050.
[50] *Id*. at 8.
[51] *Id.*

Pre-adjudication models lend themselves for referral of individuals not currently in custody, such as those on pre-trial release. Allowing non-custodial referrals can lead to high rates of inappropriate referrals because the individuals making them are more likely to be unfamiliar with the guidelines and eligibility criteria of the court. Evaluating inappropriate referrals may waste significant resources. Non-custodial referrals also present the danger of inappropriate reliance on the mental health court as a point of entry to mental health services.[52] This danger is especially problematic in courts that require guilty pleas for a defendant to participate, as this procedure can be used to coerce treatment rather than to divert individuals from incarceration.

In pre-adjudication mental health courts, no guilty plea is required for individuals to be admitted into the mental health program.[53] The charges are held in abeyance, and subsequently dropped or reduced upon completion of the program.[54]

Post-Adjudication Referrals and Plea Agreements

Other courts use a post-adjudication model, under which individuals are referred to the court after arraignment. Although some post-adjudication models proceed quickly, typical post-adjudication models take more time, averaging 28 days between arrest and referral.[55] These models more closely resemble alternative sentencing programs in that referral follows conviction or pleading. They are better suited to felony cases in which public safety and due process concerns lead courts to require more intensive and regulated screening procedures. While the first mental health courts used a pre-adjudication model, use of post-adjudication has expanded as demonstrated by a 2005 study showed that six out of seven courts formed in that year used a post-adjudication model, suggesting that this model is a viable option.[56] Courts choose this model to accommodate more individuals and to preserve defendant's rights, as discussed further below.

Pre-Adjudication Archetype:
Broward Country Mental Health Court (Florida)
The court engages advanced doctoral psychology students to screen all defendants currently in-custody before the hearing. Defendants who display visible mental health issues, or who have past contact with mental health system are placed in the mental health section of the jail. They receive a full assessment by the psychiatrist contracted to provide health services to all jail inmates. The defense attorney informs the court about any mental illness symptoms found during the assessment. The residing magistrate then refers appropriate individuals to the Mental Health Court. Families, defense attorneys and caseworkers can also make referrals. The Mental Health Court judge sees referrals every day at a designated time.
Source: Goldkamp & Irons-Guynn, *supra* note 8, at 9.

In post-adjudication courts, a guilty plea or conviction is required, but some courts allow the participants' records to be expunged upon completion of the program.[57] Most courts that admit defendants charged with felonies require a

[52] Bazelon Center for Mental Health Law, THE ROLE OF MENTAL HEALTH COURTS IN SYSTEM REFORM, *available at* http://bazelon.org/LinkClick.aspx?fileticket=xQf5_1grKcI%3D&tabid=104.
[53] Almquist & Dodd, *supra* note 3, at 13.
[54] *Id.*
[55] Allison D. Redlich et al., *The Second Generation of Mental Health Courts,* 4 PSYCHOLOGY, PUBLIC POLICY, AND LAW 527 (2005).
[56] Almquist & Dodd, *supra* note 3, at 12.
[57] *Id.*

guilty plea to be admitted into the program.[58] A guilty plea relieves the prosecutor from worrying about the defendant's constitutional right to a speedy trial.[59]

Choosing a Pre- or Post- Adjudication Model

Allowing participation in a mental health court for defendants accused of violent crimes without requiring a guilty plea (i.e., holding charges in abeyance until completion of a mental health intervention) has two advantages. First, it allows participants to avoid the harsh consequences of felony conviction (e.g., difficulty finding housing or employment). Second, defendants are not forced to choose between a Constitutional right (e.g., right to a trial by jury) versus access to mental health treatment.[60] While no research has been completed to evaluate the effectiveness of courts requiring guilty pleas compared to those that do not, the harsh consequences of a felony conviction are relevant to the design of the court.[61] Upon completion of a mental health intervention, the charges either can be dismissed, reduced, or the participant can be given a jury trial. At most, a court should accept a conditional guilty plea, under which charges are dismissed if the defendant is successful in the mental health court, if it cannot defer prosecution until after the treatment period.[62]

Atypical Post-Adjudication: Anchorage Mental Health Court (Alaska)

Arraignment occurs on average within 24 hours of arrest and subsequent referral to the mental health court within 48 hours of arrest. This court can move quickly because it focuses on misdemeanor charges and requires a guilty/no-contest plea for participation.

Source: Goldkamp & Irons-Guynn, *supra* note 8, at 36.

Courts that have begun accepting violent offenders pay special attention to victims' rights as well, some even requiring the victim's consent, in addition to a plea, before allowing the offender to enter the mental health court.[63]

Coordination with other Programs

In 2012, the Hinds County Sheriff's Department created a Crisis Intervention Team (CIT). The CIT and mental health courts share similar goals: keeping people with mental illness out of jail and ensuring access to treatment. The CIT program trains police officers to respond effectively to a mentally ill individual experiencing a crisis and to connect him/her to treatment rather than make an arrest.[64] The CIT can reduce the need for a court to immediately identify individuals with mental illness, as well as the number of mentally ill individuals charged with

[58] *Id.*
[59] DESIGN AND IMPLEMENTATION, *supra* note 9, at 38.
[60] Almquist & Dodd, *supra* note 3, at 13.
[61] *Id.*
[62] PRIMER, *supra* note 19, at 39.
[63] Almquist & Dodd, *supra* note 3, at 9.
[64] Michael T. Compton et al., *A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs*, 37 JOURNAL OF THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, 47055 (2008).

misdemeanors and in custody. This allows a mental health court to focus on more serious crimes and utilize a post-adjudication, custodial referral model. Regardless of whether such a model is adopted, consultation with the local Sheriff's office is critical.

A mental health court should also collaborate with the Hinds County Circuit (Felony) Drug Court and the Hinds County Justice (Misdemeanor) Drug Court to establish a procedure for appropriate transfer. This is especially important because of the significant co-occurrence of mental illness and substance use, particularly among individuals involved in the criminal justice system.[65] Mental health court referral patterns reflect this association (e.g., in the Bronx, New York, more than a third of referrals to the mental health came from a drug court).[66] The Hinds County felony drug court does not accept individuals with SPMI.[67] The drug court screens potential participants for mental health issues using forms that contain questions related to medical history, including past diagnoses, prescription medications, and episodes of suicidal ideation.[68] Currently, the drug court refers these individuals to appropriate organizations. The mental health court in Hinds County could establish a procedure under which individuals who are screened out of the drug court for SPMI are referred to mental health court clinicians for additional screening and subsequent referral to the court program.

Informed and Voluntary Choice

Empirical data indicate that informed and voluntary consent to participation in mental health courts is often overlooked.[69] Competence to stand trial and make treatment decisions can be analyzed through a three part lens: (a) understanding, (b) reasoning, and (c) appreciation.[70]

Competency Assessment: Court Coordinated Resources Project (Alaska)

The court has an expedited assessment process via an agreement with state agencies to hire a full-time, doctorate-level clinician to conduct them.[1] The clinician evaluates misdemeanor cases quickly, often within a day of the order and always within a week.

Source: Goldkamp & Irons-Guynn, *supra* note 8, at 37.

Legal Competency

The assessment of an individual's competency, both to stand trial and to make treatment decisions, is complex and often delayed due to inefficiency and a lack of resources. This delay is particularly problematic for misdemeanor cases, where the time it takes to evaluate an individual's competency often

[65] Peters & Osher, *supra* note 38.
[66] Shelli B. Rossman et al., CRIMINAL JUSTICE INTERVENTIONS FOR OFFENDERS WITH MENTAL ILLNESS: EVALUATION OF MENTAL HEALTH COURTS IN BRONX AND BROOKLYN, NEW YORK (2012), *available at* https://www.ncjrs.gov/pdffiles1/nij/grants/238265.pdf.
[67] HINDS COUNTY CIRCUIT DRUG COURT, http://www.co.hinds.ms.us/pgs/ctydivision/drugcourt.asp (last viewed October, 2013).
[68] Email from Rene Hardwick, May 30, 2013.
[69] Almquist & Dodd, *supra* note 3, at 19.
[70] Alison D. Redlich., *Voluntary but Knowing and Intelligent?*, 11 AM. PSYCHOL. ASS'N. 605, 612 (2005), *available at* http://www.albany.edu/scj/documents/RedlichPPPL.pdf.

exceeds the maximum time he/she would have faced in jail, if convicted.[71]

Care of Defendant

The defendant's mental state, and thus competency, is vulnerable both to the individual's substance use and environment. Thus, full substance abuse withdrawal must occur before a competency assessment is made.[72] Individuals risk deterioration in terms of competency once they return to jail to await trial, so it would be prudent to minimize the time between the defendant's stabilization in the hospital and competency assessment.[73]

Competency Assessment: Akron Municipal Mental Health Court (Ohio)

The court employs a nearby psychiatric clinic to assess competency, but these assessments generally take a week or two to begin.

Source: Teller et al. *Akron Mental Health Court: Use of Services by Successful Participants During the First Two Years*, THE STROMER REPORT (February 2004).

Accessibility of Assessment Staff

A court requires a full-time clinician on staff to make prompt competency assessments. Participants also benefit from frequent evaluations prior to their competency assessments (e.g., a court coordinator might review the possible mental health issues of individuals waiting in jail on a daily basis, which makes competency assessments easier to conduct in a timely and accurate manner).[74] Finally, it is helpful for a competency assessing clinician to know which defendants have SPMI, as restoration of competency will be more complicated for these individuals.[75]

Consent

Before agreeing to treatment, a defendant must be given the chance to understand the details of any required plea, contract for treatment, and must consent to the release of medical records to the court.[76] A defendant should have an opportunity to voice a preference relating to treatment options, if applicable.[77]

A written contract, detailing terms of participation in a mental health court and treatment plan, must be provided to the defendant in plain language (non-English where necessary) and with sufficient time for him/her to fully review and comprehend the document.[78]

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[71] DESIGN AND IMPLEMENTATION, *supra* note 9, at 44.
[72] *Mental Competency-Best Practices Model*, NATIONAL JUSTICE COLLEGE (2012), *available at* http://www.mentalcompetency.org/model/model-sec-I.html.
[73] Rossman, *supra* note 66, at 56.
[74] *Dougherty Superior Court*, ALBANY AREA COMMUNITY BOARD, http://www.albanycsb.org/treatment.htm (last visited October 2013).
[75] Redlich, *supra* note 70, at 611.
[76] *Id.* at 612.
[77] *Id.*
[78] *Mental Competency*, *supra* note 72.

Role of the Public Defender

The defense attorney is also essential for ensuring that individuals understand the terms and consequences of their participation in a mental health court.[79] This advice plays an important role in influencing defendants to agree to treatment; there is an insufficiency of data and mechanisms for measuring voluntariness, but mental health courts often report that individuals who feel like they voluntarily chose treatment are more responsive to treatment than those who feel coerced into participating.[80]

Voluntary Participation: The Bronx County Mental Health Court (New York)

Public defenders give their clients an "orientation" to the court. This orientation is an inexpensive and productive way to increase participant autonomy.

Source: Rossman, *supra* note 66, at 59.

Advice given by defense attorneys is often not regulated or even understood by the defendants.[81] A court should mandate that defense attorneys explain the treatment process and possible consequences to their client, so they get verbal instructions in addition to any written documents they read.[82] This discussion should occur in a one-on-one meeting so the defendant feels like they are being given a choice and voice, rather than being pressured in front of others. Public defenders should explain both terms of participation and go over the treatment plan with their clients.[83]

Judge's Instructions

There is evidence that opt-out consent results in a higher rate of participation in mental health courts than opt-in (e.g., a judge asks a defendant if he/she would like to be removed from participation, rather than if he/she would like to participate).[84] Regardless, a judge must ensure that participation is voluntary by explaining to the defendant that he/she is eligible and that his/her participation is voluntary.[85]

Voluntary Participation: The Bonneville County Mental Health Court (Idaho)

Potential participants must attend at least one mental health court hearing so that they are exposed to the process and issues discussed in court.

Source: Henry J. Steadman et al., *From Referral to Disposition: Case Processing in Seven Mental Health Courts,* 23 BEHAV. SCI., LAW 215, 217 (2005).

Participant Input

Individuals who find the court approachable and open to their opinions are more likely to comply with their

[79] *Id.*
[80] Redlich, *supra* note 70, at 610.
[81] *Mental Competency*, *supra* note 72.
[82] Redlich, *supra* note 70, at 610.
[83] Rossman *supra* note 66, at 59.
[84] Redlich, *supra* note 70, at 609; Eric Trupin & Henry Richards, *Seattle's Mental Health Courts: Early Indicators of Effectiveness*, INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY 26, 22-53 at 37 (2003), *available at* http://www.floridatac.org/files/document/trupin_ijlp_jan03.pdf.
[85] Redlich, *supra* note 70, at 609.

treatment plans.[86] Thus, it is highly important for courts to involve participants in their treatment processes. For example, participants can be offered options for the location of treatment, the chance to voice concerns regarding their treatment plans, and opportunities to explain any noncompliance.[87] Additionally, court team members can create a congenial environment for participants by avoiding stigmatizing language and familiarizing themselves with the participant's history and interests.[88] These steps will lead to a positive and open environment for the participants, making them feel supported and thus less hesitant to provide their opinions.

Special Considerations for Inpatient Treatment Orders

Court-ordered inpatient treatment, particularly pre-conviction, implicates due process and civil liberty concerns. Thus, it must only be used when strictly necessary.[89] Each state has its own laws iterating the criteria for when court-ordered inpatient treatment is appropriate.[90] Mississippi, along with twenty-six other states, bases these criteria on a participant's "need for treatment," in addition to the probability that he/she poses a danger to him/herself or others.[91] More specifically, these criteria examine whether the individual: 1) recently threatened to harm anyone, included him/herself; and 2) has been able to provide him/herself with essential items (e.g., food, clothing, shelter, healthcare).[92] Considering that mental health courts emphasize an individual's voluntary participation, as described above, mental health courts would benefit from more specific and robust criteria for inpatient orders.

The Disability Rights Center in Maine describes a model for mental health courts that includes a detailed set of questions to ask when deciding whether an individual should be involuntarily committed:[93]

> 1) Does the person lack the capacity to make an informed decision regarding treatment?
> 2) Is the person is unable or unwilling to comply with recommended treatment?
> 3) Is there a need for treatment? The need may be based upon a finding that:
> a) A failure to treat the illness is likely to produce lasting or irreparable harm to the person; or
> b) Without the recommended treatment the person's illness or involuntary commitment may be significantly extended without addressing the

[86] DESIGN AND IMPLEMENTATION, *supra* note 9, at 45.
[87] *Id.*
[88] *Id.*
[89] Jeffrey L. Geller, Patient-Centered, Recovery-Oriented Psychiatric Care, 63 AM. PSYCHOL. ASS'N. 1, 3 (May 2012), http://ps.psychiatryonline.org/article.aspx?articleid=1109168.
[90] *Mississippi*, TREATMENT ADVOCACY CENTER, (2011), *available at* http://www.treatmentadvocacycenter.org/index.php?option=com_content&view=article&id=220&Itemid=155.
[91] *Mississippi*, *supra* note 90.
[92] *Id.*
[93] *Id.*

symptoms that cause the person to pose a likelihood of serious harm.
4) Does the need for the treatment outweighs the risks and side effects?
5) Is the recommended treatment the least intrusive appropriate treatment option?

The court only orders inpatient treatment if all the questions are answered in the affirmative.[94] This court would benefit from adopting a similarly specific series of questions when mandating inpatient treatment, especially since self-selected participants generally have more favorable treatment outcomes than individuals who are involuntarily committed.[95]

In situations where inpatient treatment becomes necessary mid-program, the court can allow the individual to leave and re-enter the program as needed.[96]

Terms of Participation

All participants must agree to follow the rules and procedures of the mental health court. While there are certain similarities between different mental health courts, each court should develop locally, reflecting the needs and resources available in the local community.[97]

Case Dispensation after Program Completion

The decision about the consequences of successfully completing the program is usually determined before the treatment program begins as part of the plea agreement, and should result in a successful legal outcome (e.g., dismissal of misdemeanor charge, reduction of felony charge, or reduced sentencing).[98] Consequences will vary based on whether a mental health court is based on a pre- or post-adjudication model. The former might result in dismissal or reduction of the charges, whereas the latter may offer termination of supervision, vacated pleas, or lifted fees.[99]

Incentives should award those who follow the treatment plan, and success should be defined in relation to predetermined criteria.[100] Success will depend on the individualized criteria, which may include "life skills training, placement, health care, and relapse prevention for each participant who requires such services."[101] While there is no standardized definition of success, beyond basic completion of the program, some factors that could help determine success include "graduation rates, improved mental health functioning, linkages to treatment, and/or

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[94] *Id.*
[95] DESIGN AND IMPLEMENTATION, *supra* note 9, at 28.
[96] ESSENTIAL ELEMENTS, *supra* note 29.
[97] Almquist & Dodd, *supra* note 3.
[98] ESSENTIAL ELEMENTS, *supra* note 29, at 4.
[99] DESIGN AND IMPLEMENTATION, *supra* note 9, at 43; ESSENTIAL ELEMENTS, *supra* note 29, at 4.
[100] Almquist & Dodd, *supra* note 3, at 5.
[101] PRIMER, *supra* note 19.

recidivism rates."[102] Perhaps most importantly, success must be an individual measure involving evaluations, before, during, and after the mental health treatment program.[103]

Unsuccessful participants will be governed by a plea agreement if applicable, or referred back to the original court of jurisdiction if not.[104]

Status Hearings

Rigorous and consistent monitoring is crucial to the success of any mental health court.[105] In fact, the BJA only funds courts that have continuous supervision and periodic reviews.[106] The principle purpose of these status hearings is to reward or dispense sanctions for the participant's performance in the treatment program.[107] Most of the time, the number of status check-ins is not constant over the period of treatment, but dependent on factors like adherence to the treatment program, or varied as part of different phases of the program.[108] For the most part, courts conduct status hearings on a weekly, bi-weekly, or monthly basis depending on the circumstances of the participant.[109] Other status check-ins could include reporting to probation, pretrial services or other court agencies.[110]

Program Length

Creating a standard program durations for specific offenses is not likely to accomplish the goals of the mental health court.[111] Thus most courts establish minimum (as short as six months) and maximum durations (as long as three years or more) and tailor the specific duration to the individual, with the majority of programs lasting between one and two years.[112] The Justice Center recommends that program duration vary according to the defendant's progress, which can be determined by the participant's adherence to the court-ordered conditions and his/her ties to community treatment.[113]

A primary factor in determining the appropriate length should be the sentences that the participants would face if otherwise convicted.[114] A program should last no longer than the maximum sentence for the charged offense, as participants and defense attorneys will resist programs that would lead to a longer period of supervision than they would have faced if

[102] Almquist & Dodd, *supra* note 3, at 22.
[103] *Id.*
[104] DESIGN AND IMPLEMENTATION, *supra* note 9, at 43.
[105] *See* DESIGN AND IMPLEMENTATION, *supra* note 9, at 24, 43.
[106] PRIMER, *supra* note 19.
[107] DESIGN AND IMPLEMENTATION *supra* note 9, at 71.
[108] *Id.* at 42.
[109] *Id.* at 71.
[110] *Id.* at 42.
[111] *Id.* at 40.
[112] *Id.* at 40.
[113] ESSENTIAL ELEMENTS, *supra* note 29, at 4.
[114] *See* Almquist & Dodd, *supra* note 3, at 9.

convicted, especially those charged with misdemeanors. Where misdemeanor sentences are particularly short, mental health needs may necessitate a longer period of treatment, and psychiatric care should be continued wherever possible following the conclusion of a court ordered program.[115]

Treatment Services

Mental health courts should connect participants to comprehensive and individualized treatment supports and services in the community. They should strive to both use and increase the availability of treatment and services that are evidenced based. The answers to which treatment and support services are best for a particular mental health court depends on which target population the court selects.

Treatment Available in the Community

The scope of community services readily available in the community will determine a court's ability to utilize different treatment programs. The court should solidify treatment options for its participants by creating memorandums of understanding with providers. The Mississippi Department of Mental Health sponsors community mental health centers (CMHC) throughout the state. The services available in these settings conform to those used in the majority of mental health courts across the country (e.g., provide individual therapy, group therapy, prescription medication, and substance abuse therapy).[116]

Resources and services available in Hinds County:

Hinds Behavioral Health Services (State CMHC)

- individual therapy
- group therapy
- medication management
- social and vocational rehabilitation
- substance abuse services
- one staff psychiatrist[117]

Region 8 Mental Health Services

- inpatient drug treatment program
- intensive outpatient drug treatment program
- indigent drug programs to help pay for psychotropic medications[118]

[115] *See* Almquist & Dodd, *supra* note 3, at 9; PRIMER, *supra* note 19.
[116] Raines & Laws, *supra* note 49, at 8.
[117] HINDS COUNTY CIRCUIT DRUG COURT, *supra* note 67.

The Southwest MS Mental Health Complex

- an onsite psychiatrist[119]

Warren-Yazoo Mental Health Services

- transitional employment program that places individuals in part-time work positions
- a chemical dependency residential treatment center
- acute partial hospitalization[120]

To the extent available a mental health court should also consider providing Assertive Community Treatment (ACT), a form of intensive case management that utilizes a team of practitioners including psychiatrists, nurses, therapists, and social workers to provide comprehensive community based care.[121]

Psychotropic Medications

Currently, psychotropic medication compliance is almost universally included in a participant's court-ordered treatment plan (i.e., a defendant must take a prescribed medication).[122] Failure to comply with a medication requirement constitutes treatment noncompliance. While participants may be removed from the program for refusal to take medications, a court cannot force a defendant to take a medication without a separate legal order.[123] Most clients pay for medications through SSI or Medicaid benefits (a court pays when a defendant has no means of coverage or out of pocket resources).[124]

Absent a judicial order, a court must obtain informed consent for each prescribed treatment, and should solicit a written explanation in the case where a participant refuses a prescription.[125] Peer mentors should be available to assist participants in making an informed decision about treatment to minimize coercion, increase patient participation, and ensure that genuine misgivings about treatment is not mistaken for noncompliance.[126] This is important

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[118] REGION 8 MENTAL HEALTH, http://region8mhs.org/ (last viewed October, 2013).
[119] SOUTHWEST MISSISSIPPI MENTAL HEALTH COMPLEX, http://www.swmmhc.org/Services.html (last viewed October, 2013).
[120] WARREN-YAZOO MENTAL HEALTH, http://www.warren-yazoo.org/services.htm (last viewed October, 2013).
[121] Susan D. Phillips et al., *Moving Assertive Community Treatment into Standard Practice*, 52 PSYCHIATRIC SERVICES 771 (June 2001).
[122] Raines & Laws, *supra* note 49, at 8; M. Hughes & T. Peak, *A critical perspective on the role of psychotropic medications in mental health courts*, 57 AMERICAN BEHAVIORAL SCIENTIST 244 (2013).
[123] Hughes and Peak, *supra* note 122, at 246.
[124] Rossman et al., *supra* note 66.
[125] Hughes and Peak, *supra* note 122, at 259.
[126] Hughes and Peak, *supra* note 122, at 255; Eric B. Elbogen, Jeffrey w. Swanson, Marvin S. Swartz & Richard A. Van Dorn, *Effectively Implementing Psychiatric Advance Directives to Promote Self-Determination of Treatment Among People with Mental Illness*, 13 PSYCHOLOGY, PUBLIC, POLICY, AND LAW 273-288 (2007).

given the controversy that surrounds the use of psychotropic medications in mental health court treatment plans (due to uncertain efficacy, potential side effects, and the personal nature of drug administration).[127]

Co-Occurring Substance Use Disorders

Co-occurring substance use disorders are of particular concern in mental health courts because they are a significant factor in predicting whether a participant will complete the program. Individuals with substance use disorders are more likely than those without to drop out of a mental health treatment program.[128] In fact, the seriousness of an individual's substance abuse was correlated with the risk of recidivism after completion of a mental health court program in California.[129] This population is critical in Hinds County because mentally ill defendants are excluded from participation in the Hinds County Circuit Drug Court.[130]

Individuals with co-occurring substance use disorders have unique needs that necessitate unique treatment considerations. For example, many psychotropic medications negatively interact with drug and alcohol use.[131] Housing and transportation are also of particular interest to individuals with co-occurring mental illness and substance use disorders as they account for fifteen to twenty percent of the entire homeless population.[132]

Depending on the court's resources, it can implement certain modifications and enhancements to the basic mental health court model to address the needs of participants with co-occurring disorders. Courts can incorporate substance use information gathering into the initial screening and assessment processes, including chronology of substance use disorders, motivation for treatment, interactive effects of the disorders, and history of treatment.[133]

Based on this screening and assessment, individuals identified as having co-occurring disorders can be moved into a specialized, intensive treatment track. This track might include structural changes such as:

- longer treatment program duration;
- higher staff-to-client ratio;
- routine drug testing;
- incorporation of specialty service providers (i.e., detoxification) into treatment team meetings;
- increased frequency of status hearings; and

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[127] Hughes and Peak, *supra* note 122, at 260.
[128] Merith Cosden et al., EVALUATION OF THE SANTA BARBARA COUNTY MENTAL HEALTH TREATMENT COURT WITH INTENSIVE CASE MANAGEMENT 30 (2004), *available at* http://consensusproject.org/downloads/santa.barbara.evaluation.pdf.
[129] Merith Cosden et al., *supra* note 128.
[130] Hinds County Circuit Drug Court, *supra* note 67.
[131] ESSENTIAL ELEMENTS, *supra* note 29, at 7.
[132] *Id.*
[133] *Id.* at 4.

- overlap in activities and planned repetition of material.[134]

Treatment programs might need to be more flexible for these populations as well; for example allowing individuals to exit and re-enter the program in response to hospitalization.

Confidentiality

Consent to Release Protected Health Information

Standard Authorization Release: Riverside County Mental Health Court (California)

Participants agree to the release of information regarding diagnosis, treatment, compliance, and pre-and/or post-plea status to the public defender's office, the district attorney, the probation department, and treatment providers.

Source: Petrila & Fader, *supra* note 136.

Prospective participants should be provided an opportunity to consent in writing to the release of medical information before a court order mandates such disclosure (both the attorney and treatment providers should be present when consent is obtained). The release forms should include what information will be released and to whom. Defendants should not sign any release forms until competency issues have been resolved. The information should not be released to the public, which includes informal public conversations about the participants' mental health or consideration for a mental health court. Information should only be provided to mental health court staff members, and only to the minimum extent necessary.[135]

In general, uniform mechanisms and procedures for disclosure of protected health information (PHI) after a defendant agrees to participate in the program enable the court to run smoothly and efficiently. Many courts utilize a uniform authorization/consent forms. Participants complete this form, with necessary assistance, before beginning treatment. The forms should specifically address:[136]

1) The name of the treatment provider permitted to make disclosures;
2) The name of the court team member(s) to whom disclosures can be made;
3) The name of the patient;
4) The purpose of the disclosure (e.g., monitoring treatment compliance);
5) How much and what kind of information can be disclosed;
6) The patients signature and date;
7) Policies and procedures related to revocation of consent; and
8) The date or event upon which authorization will expire.

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[134] *Id.*

[135] ESSENTIAL ELEMENTS, *supra* note 29, at 4.

[136] John Petrila & Hallie Fader-Towe, INFORMATION SHARING IN CRIMINAL JUSTICE – MENTAL HEALTH COLLABORATIONS: HIPAA AND OTHER PRIVACY LAWS, 23 (2010), *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/Information_Sharing_in_Criminal_Justice-Mental_Health_Collaborations-2.pdf.

These guidelines conform to the Health Insurance Portability and Accountability Act (HIPAA) and associated regulations, which permit courts to issue judicial orders requesting PHI from providers.[137]

Neither federal nor state law requires mental health court hearings to be closed, but courts retain the option to close hearings.[138] Clinical documents should be handled separately from criminal files to ensure the information is closely guarded from public disclosure.[139]

Protecting Sensitive Health Information: King County Mental Health Court (Washington)

Jail staff send a memo to the Mental Health Court with the name and charges of defendants who appear incompetent, but no other personal information. After competent defendants consent to referral to the Mental Health Court, the court monitor requests a release of treatment history information.

Source: Goldkamp & Irons-Guynn, *supra* note 8, at 24.

Linkage to Non-Treatment Services

Non-treatment services can be essential to successful completion of a treatment program (e.g., Medicaid, transportation). In general, stable housing and employment, or other sources of financial stability, facilitate participation in treatment and alleviate symptom-inducing stress.[140]

The experience of the Brooklyn, New York mental health court illustrates the importance of stable housing, case management, and transportation services in successful completion of treatment programs.[141] Courts should generally prioritize these services, especially where resources are in short supply, as well as services that assist participants in acquiring them (e.g., ACT). Formal linkage to services increases the likelihood that they will contribute to successful program participation and lasting positive outcomes.[142] The court can implement systematic linkage by contracting with one or more community organizations to serve as referral hubs for participants. The court should establish guidelines for these organizations, vet them before selection, and regularly evaluate efficacy. Limited term contracts allow a court to regularly assess efficacy.[143]

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[137] 45 CFR 164.512(e)(i).
[138] Petrila & Fader-Towe, *supra* note 136.
[139] ESSENTIAL ELEMENTS, *supra* note 29, at 4.
[140] Bobbi Donovan, *Mental Health Court Provides Offenders an Alternative to Traditional Incarceration*, 9 THE JOURNAL OF THE ALLEGHENY COUNTY BAR ASSOCIATION 4 &10 (2007), *available at* http://www.acba.org/ACBA/pdf/TLJ/TLJv9-19_091407r.pdf.
[141] Kelly O'Keefe, THE BROOKLYN MENTAL HEALTH COURT EVALUATION: PLANNING, IMPLEMENTATION, COURTROOM DYNAMICS, AND PARTICIPANT OUTCOMES 7 (2006), *available at* http://www.courtinnovation.org/sites/default/files/BMHCevaluation.pdf.
[142] O'Keefe, *supra* note 141.
[143] ESSENTIAL ELEMENTS, *supra* note 29, at 3.

Court Team

Mental health court teams vary across jurisdictions but generally include both legal and clinical members (judges, prosecutors, defense attorneys, supervision staff, and treatment providers).[144]

Legal team members should be trained in mental health concepts, and clinical team members should cultivate an understanding of the basic legal procedures at hand.[145] Team members should also build their professional expertise by observing other mental health courts and partaking in an orientation for the specific court before they begin work.[146]

Legal Members

District Attorney

The role of the district attorney (DA) is most important during entry into the mental health court program. This attorney may advocate that particular defendants be included or excluded from the program based on failure to meet eligibility criteria or discretion where eligibility criteria allows. The DA might play an active role in the transfer of offenders who are screened out of drug court because of a co-occurring serious mental illness (SMI) to the mental health court depending on the structures of the Hinds County Felony Drug Court.[147] Their role diminishes during the monitoring stage, but they may be involved in sanctioning and sentencing recommendations.

Defense Attorney

The defense attorney plays a particularly important role in the court as the potential for coercion is inversely related to the quality of advocacy a defendant obtains. During screening and referral the defense attorney negotiates eligibility for mental health court participation with the DA's office.[148] Such negotiation does not involve alteration of the court's eligibility criteria, but rather establishment that an individual qualifies or advocacy when the criteria allow for discretion (e.g., argue that a violent offender be allowed to participate in a court that evaluates these defendants case-by-case basis). Defense attorneys have a particular duty to ensure informed and voluntary participation in the program, to preserve confidentiality throughout the program, and to communicate compliance and adherence requirements.

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[144] *Id.*
[145] *Id*. at 4.
[146] *Mental Competency*, *supra* note 72.
[147] Rossman, *supra* note 66, at 52.
[148] Rossman, *supra* note 66.

Clinical Members

The clinical team manages each case throughout the program, conducting initial assessments and linking a participant to services, assisting the judge to develop a general treatment plan and advise him/her during status hearings, and implementing rewards and sanctions.[149]

Larger Court Clinical Team: Bronx Mental Health Court (New York)
The clinical team includes a psychologist, two part-time consulting psychiatrists, 12 case managers, and a supervising case manager. *Source:* Rossman, *supra* note 67,34-36.

Treatment providers may report directly to the court, work through court staff to coordinate correspondence with the judicial team, or a combination of the two, depending on the resources a court has on hand.[150] For example, the Hattiesburg Behavioral Health Court created a position to oversee and coordinate each case. Other courts utilize probation and parole officers to serve this function; this is especially appropriate in a post-adjudication model, especially those that deal with felony cases, because probation will be involved regardless.[151]

Monitoring Adherence to Court Requirements

Mental health courts use a variety of methods to monitor adherence to court requirements that differ based on philosophy, resources, community, and participants. Regardless, all incentivize adherence through rewards, sanctions, and by adjusting treatment plans as necessary.[152]

Adherence Team

Adherence to a court negotiated or mandated mental health treatment plan can be monitored by mental health providers, criminal justice staff, or both.[153] Because monitoring by both health providers and criminal justice staff have pros and cons relating to efficacy, public safety, and efficiencies, the BJA recommends a team that includes both types of professionals[154]

Mental health providers are well positioned to identify potential causes for non-adherence, and determine potential resolutions that involve changes to treatment rather than sanctions.[155] This is critical; many behavioral problems may be related to inadequacies of treatment, rather than non-compliance. However, a provider may not have the capacity to monitor adherence to a treatment plan designed in response to a felony.[156] Moreover, monitoring adherence to a

[149] Rossman, *supra* note 66, at 48.
[150] Redlich, *supra* note 70, at 611.
[151] *Id.*
[152] DESIGN AND IMPLEMENTATION, *supra* note 9.
[153] *Id.* at 68-69.
[154] *Id.* at 70.
[155] *Id.* at 68.
[156] *Id*. at 69.

treatment plan can create role conflict, confounding treatment with sanctions.[157] This could defeat a primary goal of the mental health court design: to encourage the perception of treatment as a beneficial, long-term aspect of the participant's life, not as a punishment for wrongdoing.[158] One way to mitigate the potential for this is to ensure that the judge, in sanctioning the participant, emphasizes to the participant that all sanctions are determined by the entire team, not the provider.[159]

The advantages and disadvantages of criminal staff supervision are generally the inverse: they may not have experience with treatment and so may have trouble identifying causes and solutions for non-adherence. However, they are more familiar with court procedures and requirements, and can therefore manage them more efficiently. Moreover, court staff do not act as both treatment provider and sanction administer and therefore are able to avoid role conflict.

Regardless of who directly monitors compliance with a treatment plan, all team members should be involved in regular case staffing meetings, to discuss treatment progress as well as any problems.[160]

Two Phase Approach: Akron Mental Health Court (Ohio)

Phase I: Participants' needs are assessed, they receive extensive treatment and support services, and must meet with the judge regularly.

Phase II: Participants have less intensive management and fewer status hearings with the judge.

Each phase lasts for approximately one year.

Source: Teller et al. *Akron Mental Health Court: Use of Services by Successful Participants During the First Two Years*, THE STROMER REPORT (February 2004).

Incentives, Sanctions, and Treatment Modifications

Courts should apply incentives, sanctions, and treatment modifications on a case-by-case basis[161] with input from a mental health professional regardless of the model of direct supervision used.[162] In all cases, however, the range of and reasons for incentives and sanctions should be clearly set forward[163] and there should be as many - if not more - potential incentives than sanctions.[164]

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[157] *Id.* at 68

[158] *Id.* at 74.

[159] *Id.* at 68.

[160] *See*, *id.* at 68; Council of State Governments, *Washoe County, Nevada, Mental Health Court*, BUREAU OF JUSTICE ASSISTANCE at 2, Washoe.snapshot.pdf (last visited October, 2013); ESSENTIAL ELEMENTS, *supra* note 29, at 9.

[161] ESSENTIAL ELEMENTS, *supra* note 29, at 9.

[162] *Id.*

[163] Council of State Governments, *Facilitating the Success of Mental Health Court Participants*, JUSTICE CENTER at 21, 26, http://learning.justicecenter.csg.org/?page_id=334 [hereinafter *Facilitating Success*] (last visited October, 2013).

[164] *Facilitating Success*, *supra* note 163, at 18 ("Research indicates that applying positive reinforcement four times as frequently as negative reinforcement is most effective in moving an individual's behavior in the desired direction.").

Examples of incentives include:

- praise from the judge, applause in court;
- less frequent status hearings;[165]
- certificates;
- priority position in hearing order or priority seating in court;
- gift certificates from local businesses;
- extended privileges such as travel or a later curfew ; and
- graduation ceremonies.[166]

For less serious violations, possible sanctions include:

- judicial reprimands;
- writing assignments (e.g., journaling, letters to judge or team members);
- increased supervision (e.g., more frequent status hearings, more frequent meetings with case manager, keeping an activity / financial journal);
- restriction of privileges; or
- community service.[167]

For the most serious violations, potential sanctions include:

- short jail time or
- expulsion from the program, likely leading to a prison sentence.[168]

There should be a set of incentives that are tied to progress through specifically defined phases.[169] These phases should be sufficiently vague so that they can be tailored to individual participants, but also sufficiently defined so that participants can understand their progress towards achieving them. For example:

1. adjustment;
2. engagement in treatment;
3. progress in treatment; and

[165] This incentive is an example of the importance of the individualization of incentives and sanctions. Some participants find the status hearings comforting, and so reducing their frequency may not be an appropriate incentive. *See* Center for Court Innovation, *Mental Health Court Strategies to Help Defendants with Mental Illnesses Make Progress in Treatment and Comply with Court Requirements*, JUSTICE CENTER at 1, http://learning.justicecenter.csg.org/wp-content/themes/c4-mhc/content/Module_7_Prep_Work/CCI_Prep_Work.pdf (last visited October, 2013).
[166] DESIGN AND IMPLEMENTATION, *supra* note 9, at 72.
[167] *Id*, at 75-76.
[168] *Id.* at 76.
[169] *Id*. at 73.

4. continued progress in treatment and successful completion of the mandate.[170]

In situations of lack of adherence, the mental health provider should be the first to determine when a treatment alteration versus a sanction is appropriate, although other team members should have input, particularly in cases where public safety might be a factor. If the case manager or team determines that a sanction is appropriate, the response "should balance the court's need for accountability with the recognition that relapse is an expected component of recovery."[171]

Sanctions should only minimally disrupt a treatment plan, if at all.[172] Thus, prison time should only be used in cases where the violation is serious, repeated and graduating in intensity, or indicates public safety concerns.[173] Current programs have a large variety in how likely they are to use jail as a sanction because there is limited evidence as to its efficacy in deterring non-compliance, and ample evidence that mental illness is exacerbated in prison.[174] As with all rewards and incentives, the court should track its use to enable research into its effectiveness with participants over time.

In cases where team members disagree about appropriate treatment changes, sanctions, or incentives, the judge will have the final say.[175] Mental health court judges can be expected to be sensitive towards the mental health issues involved and accordingly consider the mental health supervisor's recommendation with appropriate seriousness, while also balancing the importance of public safety outcomes.[176]

Sustainability

When mental health courts are launched, they usually receive significant funding from the federal government and private foundations, and they are driven by the efforts of committed individuals who are already part of the criminal justice system. Without careful planning for long-term sustainability, however, mental health courts often struggle when outside funding dries up or their key leadership moves on to new projects. The Council of State Governments (CSG) recommends that mental health court leadership create plans as early as possible for "developing written policies and procedures, collecting outcome data, securing funding, responding to failures, effectively reaching out to the community at large, and eventually

[170] *Id.* at 73. ("When a phase is completed, the defendant receives a certificate from the judge, which has proved a powerful motivator for many participants. Completing a phase may result in less intensive supervision or less frequent status hearings.").
[171] *Id.* at 73.
[172] *Id.* at 74.
[173] *Facilitating Success*, *supra* note 163, at 31.
[174] DESIGN AND IMPLEMENTATION *supra* note 9, at 76.
[175] *Id*. at 67.
[176] *See, generally*, Alison D. Redlich et. al., *The Use of Mental Health Court Appearances in Supervision*, 33 INT'L J.L. & PSYCHIATRY, 272, 272 (2010); *Facilitating Success*, *supra* note 163.

coordinating the activities of multiple courts."[177] Sustainability efforts should focus on developing a self-sustaining institutional structure, building a wide base of governmental and public support, and securing permanent sources of funding.

Building a Stable Institutional Structure

Mental health courts often begin as ad hoc operations, and while informality allows for flexibility and experimentation, it can undermine the sustainability of the operation. More formal institutional practices allow for greater stability in the face of staff turnover, changing priorities among various government departments, and demands for proven positive results from funders and important government leaders. To build a self-sustaining, permanent institutional structure, mental health court planners should formalize their policies, procedures, and partnerships[178] and begin tracking and analyzing data immediately.[179]

Formalized policies and procedures should include the following:[180]

- Project history and partners;
- Project goals and objectives;
- Eligibility criteria;
- Information sharing protocols;
- Referral and screening procedures;
- Treatment resources;
- Case staffing and status hearing procedures;
- Sanctions and incentives; and
- Advocacy efforts.

This information allows for program evaluation, efficient integration of new team members, and creates a body of institutional knowledge.[181] The mental health court should also draft Memoranda of Understanding for its partners to clarify and institutionalize the roles different offices will play in the court's operation.[182]

One of the most important elements of a sustainable mental health court is also one of the most commonly neglected: data collection and analysis. Mental health courts should track information about their participants, the services provided to each, subsequent criminal justice

[177] DESIGN AND IMPLEMENTATION, *supra* note 9.
[178] DESIGN AND IMPLEMENTATION, *supra* note 9, at 77-78.
[179] *See generally*, Council of State Governments, A GUIDE TO COLLECTING MENTAL HEALTH COURT OUTCOME DATA (2005), *available at* http://csgjusticecenter.org/wp-content/uploads/2013/05/MHC-Outcome-Data.pdf.
[180] DESIGN AND IMPLEMENTATION *supra* note 9, at 77-78.
[181] ESSENTIAL ELEMENTS, *supra* note 29.
[182] DESIGN AND IMPLEMENTATION, *supra* note 9, at 78.

outcomes, and subsequent mental health outcomes.[183] To demonstrate efficacy, the court must track:[184]

- potential systematic over- or under-inclusion;
- quality of life;
- levels of recidivism;
- rates of substance abuse; and
- levels of treatment for mental health issues.[185]

While mental health courts are often touted as cost-cutting endeavors, it can be difficult to track the associated costs and benefits, and it is difficult to identify a baseline from which to measure the mental health court's expenditures and savings. Thus, emerging systems should not track cost data unless they have the resources to conduct a sufficiently sophisticated analysis (e.g., capacity to perform statistical analysis).[186] The court will need to gather information from a variety of sources, and the process will require considerable inter-departmental coordination; technical assistance is available via the CSG and BJA.[187]

Building and Maintaining Broad Support

Formal policies and procedures and a system for tracking and analyzing data are also important first steps toward building broad support among government leaders, advocates, public employees, media, and the public. This is essential for securing long-term funding. Public education must emphasize the benefits and successes of the court, as well as the fact that the mentally ill are not inherently dangerous.[188] New courts should invite media, public officials, and potential funders to watch proceedings, hold information sessions for community members, distribute brochures, and publish reports at regular intervals.[189]

Representatives should also develop a plan for responding to bad outcomes. Even in the face of data showing great success on an institutional level, a single high-profile crime committed by a program participant can threaten the future of a mental health court.[190] In such a scenario, a judge or prosecutor should act as lead spokesperson, emphasizing increases in mental health services, decreases in recidivism, and other positive outcomes of the court.[191] Proactively

[183] *Id.* at 5.
[184] *Id.* at 8-9.
[185] *Id.* at 8-9.
[186] *Id.* at 8, 14 ("Cost data, usually structured to show savings, are very complex data to gather correctly. Cost studies done 'on the cheap' easily backfire, showing short-term costs that are dramatically higher for mental health court participants than inmates with mental illnesses who are housed in the jail.").
[187] DESIGN AND IMPLEMENTATION, *supra* note 9, at 6, 16.
[188] *Id.* at 80
[189] *Id.* at 79-81.
[190] *Id.* at 79-80.
[191] *Id.* at 79-80.

making connections with politicians, media, and the public in advance of such crises may help minimize negative publicity.

Securing Long-Term Funding

Ultimately, maintaining a mental health court is a matter of securing stable, long-term sources of funding. Grant funding is usually available for a limited period of time and for limited purposes. BJA's Justice and Mental Health Collaboration Program (JMHCP), perhaps the most prominent source, offers grants for planning, implementing, and expanding mental health courts.[192] Nonetheless, stable long-term funding will ultimately have to come from a combination of state and local government money. Securing long-term funding will require proof of efficacy, both in reducing expenditures and recidivism.

Savings: Alleghany County Mental Health Court (Pennsylvania)
A RAND Corporation study found government savings of about $9,584 per participant in the second year after program completion.
Source: Ridgely *supra* note 193 at 19.

Establishing savings to the state is relatively straight forward, so long as a mental health court results in improved mental health outcomes and decreased jail sentences.[193] A RAND study found that a mental health court resulted in a slight increase in expenditures per participant in the first year due to increased mental health care costs,[194] but the long-term results suggest that these mental health care expenditures are a good investment, reducing the number of hospitalizations as well as incarcerations.[195] Establishing reduced recidivism is also accomplished if the mental health court results in shorter stays in jail and increased participation in mental health treatment programs.[196]

With a stable institutional structure, a broad base of support, strong partnerships, and a record of success in both economic and human terms, a mental health court can maximize its likelihood of securing long-term financial support from state and local government.

Conclusion

There is no best practice for establishing a mental health court, but a basic framework of evidence-based strategies is instructive. Specifically, straightforward forms and procedures exist to ensure participants have the opportunity to provide informed consent and to protect

[192] Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, JUSTICE AND MENTAL HEALTH COLLABORATION PROGRAM CLOSEOUT REPORT—JANUARY–DECEMBER 2011 at 2, (Nov. 2012), *available at* https://www.bja.gov/Funding/11JMHCSol.pdf (Planning grants typically last twelve months, while implementation and expansion grants typically last for twenty-four months each).
[193] *See generally,* Susan M. Ridgely, et al, JUSTICE, TREATMENT, AND COST: AN EVALUATION OF THE FISCAL IMPACT OF ALLEGHENY COUNTY MENTAL HEALTH COURT, RAND Corporation (2007) (surveying prior research on MHC outcomes), *available at* http://www.rand.org/content/dam/rand/pubs/technical_reports/2007/RAND_TR439.pdf.
[194] Ridgely, *supra* note 193, at 19.
[195] *Id.* at 33.
[196] *See, e.g.*, Ridgely, *supra* note 193, at 3-5 (surveying prior research on MHC outcomes).

the confidentiality of health information. Severity of illness will dictate treatment and support services and program length, just as seriousness of a crime will affect the referral process, plea arrangement, and nature of rewards and sanctions. In general, a court will use a pre-adjudication model for misdemeanors and a post-adjudication model for felonies.

Treatment and support services, court team members, and data collection are limited by the prevalence of government programs, general court funds, and community knowledge base, some of which can be altered through robust public education efforts.

Hinds County has the opportunity to begin a program that can improve the lives of people with mental illness, while simultaneously strengthening local communities. In order to successfully apply for grant funding, the planning team should decide which populations the new court will target, which crimes are eligible for diversion, and which adjudication procedure to follow. It should then outline a basic referral process, choose general incentives and sanctions, and formalize relationships with treatment providers, police authorities, and other interested parties through memorandums of understanding. Finally, it should reach out to legislators and begin cultivating support that will last beyond the two years of BJA funding.