

# Mental Health Courts and the Complex Issue of Mentally Ill Offenders

Amy Watson, M.A.  
Patricia Hanrahan, Ph.D.  
Daniel Luchins, M.D.  
Arthur Lurigio, Ph.D.

**Mental health courts are emerging in communities across the country to address the growing number of individuals with serious mental illness in jails and the complex issues they present to the courts. Based on concepts of therapeutic jurisprudence and patterned after drug courts, mental health courts attempt to prevent criminalization and recidivism by providing critical mental health services. The authors describe mental health courts in Broward County, Florida; King County, Washington; Anchorage, Alaska; and Marion County, Indiana. Each of these courts is designed to meet the specific needs and resources of its jurisdiction. The courts' experiences suggest that involving all players from the beginning is essential. The authors discuss the issues of due process, availability of services, and control of resources, which must be addressed before mental health courts are widely implemented. (*Psychiatric Services* 52:477-481, 2001)**

A handful of communities have created specialized mental health courts to address the complex issues that mentally ill defendants present to the courts. Although each jurisdiction has developed its own variation of a mental health court based on local needs and realities, they share several basic features (1).

Mental health courts handle only cases involving offenders with mental disorders. The judge, prosecutor, defense attorney, and other court staff often have special training in and are familiar with community mental health services. Court staff collaborate with community pro-

viders to implement a therapeutic intervention that may include medication management, substance abuse treatment, housing, job training, and psychosocial rehabilitation. Defendants can have their charges or jail sentences deferred if they agree to participate in services. The goal is to prevent criminalization and recidivism by providing critical mental health services (2).

In this paper we discuss the growing number of individuals with mental illness who are involved in the criminal justice system, and we examine the emergence of mental health courts as one of several responses. A description of four existing mental

health courts is followed by a discussion of important issues that must be addressed before this service innovation is widely implemented.

## Why mental health courts?

The number of individuals with mental illness who are involved in the criminal justice system is disproportionately large, and it is on the rise. Studies have found incidences of 10 to 15 percent for serious mental illness among jail inmates compared with an incidence of 2 percent in the general population (3-5). The proportion of mentally ill persons in jail increased by 154 percent between 1980 and 1992 (6). A recent Bureau of Justice Statistics survey found that 16 percent of state prison inmates, 7 percent of federal inmates, 16 percent of jail inmates, and 16 percent of probationers reported having a serious mental illness or a mental hospital stay at some time in their lives (7).

Teplin and colleagues (4,5) found that 6.4 percent of men and 15 percent of women admitted to Cook County (Chicago) Jail had a serious mental illness such as schizophrenia, bipolar disorder, or major depression. Staff at the jail have identified about 10,000 detainees a year as being mentally ill—more than the 9,000 individuals admitted to all ten state mental hospitals in Illinois (8).

The situation is similar in other parts of the country. For example, by 1992, the Los Angeles County Jail system had become, in effect, the largest mental institution in the country, with 3,300 of its nearly 21,000 inmates requiring mental health services daily

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*Ms. Watson is project director of the Chicago Consortium for Stigma Research at the University of Chicago, Department of Psychiatry, 7230 Arbor Drive, Tinley Park, Illinois 60477 (e-mail, acwatson@midway.uchicago.edu). Dr. Hanrahan is research associate in the department of psychiatry at the University of Chicago, where Dr. Luchins is chief of public psychiatry. Dr. Luchins is also chief of clinical services in the office of mental health of the Illinois Department of Human Services. Dr. Lurigio is chair and director of the department of criminal justice at Loyola University in Chicago.*

(9). Thus the jails have become the mental hospital of last resort (10).

Several explanations for this phenomenon can be found in the literature. For example, in encounters with the police, individuals who exhibit signs of serious mental illness are more likely to be arrested (11) and, if taken to jail, they may spend more time there than individuals who do not exhibit such signs. The survey by the Bureau of Justice Statistics (7) found that mentally ill offenders typically receive shorter jail sentences; however, studies of pretrial confinement have found that mentally ill inmates are less likely to be released on bail and spend significantly more pretrial days in jail (12). Also, if convicted and sentenced to prison, they receive longer sentences. According to the survey, mentally ill state prison inmates were sentenced to prison terms 12 months longer on average than those of other offenders (7).

Other factors contributing to the growing number of incarcerated mentally ill persons include changes in mental health laws, the declining public hospital census, limited access to services, and the public's negative attitudes toward crime and mental illness (3,10,11,13,14).

A factor that deserves greater attention is the lack of coordination and continuity of care for mentally ill offenders (14). This shortcoming is being recognized in a pending class action lawsuit against the City of New York and its medical provider (15). The suit charges that inmates treated for mental illness while in jail were released without medication or linkages to mental health services in the community. As of July 12, 2000, the state supreme court had granted class action status to the suit and issued a preliminary injunction requiring the city to provide inmates with medication and expedited referrals to services upon their release.

### **Mental health courts as part of a continuum**

Court interventions developed for mentally ill detainees include pre- and postbooking programs, mental health services provided in jails, and linkage to services after conviction and release (14,16,17). Prebooking

programs, which include police crisis teams and crisis or drop-off centers, attempt to divert mentally ill offenders to appropriate mental health services before they are arrested. Postbooking programs, which provide services to mentally ill offenders in courts, jails, and the community, attempt to reduce days of incarceration and recidivism by providing appropriate services. In court liaison programs, mental health professionals work with court personnel to identify mentally ill offenders and develop alternatives to incarceration. Mental health courts are a type of court-based postbooking program.

Jail-based services may include intake screening and mental health evaluation, crisis intervention, and short-term treatment that can include suicide prevention, case management, counseling, psychotropic medication, and discharge planning. Steadman and colleagues (14) have suggested that discharge planning and follow-up are the key components of jail-based mental health programs, although they are currently the weakest element of these programs nationwide.

### **Therapeutic jurisprudence and treatment courts**

The mental health court movement emerged out of recognition of inequities in the experiences of mentally ill offenders and two converging developments in the legal arena: therapeutic jurisprudence and the drug court movement. The term therapeutic jurisprudence first appeared in the law literature in the late 1980s in the context of mental health law (18). It is "the study of the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences for individuals involved in the legal process" (18). Since then, therapeutic jurisprudence has emerged as an approach for examining a wide array of legal subjects, including the criminal court system. This new "lens" allows us to examine how legal arrangements may affect therapeutic outcomes.

Another movement was forming in the late 1980s—separate but consis-

tent with the scholarly emergence of therapeutic jurisprudence. Beginning in 1989, the first drug treatment court introduced drug treatment principles into the criminal justice process for addicted criminal defendants. By 1997, a total of 325 courts were operating in 48 states. This innovative movement reflected the growing recognition and frustration among all parties in the system that traditional methods had failed to significantly reduce drug use among criminals.

The drug treatment court concept synthesizes therapeutic treatment and judicial process. Drug possession is viewed as both a criminal justice problem and a public health problem. Rather than being incarcerated or placed on probation, offenders receive treatment. Relapse is considered a stumbling block rather than a failure.

Although a variety of models have been developed, drug treatment courts have five common elements: immediate intervention, a nonadversarial process, a hands-on judge, treatment programs with clearly defined rules and goals, and a team approach (18).

Evaluations of drug courts have found promising results in the reduction of drug use, criminal behavior, and costs (18,19). Drug court conferences have been held and professional associations have been formed to disseminate information and improve drug courts. Some jurisdictions have obtained state and federal support, and in 1995 the U.S. Department of Justice formed the Office of Drug Court Programs.

As the number of drug courts has increased, so has the influx of individuals with mental health problems. In response, several jurisdictions—Honolulu and Ithaca, New York, for example—have developed mental health tracks within the drug treatment courts themselves. The court in Lane County, Oregon, has developed two mental health tracks, one for persons with serious mental illness and another for persons with personality disorders. San Bernardino County in California has separate drug treatment and mental health courts, with the same judge presiding over both

(20). Other jurisdictions have created mental health courts that are independent of the drug courts.

### **Existing mental health courts**

One of the few available studies of mental health courts is that of Goldcamp and Irons-Guynn (21). They compared four mental health courts and found that all four had separate calendars, a specialized team, and intensive supervision of participating offenders. They also found many differences among the four jurisdictions, suggesting that there is no single model.

#### *Broward County, Florida*

The first mental health court in the country was established in 1997 in Broward County, Florida, by administrative order.

In 1994, circuit court judge Mark Speiser and public defender Howard Finkelstein began work to create a mental health and criminal justice task force to address jail overcrowding and inadequate treatment for offenders with mental illness (22). The task force included representatives from the public defender's office, the state's attorney's office, the Broward County sheriff's office, community treatment providers, and the local hospital district.

Out of the work of this task force, the idea for the mental health court was born. The goal of the specialized docket is to centralize most criminal misdemeanor cases involving defendants with mental illness or developmental disabilities into one court to facilitate quick review and treatment. The process works to marshal and coordinate scarce resources as well as to develop new community resources (23).

The court is a pretrial model that diverts offenders immediately into treatment rather than allowing them to enter the traditional criminal justice system. Nonviolent misdemeanants are eligible for the process, with the exception of those charged with domestic violence or driving under the influence of alcohol or drugs. Persons charged with simple battery are eligible with the victim's consent. In the future, eligibility may be extended to persons charged with nonvio-

lent felonies. Participation in the mental health court is voluntary. Defendants may opt out and go to traditional criminal court at any time.

The process is therapeutically based and deals with the individual needs of each defendant. Treatment and compliance are monitored by the court. When the individual shows signs of achieving stability—that is, social adjustment—he or she is released from supervision (22). To date, more than 1,200 individuals have passed through Broward County's mental health court.

The MacArthur Foundation has funded an outcome evaluation conducted by investigators from the Florida Mental Health Institute at

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the University of South Florida. Preliminary observations suggest that key informants—judges, representatives from the public defender's office and the state's attorney's office, family members, and treatment professionals—are satisfied with the work of the court. However, some concern has been expressed about the shortage of certain types of services. In some cases these concerns have led to the creation of additional services based on needs identified by the court. Resources continue to be a concern as the court's caseload grows (24).

Since the inception of the Broward County court, interest in mental health courts has increased. Other jurisdictions have begun implement-

ing their own models, tailored to local needs, resources, and political realities.

#### *King County, Washington*

The mental health court in King County, Washington—like the court in Broward County—developed from a multidisciplinary task force of judges, public defenders, prosecutors, police, mental health professionals, family advocates, and government officials (25). Using the Broward County model with some modifications, King County launched its mental health court in February 1999. This court differs from conventional courts in three ways: cases are heard on a separate calendar by the same core team of professionals, there is more emphasis on linkage between the criminal justice and mental health systems, and participants in the program receive greater court supervision. Specific policies and procedures are being developed and modified as the project progresses.

King County has combined various types of resources to support the mental health court. Several public agencies have provided staff in kind out of their existing budgets. Additional allocations have come from several county funds on a temporary basis. The Federal Bureau of Justice Assistance provided an 18-month grant of \$150,000. More permanent funding sources will need to be identified if the project is continued.

The initial experiences of the court suggest that there are serious service gaps in the community, such as a lack of treatment for persons with dual disorders and a lack of transitional housing. However, participants believe that the court is a "vast improvement over the old way of handling the mentally ill misdemeanant population" (25). In fact, one of the major contributions of mental health courts may be the identification of the service gaps that greatly affect mentally ill offenders and that may play a role in their arrest and recidivism (16).

#### *Anchorage, Alaska*

The Court Coordinated Resources Project in Anchorage, Alaska, is a collaboration of designated corrections, judicial, prosecution, and defense

staff. Staff members quickly identify nonviolent, low-risk, mentally disabled misdemeanants for diversion from expensive jail beds into community-based behavioral health treatment on bail or as a condition of probation. The court works in tandem with the Jail Alternative Services Project, a postbooking jail diversion program operated by the corrections department. The tandem projects address issues related to the large proportion, 37 percent, of incarcerated individuals with mental disorders and a court order to reduce jail overcrowding (26).

The Court Coordinated Resources Project mental health court is an adjudication court, not a trial court. With the assistance of counsel, offenders who wish to have their cases heard there waive their right to a trial and plead guilty. A pretrial diversion model was not feasible because of the local culture. Individuals with mental disabilities who are charged with nonviolent misdemeanors are eligible, and participation is voluntary. Most participants have co-occurring substance abuse or dependence. Because there is no misdemeanor probation in Alaska, the mental health court is the only active monitoring available for these defendants.

In their first year, the court and the jail diversion program addressed the lack of probation for misdemeanants and relieved some of the pressure on the corrections department. The 36 offenders who passed through the jail diversion program and the court were studied. In the year before they participated, the offenders spent an average of 18 days in the hospital and 85 days in jail. During the year they participated, the same individuals averaged three days in the hospital and 16 days in jail (26)—reductions of 83 percent and 81 percent, respectively.

#### *Marion County, Indiana*

Begun in September 1996, the Psychiatric Assertive Identification and Response Mental Health Diversion Project is a cooperative effort by the Marion County superior court, the Marion County prosecutor, the Mental Health Association in Marion County, and mental health services providers. The project's goals are to

reduce rearrests and rehospitalizations of mentally ill offenders and to open up court dockets and jail beds by identifying jailed mentally ill criminal defendants within 72 hours of arrest. Diversion to the most appropriate community services follows, with monitoring for compliance with diversion plans (27).

To be eligible for the program, an individual must have an axis I diagnosis of schizophrenia, bipolar disorder, or major depression; be charged with a misdemeanor; and sign an agreement to participate in the program. Potential participants may be identified from jail screening or referred by their attorney, the court, or family members. The local mental health association operates a 24-hour hotline to take referrals.

The project consists of seven steps: referral, assessment and screening, meeting of the roundtable, service delivery, compliance monitoring, compliance hearings, and dismissal of charges. The roundtable is a weekly meeting of the public defender, the state's attorney, a jail mental health screener, service providers, and a volunteer compliance officer from the mental health association. These meetings do not include members of the judiciary. Participants discuss which offenders are eligible for the program and develop treatment plans that are then presented to the court for approval. The judge signs an order requiring the defendant to take his or her medication, to cooperate with treatment, and to stay out of trouble for one year. Defendants are required to appear before a magistrate biweekly for a compliance hearing. Because providers are involved in selecting who is eligible, they have rarely been unwilling to accept clients for services.

The court recognizes that defendants will relapse, and it tries to work with the individual to achieve the best outcome. If a defendant refuses to comply or chooses to opt out of the program, he or she is returned to the original court for traditional adjudication. Only 15 percent of participants have failed to complete the program in the past three years.

There is some disagreement about whether the project is an example of

a mental health court or simply a pretrial diversion program. Although it is less judicially centered, the project shares many features and goals with the other mental health courts. Mental health court or not, it offers a useful model for addressing some of the problems of offenders with mental illness.

#### **Public Law 106-515**

On November 13, 2000, President Clinton signed Senate Bill 865 into law (P.L. 106-515, America's Law Enforcement and Mental Health Project). The bill was originally sponsored by Senator Mike DeWine (R-Ohio); the House version was sponsored by Representative Ted Strickland (D-Ohio). P.L. 106-515 directs the attorney general to issue grants to states and state and local courts to establish up to 100 demonstration mental health courts. These courts will provide continuing supervision of offenders with mental illness, mental retardation, or co-occurring mental illness and substance abuse disorders who are charged with a misdemeanor or a nonviolent offense.

#### **Issues**

As of late 2000, about 12 courts referred to themselves as mental health courts (24). With the passage of P.L. 106-515 the number is likely to grow. As new courts spring up across the country, an examination of existing courts suggests several important issues that need to be addressed. First, there is no single mental health court model that will fit all jurisdictions. All of the existing courts have distinct features, and they vary in terms of origin, population served—that is, types of charges or diagnostic criteria—whether the intervention takes place before or after adjudication, services and monitoring provided, and available resources. Some models may be more appropriate for rural, suburban, or smaller cities than for major metropolitan areas.

Second, any effort to establish a mental health court must involve all affected players from the beginning. Without such collaboration, implementation is unlikely to be successful.

Third, due process must be kept in mind. Because of their illness,

some individuals may lack the capacity to make the decision to participate in a mental health court. It is crucial that representation is provided to ensure that mentally ill defendants fully understand the consequences of their options. Due process also requires that any treatment ordered be appropriate to the individual's illness.

Fourth, appropriate and accessible community mental health services are crucial to the success of a mental health court. A broad range of mental health and social services must be available or developed in the community. Service gaps must be identified and filled. These objectives may require cultivation of new resources and creative reallocation of existing resources.

Finally, the question of who controls the resources has important implications for services to mentally ill offenders and to others with mental illness. Who gets what from whom will be determined by whether it is the state, the county, or the court itself that funds the services. Will mental health courts bring new resources to the table, or will they simply shift existing resources to a new "priority" population? What is the most efficient and effective use of available resources? If the court controls the resources, who makes treatment decisions? All of these questions must be considered before mental health courts are implemented.

## Conclusions

Mental health courts are a promising innovation on the continuum of interventions for offenders with mental illness. Several versions or models have been implemented across the country, and preliminary impressions are positive. An empirical study is under way in Broward County, and more are needed to determine under what conditions and for which populations these models are effective. An infrastructure is needed to support evaluations and to create a national locus to disseminate information and provide technical and financial support (22). ♦

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