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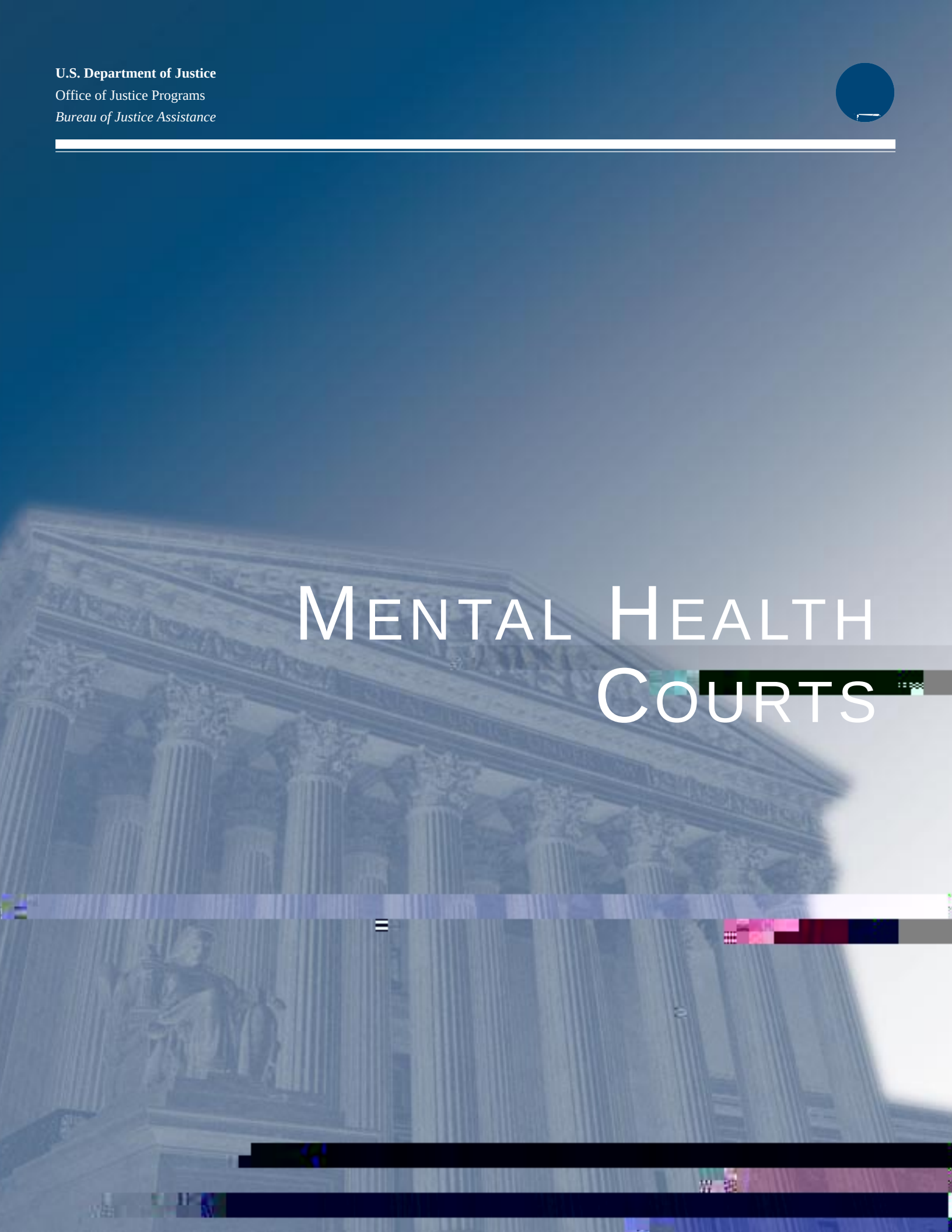

Mental Health Courts

U.S. Department of Justice
Office of Justice Programs
810 Seventh Street NW.
Washington, DC 20531

Janet Reno
Attorney General

Daniel Marcus
Acting Associate Attorney General

Mary Lou Leary
Acting Assistant Attorney General

Nancy E. Gist
Director, Bureau of Justice Assistance

Office of Justice Programs
World Wide Web Home Page
www.ojp.usdoj.gov

Bureau of Justice Assistance
World Wide Web Home Page
www.ojp.usdoj.gov/BJA

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Anchorage, Alaska

We are appreciative of the assistance and encouragement of the Honorable Stephanie Rhoades, who made herself available to answer questions and provide documentation about the work of her court. We would like to thank JAS Coordinator / Caseworker Laura Brooks and Mental Health Coordinator Colleen Reilly as well for their thorough descriptions and prompt responses to requests for information. Chief Municipal Prosecutor John Richards was particularly helpful in providing information and offering valuable insights into aspects of the mental health court programs. In the Public Defender's Office, Margi Mock was the source of important information from the perspective of the mentally ill offender.

Broward County, Florida

We are very grateful for the assistance, cooperation and helpful discussions with the Honorable Ginger Lerner-Wren in Broward County, the nation's first mental health court judge in the first mental health court. She invited us to observe her courtroom, arranged a meeting of all key actors, including the Honorable Mark Speiser who played a major role in planning the court, in which our questions were very patiently answered. Judge Lerner-Wren welcomed the research and offered critical insight into the operations of the court and objectives of her program. We appreciate the assistance of Broward Mental Health Court staff, particularly Judicial Assistant Christine Paganelis and Court Monitor Bertha Smith, who provided information about treatment issues. We thank Assistant District Attorney Lourdes Roberts, who patiently provided requested information.

King County, Washington

Our observation of the King County Mental Health Court was equally eye-opening. We thank the Honorable James Cayce, Presiding Judge of King County District Court and Mental Health Court judge, for his open support and cooperation. He gave freely of his time in person and over the phone and made sure we had our many questions answered. Program Manager Kari Burell tirelessly answered all of our questions and responded promptly to numerous requests for information. The help provided by Court Monitor Susie Rozalsky is also greatly appreciated. Mark Larson, Chief Deputy District Attorney of the Criminal Division, thoughtfully explained the issues, perspective and interests of the prosecutor relating to the Mental Health Court. We appreciate the cooperation of Public Defenders Floris Mikkleson and Dan Gross and their willingness to describe the issues faced by the defendant, and the assistance of Probation Officer Susan Butler in informing us about supervision and treatment issues.

San Bernardino, California

Our visit to San Bernardino was originally intended to conduct focus groups with participants in the San Bernardino Drug Court presided over by the Honorable Patrick Morris. He invited us to observe the mental health court. His court was impressive, differing from the others in taking felony as well as misdemeanor matters. Its full docket dealt with very difficult cases and raised many questions for us, which Judge Morris patiently discuses a ibee0 -moDrable PatlrickPthe Ca whihic eour many questions anth

Contents (continued)

Common Features of the Four Mental Health Courts

The four pioneering mental health court initiatives share a number of common attributes. Each court is voluntary; the defendant must consent to participation before he can be placed into the court program. Although the mental health eligibility requirements for participants differ somewhat from court to court, each jurisdiction accepts only persons with demonstrable mental illness likely to have contributed to their involvement in the criminal justice system. The mental health courts share the objective of preventing the jailing of the mentally ill and / or of securing their release from jail to appropriate services and support in the community. In addition, each of the courts gives a high priority to concerns for public safety, in arranging for the care of mentally ill offenders in the community. This concern for public safety risk explains the predominant focus on misdemeanor and other low-level offenders and the careful screening or complete exclusion of offenders with histories of violence. The King County court is open to defendants with a history of violent offenses which have been triggered by mental illness, who are then provided with a level of supervision sufficient to protect the public.

The four mental health courts also seek to expedite early intervention through timely identification of candidates. Screening and referral of defendants takes place within timeframes ranging from immediately after arrest to a maximum of 3 weeks after the defendant's arrest, depending on the jurisdiction. Each of the courts makes use of a dedicated team approach, relying on representatives of the relevant justice and treatment agencies to form a cooperative and multidisciplinary working relationship with expertise in mental health issues. Another core ingredient of the mental health courts' approaches is the emphasis on creating a new and more effective working relationship with mental health providers and support systems, the absence of which in part accounts for the presence of mentally ill offenders in the court and jail systems. Each mental health court provides supervision of participants that is more intensive than would otherwise be available, with an emphasis on accountability and monitoring of the participant's performance. The four mental health courts share the core role of the judge at the center of the treatment and supervision process, to provide the therapeutic direction and overall accountability for the treatment process.

Differences Among the Four Mental Health Courts

The nation's first four mental health courts also differ from each other in important respects. The nation's first mental health court in Broward County was designed to be pre-adjudicatory and diversion oriented in its

offenders with a previous diagnosis of mental illness as well as a record of prior convictions. In addition, most of the San Bernardino mental health court population has serious co-occurring substance abuse problems.

Issues Raised by the Emergence of a Mental Health Court Model

Early Identification of Mental Health Court Candidates

Problem-solving courts of different types share in common the need to identify their target population candidates as early in criminal processing as possible. The original drug court model was premised on the assumption that intervention with addicted offenders should occur shortly after arrest to maximize the opportunity to begin treatment when individuals may be most open to the possibility. In domestic violence courts, there is urgency to correctly assess the risks posed to victims and implement options for treating or otherwise dealing with the offenders before further harm can occur. To be effective, mental health courts share that critical need to identify mentally ill or disabled candidates at the earliest possible stages of processing to avoid the damaging experience of arrest and confinement, to intervene medically to stabilize offenders and then to situate them in an appropriate placement process.

Like the other types of courts, however, the mental health court model faces serious challenges in identifying appropriate candidates early through appropriate and effective screening and evaluation procedures. Collectively, the early mental health courts employ informal and formal methods for identifying possible candidates and assessing them in some depth before detouring them from the normal adjudication process. These methods may include informal referrals at arrest, arraignment or jail admission of persons appearing to suffer from mental illness or disabilities. They are followed by more indepth clinical interviews at the jail or in court to assess the eligibility of defendants for the mental health court programs.

Fair, appropriate and effective screening procedures face three principal challenges: timeliness, accuracy, and confidentiality. Each of the courts has established procedures that identify mentally ill or disabled candidates as early as possible in the criminal process to maximize the opportunity to intervene and assist. The need to identify and assess the conditions of candidates quickly potentially conflicts with the need to conduct the thorough clinical assessment required for a reliable diagnosis on the basis of which processing in the mental health court can begin. To put it simply, it is hard to rush such an assessment and still have it be accurate and complete. This may be particularly true because of the difficulty associated with communicating with some mentally ill defendants.

mental health courts, it means that sufficient time must be taken by defense counsel and by the court itself to make certain that the candidate's decision to enter the mental health court is in fact voluntary. This means having a grasp, beyond the threshold question of competency, of a defendant's mental condition. The potential fear is that defense counsel and / or the court may make decisions in the candidate's best interest when in fact the candidate, though competent, is thoroughly confused and afraid.

Conflict Between Criminal Justice and Mental Health Treatment Goals

A challenge in the design of each type of problem-solving court was the need to craft an approach that resolved conflicts in values and goals inherent in criminal justice and treatment orientations (Goldkamp, 1999). For example, when substance abuse treatment professionals might stress tolerance for relapse and erratic performance (or a positive drug test) by drug abusers as part of the therapeutic process, criminal courts might normally be inclined to revoke conditional release (probation) and impose sanctions. While the criminal process might need to proceed expeditiously to adjudicate criminal charges, mental health professionals require time to diagnose the mentally ill defendant's condition, take immediate steps to stabilize the defendant and then to place the defendant in appropriate supportive services for treatment. From the perspective of mental health treatment, potentially the worst experience for many mentally ill persons would be arrest, jail and formal proceedings in the criminal court. In short, these conflicts in method, aims, values and style pose a particular challenge in the emerging mental health court initiatives to produce a hybrid model that attends to the basic requirements of each.

Defining Success

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individual to individual. While a goal for substance abusers can clearly and measurably be abstinence within the timeframe of the drug court treatment program, such a practical framework is not so readily available in the treatment of mental illness. Courts cannot say, "be cured within 12 months." They can expect that participants successfully follow the steps to improved functioning outlined in a treatment plan agreed upon by the participant and the mental health professionals. Thus, the challenge for setting achievable milestones for mental health court professionals is more complex and the functional equivalent of graduation may differ considerably from individual to individual.

Range of Responses to Participant Behavior/ Performance

To an observer of other problem-solving courts, particularly drug courts where some of the in-court techniques were first developed, the mental health court model faces special challenges in devising responses to participant performance in treatment. One might argue that the experience of drug courts in the United States suggests that drug abusers respond well to a very structured system of incentives and sanctions when moving through the treatment process toward sobriety and improved functionality. These approaches are crafted based on assumptions about the behaviors of addicted persons, including a belief that very basic lessons and behaviors may have to be taught and retaught for substance abuse treatment to be successful. Many drug courts have devised a rich range of responses rewarding participants for forward progress through treatment stages (until graduation). When these elements of the drug court model are applied to the mentally ill and disabled in the criminal justice system, the translation of the "rewards and sanctions" approach to mental health courts raises some difficult challenges. It is apparent that, because of the nature of mental illness (as compared to substance abuse or domestic violence), judicial responses have to be more generally encouraging and supportive as the court process seeks to move mentally ill and disabled participants into treatment and supportive services. Thus, depending on a defendant's illness, the judge's repertoire may need to draw on a wider range of incentives and supportive responses to participant progress than other problem-solving courts.

The notion that mental health courts should also call upon sanctions for poor performance is more difficult. In some cases, it may be clinically appropriate to employ the kinds of sanctions employed by drug courts in responding to noncompliance in treatment, including returning participants to earlier and more restrictive treatment stages or, even, making use of jail in selective instances. In other types of cases, however, it may be questionable as to whether sanctions (based on assumptions of deterrence) are at all

appropriate to produce the improved mental health outcomes desired. Real questions, therefore, are raised about how the coercive power of the courts can be channeled to promote the goals of mental health treatment. Can a court sanction a defendant who fails to take medication? Does a court sanction a defendant who has difficulty functioning and understands little of the current circumstances or expectations due to mental illness?

Community Linkage and Resources

A critical element of the emerging mental health court model involves identification of the necessary treatment and related services in the community and the development of an effective working arrangement between the courts and the service providers that helps place participants in appropriate services, and moves them out of jail, as quickly as possible. Moreover, the model is premised on a working relationship, as represented by the dedicated team approach, that facilitates ongoing supervision and case-management. Two important problems are faced by the mental health court approach.

First, if it is true that the court system finds itself having to address the needs of the mentally ill population, it is at least partly because existing institutions and services in the community (at least outside of criminal justice) have failed to serve this population. There is some irony, then, in designing a program that uses the court to place mentally ill and disabled participants in those very systems. Secondly, if the rationale for making use of these existing services is that the mental health court creates a new, synergistic relationship that improve both the court and treatment approaches, then the actual availability of these services and the resources to support them becomes a critical concern. A mental health court approach with a large population of persons in need of treatment but few services available in the area may have great difficulty in delivering treatment. Moreover, even when services are available and providers are enthusiastic about the court-based mental health treatment approach, effective identification of candidates in the criminal justice population risks placing a new and large demand on treatment resources.

Each of the mental health courts described in this report have identified potentially large populations of mentally ill and disabled defendants who are in need of mental health and related supportive services. Each has also found that treatment resources and funding are insufficient for the populations they are serving and plan to serve in the near future. When resources exist, they do not adequately provide the type or range of services the mentally ill and disabled persons in the criminal justice population require.

Mental Health Courts as a Community Justice Initiative

The mental health court strategy shares with prior problem-solving court undertakings the fact that a difficult problem has not been adequately

dealt with through community institutions and services. Presumptively, effective community interventions could prevent the need to find and treat mentally ill citizens in the criminal justice system. The criminal behavior of the mentally ill ranges from nuisance and quality-of-life levels to more serious offenses that sometimes endanger themselves or other citizens. Although there are a range of behaviors associated with the mentally ill and disabled, it is highly unlikely that they have gone unnoticed in the community until their encounters with the criminal justice system. In fact, the presence of untreated, low-level mentally ill offenders represents an important quality of life and community justice concern in many localities.

Because other community networks or institutions have not effectively treated and supported the mentally ill—because community-based safety nets have failed—they enter the justice system, usually involved in minor, nuisance, and quality of life offenses. Often, by then, they have other serious problems—such as alcohol or other drug addiction, housing, employment and physical health problems—that also have not been addressed. In many instances, the mentally ill or disabled find themselves in criminal justice primarily because of their mental illness and their inability to connect with or stay in supportive community-based treatment services.

Like the other special court approaches, the mental health courts described in this report attempt to address the problems of their target populations on two levels:

- By dealing with their problems in the criminal justice system.
- By building linkages to community services and support structures that have for a variety of reasons failed to reach them prior to their criminal justice involvement.

Each of the mental health courts discussed has developed strategies for identifying mentally ill and disabled offenders at the earliest stages of processing, sometimes involving contacts from police officers at the arrest stage. Each jurisdiction has taken steps to implement early screening procedures to evaluate candidates for the court treatment process as soon as possible so that unnecessary delay, criminal justice processing, and jail confinement can be avoided. Each of the courts began with a primary focus on defendants entering the criminal process shortly after arrest, but expanded to accept referrals from other courts, attorneys, police, friends, relatives or other community contacts aware of mentally ill or disabled individuals caught up in the justice system. Each of the courts established a close link to the local jail, so that mentally ill inmates could be identified and admitted to the mental health court treatment process, at whatever stage of processing in the criminal justice system. In short, consolidating justice procedures to identify and enroll candidates in treatment has been an aim of these first pioneering mental health courts.

Four Pioneering Mental Health Courts: Descriptive Summary

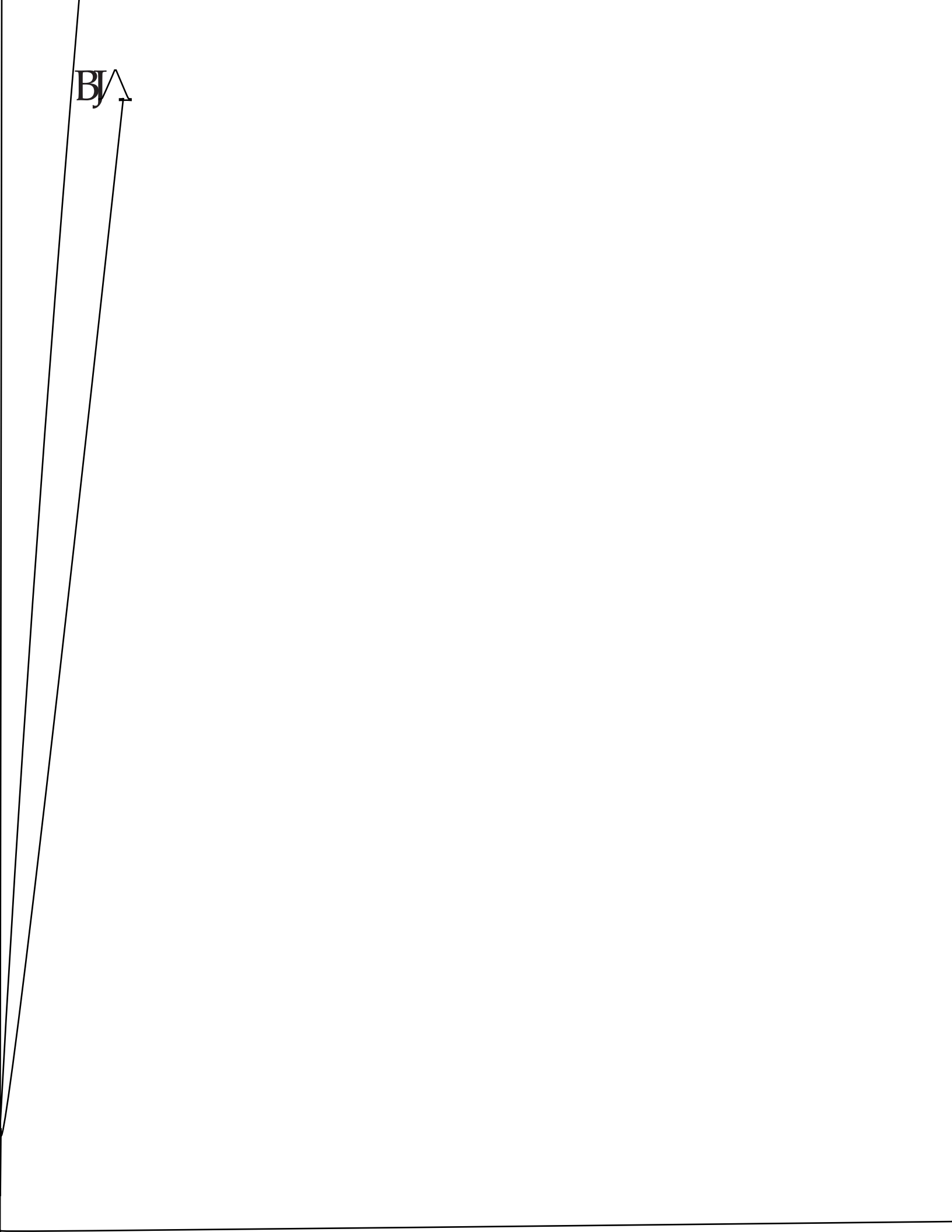
Defining Features	*Broward County (FL) Mental Health Court*	*Anchorage, Alaska*	*King County, Washington*	*San Bernardino, California*
Court start date	June 6, 1997	July 6,1998	February 17, 1999	February 17, 1999
Supervising Judge	Honorable Ginger Lerner Wren, Criminal Division,17th Judicial Circuit, County Court.	Honorable Stephanie Rhoades, Honorable John Lohff, Third Judicial District Court Judge.	Honorable James Cayce, Presiding Judge, District Court.	Honorable Patrick Morris.
Mental Health Court Goals	Expedite case processing, create effective interactions between mental health and criminal justice systems, increase access to mental health services, reduce recidivism, improve public safety, reduce length of confinement of mentally ill offenders.	Expedite case processing, improve access to community health resources, relieve jail overcrowding, reduce clinical and legal recidivism, improve public safety and order.	Expedite case processing, create effective interactions between mental health and criminal justice systems, improve mental health and well being of participants, protect public safety, reduce clinical and legal recidivism, improve access to mental health resources, improve monitoring of mentally ill offenders.	Provide mental health services to eligible defendants to improve their community functioning, reduce rate of reincarceration and recidivism, maintain defendants in least restrictive mental health environment.
Stage of intervention	Post arrest.	Plea/sentencing hearing.	Plea/sentencing hearing.	Plea/sentencing hearing.
Method of entry	Diversion program; entry prior to disposition of charges.	Plea required prior to program entry; a few deferred dispositions are allowed.	Plea required for official program entry; stipulated order of continuance possible for domestic violence; some deferred prosecutions allowed.	Plea required prior to program entry.
Eligible criminal offenses	Misdemeanors, excluding DUI and domestic violence, battery eligible with victim consent only.	Misdemeanors.	Misdemeanors.	Misdemeanors and low-level felonies.
Eligible criminal history	Misdemeanors, and felonies allowed; with careful screening	Misdemeanors and felonies allowed with careful screening	Misdemeanors and felonies allowed; violent priors accepted	Prior record required for admission misdemeanors;

Four Pioneering Mental Health Courts: Descriptive Summary (cont.)

Defining Features	*Broward County (FL) Mental Health Court*	*Anchorage, Alaska*	*King County, Washington*	*San Bernardino, California*
Length of Mental Health Court treatment	Defendant may be monitored for up to 1 year while charges are held in abeyance.	Typical treatment probationary term: 3–5 years; misdemeanor probation may last up to 10 years.	Treatment probationary period: typically 2 years; for DUI charge, term is extended to 5 years.	Treatment probationary term: 2 years for misdemeanors, 3 years for felonies.
Disposition of charges	Disposition conclusion of treatment; in most cases adjudication withheld, no conviction ever entered; in serious cases guilty plea with credit for time served.	Most defendants have convictions at conclusion of treatment and their sentence is suspended; deferred dispositions result in dismissal of charges upon successful completion.	Most defendants have convictions at the conclusion of treatment, sentence is suspended; the few with deferred dispositions are eligible to have their charges dismissed upon successful program completion.	Charges are dismissed upon successful completion; defendant may petition for expungement.
Effect of request for trial	Defendant will be transferred to traditional court for trial, but can access community-based treatment and services through the Mental Health Court team.	Defendant may still be eligible for treatment court; trial may proceed before Judge Rhoades, who also maintains a criminal calendar.	Defendant no longer eligible for treatment court; case referred to traditional court.	Defendant may still be eligible for treatment court; considered on case-by-case basis.
Supervision	Court monitor supervises with assistance from case managers and program staff; probation officer rarely used because most defendants are not on probation.	CCRP: no outside supervision, court and prosecutor monitor; JAS: caseworker with small caseload provides close supervision up to several times weekly, as needed.	Probation officer and Mental Health staff at assigned treatment facility closely monitor the defendant; court monitor supervises provisional treatment plan.	Probation officer and case manager with limited case-load oversee client on as needed basis, up to several times weekly.
Frequency of status and review hearings	Hearings held at regular intervals and as needed.	One hearing scheduled after release; thereafter on as-needed basis unless high risk defendant-hearings every 30 days.	Hearings held at regular intervals and as needed.	Hearings held every 3–4 weeks.
Sanctions for noncompliance	Hearings before judge; change in treatment, support and encouragement; use of jail as sanction extremely rare.	Minor violations: adjustments made in treatment; jail used as threat; jailed after repeated attempts at counseling.	Jail used sparingly if defendant noncompliant after repeated counseling and court hearings.	Sanctions range from reprimands by judge to stricter treatment conditions, community service, and jail, which are used liberally.
Successful termination from Mental Health Court	Most cases: deferred prosecution, withdraw guilty plea, no conviction on record; serious cases: guilty plea entered, credit given for time served.	Few deferred prosecutions may withdraw plea; most cases, credit given for time served, conviction remains on record.	Deferred prosecution; defendant may withdraw plea; most cases, credit given for time served in program, guilty plea remains on record; may dismiss charges on District Attorney recommendations.	Charges dismissed; defendant may petition for expungement.

Four Pioneering Mental Health Courts: Descriptive Summary (cont.)

Defining Features	*Broward County (FL) Mental Health Court*	*Anchorage, Alaska*	*King County, Washington*	*San Bernardino, California*
Unfavorable termination from Mental Health Court	Defendant commits serious new crime, repeated willful violations, or wants to get out of program, adjudication may be withheld or plea taken; judge has full array of sentencing options.	Defendant commits serious new crime or repeated willful violations, original charges referred to criminal court.	Defendant commits serious new crime or repeated willful violations, original charges referred to criminal court.	Defendant commits serious new crime or repeated willful violations, original charges referred to criminal court.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Setting the Stage for Court Responses to Mental Illness in Criminal Justice Caseloads: Recent Precursors to Mental Health Courts

The potentially large numbers of mentally ill persons in the criminal justice population have in common a processing in the criminal courts. Simple math suggests that the potential impact of the problems associated with the mentally ill on the judiciary in disposing of its criminal caseload is significant. Beyond the relatively infrequent special judicial determinations relating to civil commitment, competency, insanity and guilty-but-mentally-ill defenses, mentally ill defendants and offenders raise a more general challenge to normal case processing, when it appears that patterns of offending are explained by mental illness or disability and/or that effective treatment could control or prevent the occurrence of such patterns.

Two more recent developments have played an influential role in the emergence of mental health courts: the national crisis of overcrowding in local jails and the development of drug courts. At the conclusion of the 1980s, jails in many American jurisdictions reached critically overcrowded levels, driven in part by the large increases in arrests for drug-related crimes. This meant that in addition to previously unknown concentrations of substance abuse involved inmates, they also had to deal with growing numbers of inmates with mental health problems. Court systems in the most crowded jurisdictions participated in systemwide review of practices and problems that contributed to delays in processing and to the avoidable use of confinement of defendants and offenders in local jail facilities. Whether in response to Federal lawsuits or the need to address system dysfunction, many jurisdictions developed strategies to improve justice practices and implemented alternatives to routine processing and incarceration. To do this, they focused on the categories of inmates that contributed most to the excessive jail population levels, including drug offenders.

The "decarceration" of categories of inmates in local jails, through emergency release procedures or more planned system improvements, forced local criminal justice systems to devise strategies to manage higher-risk defendants and offenders in the community. Key in most significant alternatives to incarceration or system improvement strategies were the criminal courts, because their procedures for organizing and disposing of the criminal cases and their uses of local confinement at pre- and post-conviction stages were the dominant influence on the local correctional population. system n2posing of the cr avotof prats, stages wes were tt axorj0y smer-he exityederagrip mentalminanlated

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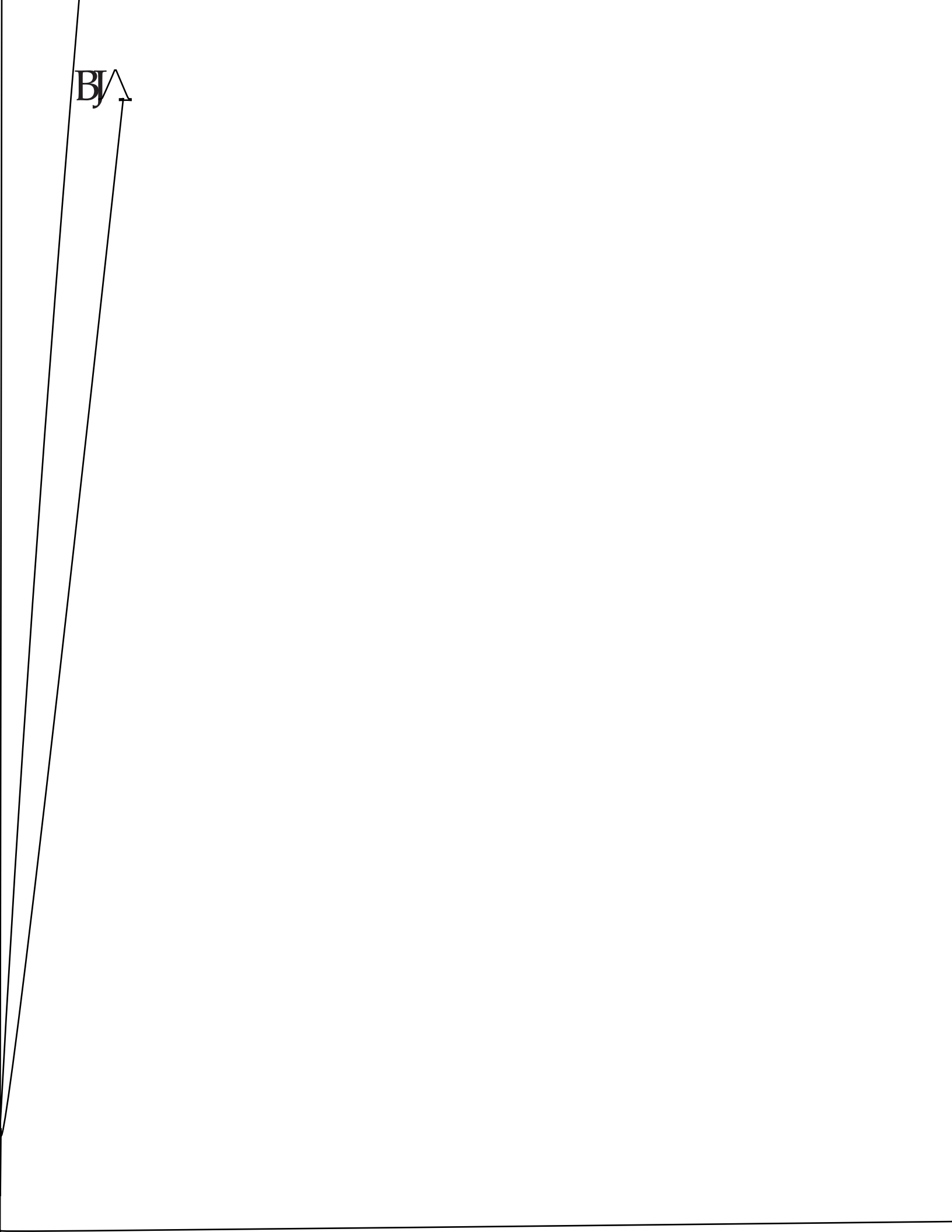
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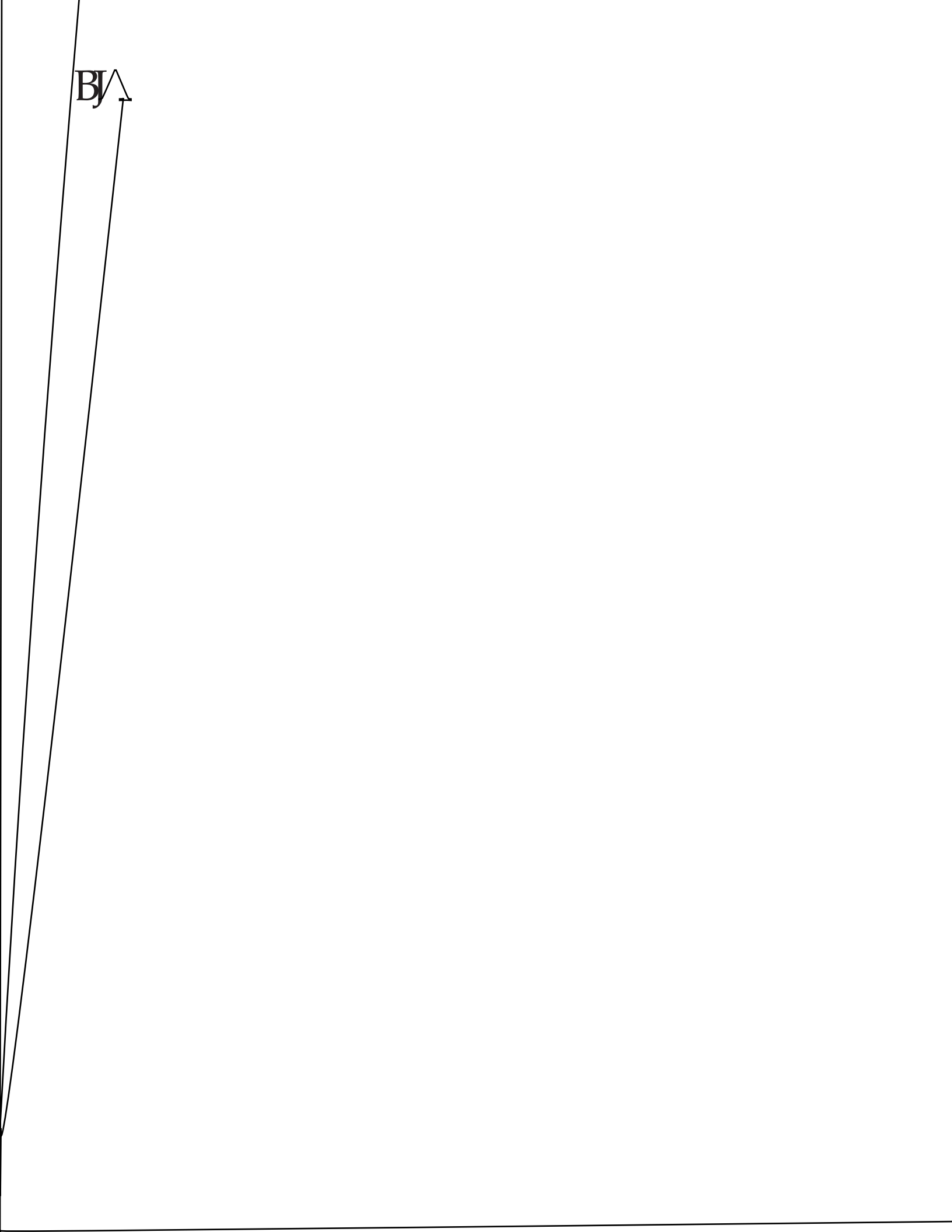
The success of the drug court idea in the United States and abroad is now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Chicago model because it was easier for police to access.[7] Male arrestees were taken to Bellevue Hospital, while females were taken to Elmhurst Hospital. Both Hospitals had prison wards that were administered by the department of corrections, a connection that facilitated interactions between the criminal justice system and the mental health system in New York City.

When defendants were referred for competency / responsibility evaluations by the court, according to Matthews (1970:187) they were committed by court order to 30 days of in-patient observation and examination. Felony defendants were given a hearing in the prison ward, of which a transcript was kept. The hospital prepared a report and recommendation for the court that included medical opinions regarding the defendant's ability to get along outside of the hospital and / or on probation, and relating to the defendant's criminal responsibility and competency to stand trial. When a noncriminal disposition was proposed, a treatment plan was prepared. If a felony defendant was found incompetent, New York law mandated commitment to Mattawan State Hospital. Civil commitment was often recommended in the cases of incompetent misdemeanor defendants. The court frequently followed the medical recommendation for nonpenal dispositions. Elmhurst Hospital generally arranged the treatment program and began treating its female patients before the case was referred back to court for final disposition. Bellevue did not arrange for the treatment of the male patients processed there.

Early Mental Health Court Approaches in Four Jurisdictions

The recent emergence of mental health court strategies can be understood in part against the background of longstanding criminal justice difficulties in dealing with mentally ill persons, earlier court-based initiatives, the deinstitutionalizing of the mentally ill, the pressures of jail crowding, the exploding drug caseloads, and, more recently, the alternative judicial philosophy and methods of the treatment drug court model. Momentum for the development and implementation of such initiatives has also been created by dramatic incidents involving random violence, focusing public, media, political and criminal justice system attention on the problems of the mentally ill in the criminal justice system.

[7]"The importance from the police viewpoint of a clear and expeditious emergency detention procedure can scarcely be exaggerated. Emergency detention offers the policeman a quick and simple method of dealing with apparently disturbed persons who are unwilling or unable to go voluntarily to a hospital or some other place where care may be had. If the police do not have clear-cut authority to make an emergency detention on the grounds of apparent mental illness, or if the emergency detention procedure is cumbersome, as it was under the Illinois Code, the police fall back on the criminal arrest for disorderly conduct..." (Mathews, 1970: 173-174).

Within this historical context, this report examines four pioneering mental health courts to identify common, critical ingredients that may form basic elements of a mental health court model, as this judicial problem-solving strategy becomes more prominent. At the time of this writing, the mental health court initiatives in Broward County, Florida; King County, Washington; Anchorage, Alaska; and San Bernardino, California, represent the first judge-supervised, court-based innovations designed to address the problems of mentally ill defendants and offenders in the criminal caseload in the United States.

The Broward County (Fort Lauderdale) Mental Health Court

Target Problem and Rationale

The Broward County judicial strategy, focusing on misdemeanor cases in
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Target Population

The Broward County Mental Health Court was begun as a part-time court designed to respond on an as-needed basis to an unknown volume of cases involving mentally ill misdemeanor defendants. The decision to intervene in misdemeanor cases was intended as a prevention strategy to target defendants who, without treatment and supportive services, could become involved in more serious matters at a later time when appropriate treatment would be more difficult to arrange. The Broward Mental Health Court currently accepts and screens mentally ill defendants charged with a range of misdemeanor offenses (which carry a statutory maximum of 1 year in jail under Florida law). Defendants charged with driving-under-the-influence (of alcohol or a controlled substance) or with domestic violence are ineligible because separate court programs are already in place to handle these types of cases. In addition, defendants charged with misdemeanor battery are eligible only with the consent of their victim.

Because the Mental Health Court was designed to deal with minor offenders who, because of their illness, return frequently to the criminal justice system, the Broward Court accepts defendants with prior convictions. Defendants with criminal histories that include violent crime are carefully screened to avoid involving defendants who pose an extreme threat to public safety. However, if a candidate with crimes of violence on their record expresses a genuine desire to participate and nothing prevents the candidate from achieving therapeutic gains, he or she may be admitted into treatment court.[9] Beyond current charges and prior criminal history, potentially eligible misdemeanor defendants must have been diagnosed with an Axis I mental illness,[10] have an organic brain injury or head trauma, or be developmentally disabled. Use of these clinical criteria in screening potential candidates was intended to ensure that the Mental Health Court would focus its resources on the seriously mentally ill or disabled in the misdemeanor population.

Program statistics maintained by the Broward Mental Health Court indicate that from July of 1997 through September 1999, 882 cases were placed under Mental Health Court jurisdiction. As of September 29, 1999, a total of 445 cases were disposed since the program's inception in the summer of 1997. According to court data, the typical court participant is male and is

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[9]An important assumption of the Broward approach is that there are many mentally ill defendants who are recycled through the justice system in need of treatment who are not violent or dangerous. Untreated they represent a great likelihood of posing criminal and other behavioral problems in the future.

[10]Axis I is primary mental heath diagnosis that is usually first diagnosed in childhood, including schizophrenia, mood or anxiety disorders, certain impulse control disorders, and major depression. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* Fourth Edition. Washington, DC: American Psychiatric Association, 1994.

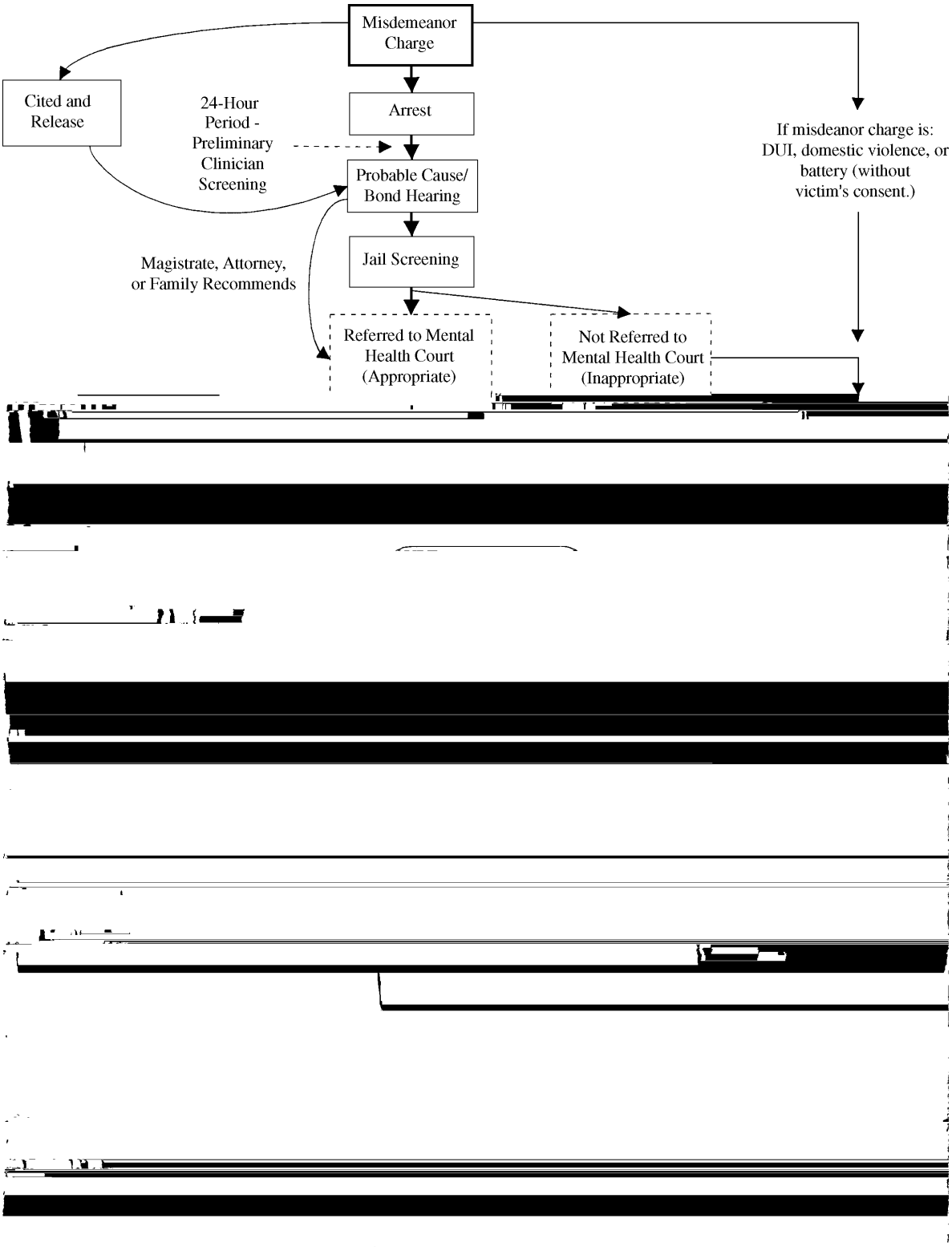
between the ages of 28 and 54. About 21 percent had at least one prior misdemeanor arrest, and 17 percent had prior felony arrests. One of four mentally ill participants entering the Court during that year was diagnosed as having a co-occurring substance abuse disorder. Out of the 469 new participants who entered the program between July 1998 and September 1999, 26 percent were homeless.

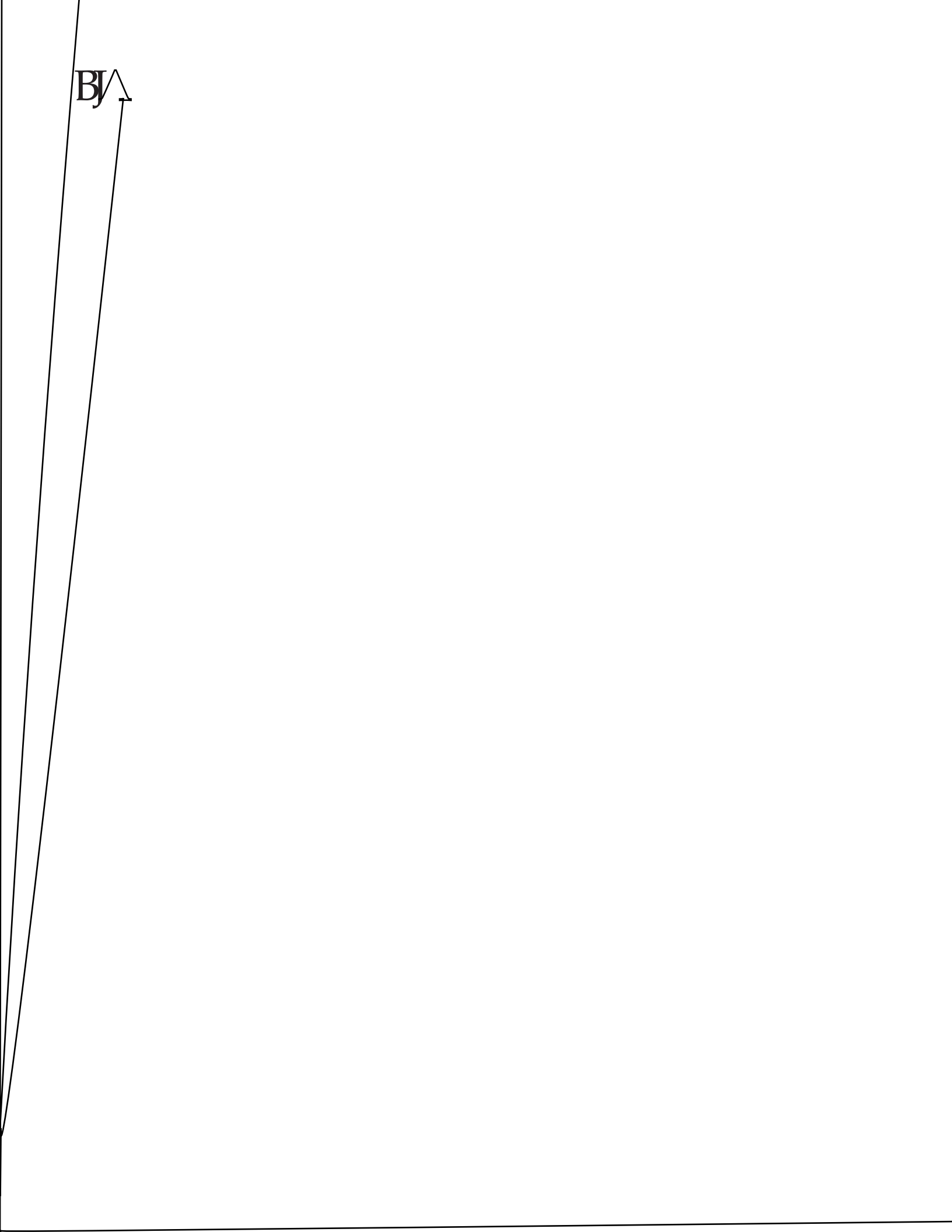
Broward County Mental Health Court Procedure

By design, the Broward Mental Health Court seeks to identify and intervene in the cases of mentally ill defendants as early as possible in the misdemeanor criminal process. (For an overview of the Broward County Mental Health Court procedure, see Figure 1.) The Mental Health Court serves principally as a pre-adjudication diversion program, although there is some flexibility in accepting candidates that are identified in later processing stages, including defendants who may have been convicted and placed on probation by other judges in traditional court. The Court's rationale in focusing on pre-adjudication intervention in misdemeanor cases is to avoid criminalizing mental health problems by preventing the unnecessary (and counterproductive) use of confinement and further criminal processing. Instead, the Court seeks to link mentally ill arrestees to appropriate diagnostic and treatment services. A guiding premise for the initiative is that jail and formal adjudication will do little to address the reasons for the involvement of mentally ill individuals in the justice system, will probably exacerbate their conditions, and will likely contribute to their recycling in and out of criminal court.

Many candidates for Broward Mental Health Court are identified at the misdemeanor bail stage (probable cause/bond hearing stage) within 24 hours of their arrest. Clinicians (advanced doctoral students from Nova Southeastern University) assigned to the Public Defender's office screen in-custody defendants for mental illness prior to the first probable cause/bond hearing. Any inmate who has visible mental health issues during intake at the jail, or who admits to any past contact with the mental health system will be housed in the mental health section of the jail pending a full assessment of his status by the EMSA psychiatrist. When symptoms of mental illness are found at the clinical screening interview, the Defender informs the court about the defendant's situation during the hearing, which is generally conducted via closed circuit TV. The County Court Magistrate presiding at the bond hearing refers possible candidates to Mental Health Court the same day or the next day depending on the time of arrest. The Mental Health Court judge sees defendants referred from the in-custody screening process and other first referrals every day at 11:30 a.m. Referrals also include some jailed defendants who were not identified at earlier proceedings and who are being held in custody pending a probable cause hearing or other pre-adjudication proceedings. These

Figure 1. Broward County Mental Health Court Referral Process

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Following the defendant's agreement to participate in the Mental Health Court, the state's attorney may hold the criminal charges in abeyance, pending ongoing review of progress in treatment.[12] The Mental Health Court can monitor cases for up to 1 year. The actual length of supervision of the defendant by the Mental Health Court varies on an individual basis, depending on the particular needs and progress of each defendant. Defendants who participate in the appropriate mental health services, stabilize and perform well in the community may have court supervision terminated before the end of 1 year. Once treatment is completed (and after consulting with the mental health professionals, defense and prosecution, the defendant and, in some cases, family members), the judge may resolve the charges. Defendants with minor charges and no criminal history may have the charges dismissed with the consent of the prosecutor. In most cases, adjudication is withheld, meaning that there is a record of the arrest and treatment court disposition, but no adjudication is ever entered.

During the treatment process, participants regularly report to Mental Health Court so that the judge can review their progress. Status review hearings are held periodically on an as-needed basis determined by the judge, but usually after 2, 3, and finally 4-week intervals, as participants demonstrate satisfactory progress. An observer of status reviews is struck by the problem-solving nature of these hearings, as the judge draws on the staff to help first solve any treatment-related concerns and criminal justice issues defendants may be facing and to encourage the defendant's full par-

Defendants participating in the Mental Health Court while on pretrial release are supervised by a case manager who stays in contact with them and ensures that court recommendations are followed. When difficulties arise, the case manager reports violations of the agreement to the court (mental health) monitor, who reports the violation and requests a hearing before the judge. Criminal charges are not disposed of until after the participant has been shown to be stable and has performed consistently in treatment, long enough to demonstrate responsibility. When these standards have been met, the charges are resolved, most often through withholding of adjudication. In the most serious eligible misdemeanor cases, a plea may be taken with credit given for time served in the Mental Health Court treatment process. In this situation, a conviction is recorded but the defendant has still had access to mental health services.

The Treatment Approach in the Broward County Mental Health Court

The debate first instigated by the establishment of drug courts about the appropriateness of courts serving as the "social service institution of last resort" (and the social worker role of the judge) was already partly academic by the time the Broward Mental Health Court was established. Like the earliest drug courts, the Broward County Mental Health Court grew out of the recognition that community treatment and social service agencies simply had not engaged a large part of the local populations with serious behavioral health needs, persons who would find their way into the criminal justice population. This understanding of the reason for the prevalence of serious mental health problems in the criminal justice population was based on a perception that community-based treatment services had failed mentally ill citizens in important ways. They had failed to locate them, to engage them in services, and to keep them stable and in treatment.

According to this understanding, the mentally ill, like the substance abusers addressed by drug courts, form an elusive population that, due to its nature, is characterized by individuals who do not perform simple functions well. Both populations are made up of people who routinely do not hold jobs, make and keep appointments (e.g., with treatment agencies) or function predictably and consistently—except in a negative sense. Recognizing that the social service and treatment failure that has allowed so many mentally ill individuals fall through the cracks and be without services, the Broward Mental Health Court has sought to identify and, through clinical assessment, facilitate treatment for misdemeanants with mental illness. The court's goals include helping defendants access appropriate treatment and services to improve their functionality and quality of life in society, promoting personal responsibility, and enabling participants to manage their own mental health needs and coordinating fragmented mental health services through the Mental Health Court process and under the strict supervision of a judge.

The courtroom is a critical arena for the therapeutic process in the Broward Mental Health Court. Borrowing again from the method of drug courts, the Broward Mental Health Court was designed to be informal, often in-

function, to seeking input from a care provider who did not appear in court, to arranging temporary housing for a participant who has no place to stay. The mental health courtroom differs from the drug court experience because in courts, with the exception of some participants with co-occurring disorders and disabilities, participants appear to understand the proceedings and events going on around them fairly well. This cannot be so easily assumed in the mental health court.

In the Broward Mental Health Court, understanding and communication are viewed as part of the problem-solving process. In some cases, the judge speaks very slowly and waits patiently for participants to understand and respond—sometimes with the help of mental health professionals or lawyers in the courtroom. The patience and tolerance for the problems of comprehension and communication that defendants may have create an impression that speedy disposition of a large number of cases is not necessarily high priority. Some hearings go smoothly and quickly because participants are doing well in their various treatment settings, while others are almost painfully slow as difficult problems and suitable options are identified and discussed.

The Broward Mental Health Court calls on both county and private service providers to respond to the treatment needs of its participants. At the initial stages, once a referral is made, the court monitor interviews the defendant. She checks to see if the defendant is already involved in mental health treatment and, if so, consults with his caseworker about the nature of his illness and his treatment needs and progress. If the defendant is not already in treatment, he is referred to the Henderson clinic or the Nova University Community Mental Health Center to determine whether he meets the mental health eligibility requirements. In-court screening interviews are carried out before the hearings by a court clinician, who is a licensed clinical social worker, in addition to advanced doctoral interns associated with the clinical psychology program at Nova Southeastern University. The local jail contracts with EMSA, which provides several staff with specific training in mental health including a psychiatrist and a psychiatric nurse, who help identify candidates for the court from the jail population. The court refers newly arrested persons in need of immediate diagnosis and emergency treatment services to a nearby state mental health facility. Once participants are stable or able to be placed in appropriate longer-term services, the Mental Health Court refers them to one of two different treatment providers with a range of services located in different parts of Broward County.

The court monitor has access to most area providers, but the two major sources of care are the Henderson Mental Health Center and Nova University Community Mental Health Center. Services provided include short- and long-term residential treatment, including supportive housing, substance abuse treatment, and assertive community treatment. Assertive

How the court encourages the treatment process and participants' compliance may differ considerably under the two models. Some drug courts rely heavily on sanctions, including time in jail, to encourage compliance. How well punitive (deterrent) sanctions serve to promote the therapeutic process in a mental health setting remains an important and somewhat controversial question. The Broward Mental Health Court was designed with the knowledge that if it enrolled its target population, compliance problems would be common among its participants—by definition. Generally, the participants have found their way into the Mental Health Court precisely because they have not succeeded in meeting the minimum demands of normal life or of the community-based mental health treatment process.

The Broward Mental Health Court judge has rarely employed confinement as a means of furthering the treatment process, although defendants who are arrested on new charges and those who simply have not cooperated may ultimately be held in jail while awaiting adjudication. By philosophy, the Broward Mental Health Court judge views jail as the opposite of what mentally ill persons caught up in the criminal justice system need and sees jailing of the mentally ill as representing the failure of all prior intervention efforts. The judge would be likely to order confinement only if the nature of the offense demanded it. Should defendants fail to take necessary medication and become a threat to the public as a result, the judge might agree that a temporary stay in jail was required pending development of more appropriate means of dealing with the person. In the event that a relatively serious new crime was committed while the defendant is on release, the state attorney may move to revoke a participant's status in Mental Health Court and request adjudication and sentence. Any time current or former participants are arrested on a new misdemeanor, they are ordered to appear in Mental Health Court for disposition in the interest of continuity of treatment.

In drug courts, graduation from a 1-year to 18-month process of treatment rewards periods of abstinence and crime-free behavior. The Broward Mental Health Court seeks the same among its participants with drug problems, but the goals for mental health issues may differ among defendants. Generally, the Broward Court completes its relationship with a participant when he or she has made the transition into the required treatment and supportive services, which may involve medication, counseling, housing, training or employment. When the criminal court is no longer needed to facilitate those connections, the participant is considered to have been "successful" and has the charges resolved.

The King County District Court Mental Health Court

Target Problem and Rationale

The process that formed the King County Mental Health Court was catalyzed by the brutal, random murder of Fire Department Captain Stanley Stevenson by a mentally ill offender in a Seattle park in August 1997. The assailant was a misdemeanor defendant who had been found incompetent by the Seattle Municipal Court. The defendant was released into the community by the court just prior to the homicide. The shocking incident prompted King County executive Ron Sims to convene a task force including broad representation of mental health and justice system professionals to review how mentally ill offenders were handled by the justice system. The Mentally Ill Offenders Task Force, chaired by the Honorable Robert Utter, retired chief justice of the Washington Supreme Court, was given the responsibility of making recommendations for improving the handling of mentally ill persons in the criminal justice system. Among many other suggestions, including reevaluation and reform of competency law, the Task Force recommended the establishment of a mental health court in the King County District Court on a pilot basis.

King County District Court Chief Judge James Cayce led a Mental Health Court Task Force to develop plans and examine the feasibility of establishing such a court. In February 1998, as part of that process a group of judges, as well as other justice and health system officials, visited the Broward Mental Health Court and, upon their return, incorporated their observations into a plan released by the Mental Health Court Task Force in August 1998. After further planning, budgeting and coordinating activities, the King County District Court Mental Health Court began operation in February 1999.

King County's Mental Health Court Task Force identified several areas in justice processing that failed to address difficult issues raised by the mentally ill and that appeared likely to contribute to their frequent returns to the system. Under normal court procedures, defendants might appear before a number of different judges as their cases were heard at various stages of processing, even in the same case. With little extra attention paid to individual defendants as cases moved through a high-volume court system, mentally ill defendants—whose mental illness may have caused their involvement in criminal justice—were simply moved through the court process like everyone else. Moreover, judges presiding over high-volume courtrooms did not have special training in dealing with the special issues presented by the mentally ill, nor were they generally aware of the

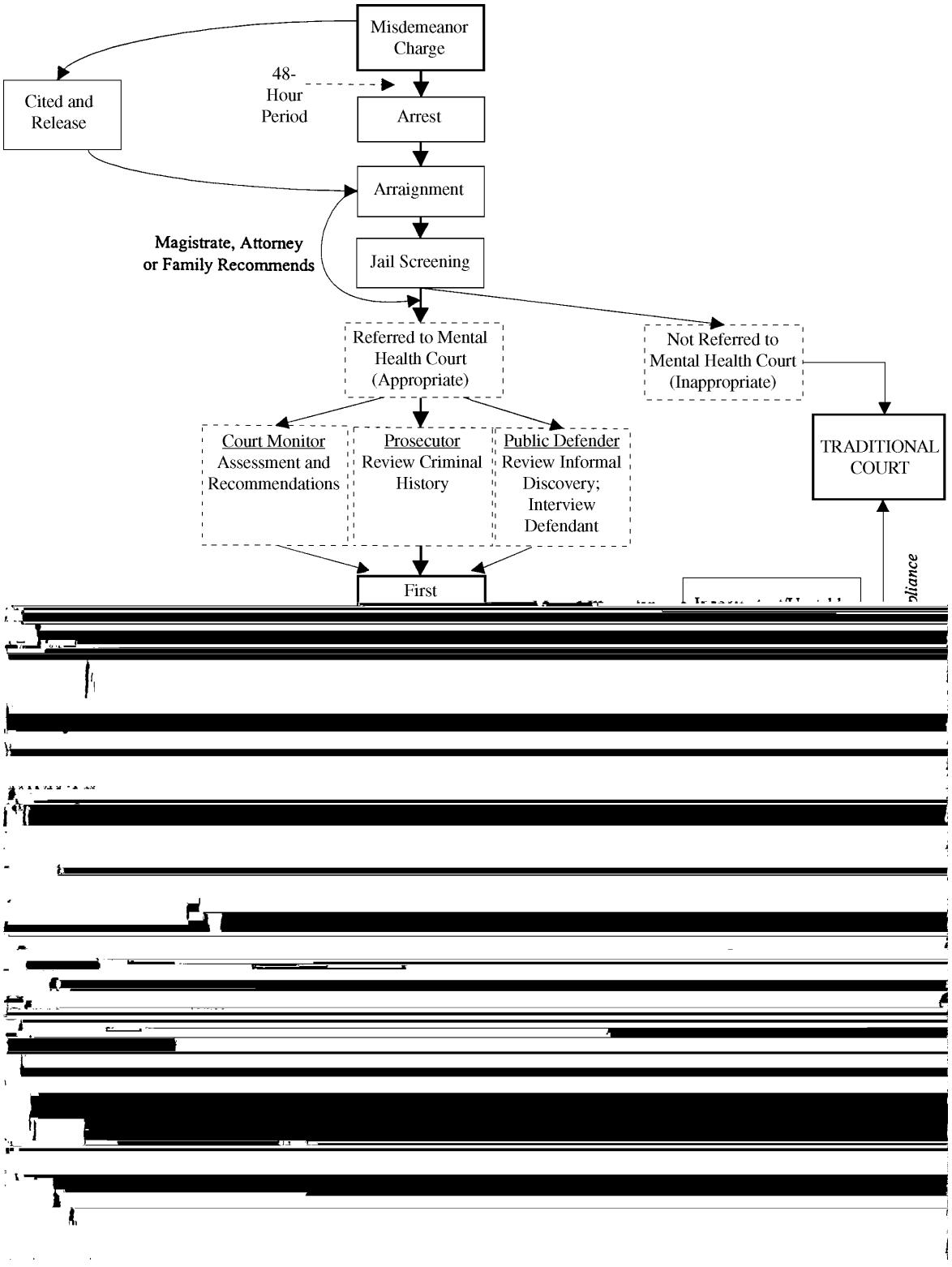
treatment resources that might be available in the county to treat the offender and protect the public.

When charges were dismissed, the mentally ill defendant merely disappeared from the court's jurisdiction, hopefully to be handled by other agencies elsewhere. Other mentally ill offenders would, upon conviction, be sentenced to probation or local jail time, two options also usually poorly suited to their problems. The Mental Health Task Force found that, as a result of normal procedures, mentally ill defendants and offenders often reoffended and were recycled through the system again and again. In fact, the King County Mental Health Court Program Narrative reports that a

mental health and the criminal justice system. In King County the dedicated team approach is intended to eliminate the gaps and problems in communication characteristic between agencies and organizations that are

Candidates for the Mental Health Court are identified principally at the post-arrest stage by the jail medical staff while awaiting their first court appearance in the county jail. However, referrals also come from justice officials, other misdemeanor courtrooms, or friends or family who may believe that an individual's involvement in the criminal process is the product of mental illness. To expand the scope of misdemeanor defendants eligible for its services, the District Court has been negotiating with misdemeanor courts from nearby cities, including Bellevue and Shore Line, to have their defendants referred for participation in the King County Mental Health Court.

The King County Mental Health Court has received 199 referrals since February 1999. Most (76 percent) were male, between the ages of 31 and 50 (61 percent), and white (74 percent). About half (51 percent) had been referred by the jail, with an additional 43 percent sent by judges, 3 percent by defense attorneys and the remainder by family members or probation officers. Seventy-one percent of the defendants were in custody at the time of the referral. The majority of the referred defendants (55 percent) were not in mental health treatment at the time of the referral. Twenty-five percent were homeless at the time of referral. Only 22 percent were able to live independently. The remainder lived in either some form of supported living arrangement, or their residence location was unknowr To epsa b h TD(82 l5t-tut)Tj0 -1.1


Misdemeanor Charge
48-Hour Period
Cited and Release
Arrest
Arraignment
Magistrate, Attorney or Family Recommends
Jail Screening
Referred to Mental Health Court (Appropriate)
Not Referred to Mental Health Court (Inappropriate)
Court Monitor Assessment and Recommendations
Prosecutor Review Criminal History
Public Defender Review Informal Discovery; Interview Defendant
TRADITIONAL COURT
First

information obtained is assured. When a defendant appears to be mentally incompetent, the court is alerted by the jail staff, who then send a memo to the court containing the defendant's name and charges only, without detailed defendant information. When a defendant does give consent, the assessment information is provided to the court for review. All members of the Mental Health Court team of professionals are notified by e-mail that the particular defendant is being referred. In this way, each actor in the court process has an opportunity to prepare for the defendant's first appearance in the court, usually the following afternoon.

Generally prior to their first appearance in the Mental Health Court, candidates are interviewed at the jail by the court monitor. Her job is to gain an understanding of the defendant's mental health issues. As part of that process, she requests a release of information approval from the defendant to enable her to access the defendant's treatment history, if any. If possible, she will also communicate with the case manager who has handled the defendant's treatment in the past. The court monitor prepares a report for the Mental Health Court containing information about the defendant's history, including any current medications, history of compliance with treatment, behavior at home and/or in the jail, as well as information about housing and family support, if any.

In addition, the monitor prepares a treatment plan that would go into effect upon the defendant's release and participation in the King County Mental Health Court, including living arrangements and provisions for supervision and treatment. During this process, the monitor spends time getting to know the defendant as well as explaining the workings of the Mental Health Court to the defendant and offering preparation for the hearing and the period following. Ideally, the report and proposed treatment plan that the monitor produces are provided to each of the relevant courtroom staff prior to the defendant's first hearing. The Mental Health Court is also alerted to competency issues based on the opinion of the court monitor through her informal evaluation and information given to her by the jail medical staff. There is currently no formal assessment instrument, although such a tool is being developed for use by Mental Health Court staff.

Prior to the start of the first hearing, the prosecutor, the public defender and the court monitor, will meet to review the information gathered about the candidates and to discuss the particular mental health issues that may be involved. The discussion includes the analysis and recommendations of the court monitor as well as analysis from the jail mental health staff, with input from the prosecutor and defense counsel.

The first hearing begins with a determination of probable cause, particularly if defendants were referred to mental health court before a probable cause hearing was held in the normal fashion before a traditional court judge. Once probable cause has been established, the King County Mental Health Court judge then proceeds to address the major threshold issues: competency and detention. Most of the defendants who are candidates for this court are in custody due primarily to homelessness or instability related to their illness that puts them at higher risk than nonmentally ill defendants to fail to appear in court for the next hearing date. One of the Court's principal objectives is to place candidates in treatment as soon as possible and avoid further confinement.

The Program Manager reports that an estimated 15 percent of the candidates appearing at the first hearing in Mental Health Court appear to be incompetent and are referred to Western State Hospital for competency evaluations through an order of the judge. Defendants who are found competent are returned to the Mental Health Court. Incompetent defendants charged with a violent offense, who have a history of violence, or have been found not guilty by reason of insanity or incompetency on charges involving physical harm in the past, may be held under the state's competency statute, Title 10 RCW, section 10.77.090,[15] which allows for hospitalization for up to 29 days (including the time it takes to complete the evaluation), and/or 90 days of out-patient treatment, to try to restore competency. Defendants who do not meet the criteria may not be held by the

[15]For a more thorough explanation of this stature, see Washington State Rules of Criminal Procedure, Title 10 RCW: Criminal Procedure, Section 10.77.090. It provides, in relevant part, that: (1)(a) If at any time during the pendency of an action and prior to judgement the court finds a defendant is incompetent, the court shall order for the proceedings against the defendant be stayed. (d)(1) If the defendant is:(A) Charged with a non-felony crime and has: (I) A history of one or more violent acts, or a pending charge of one or more violent acts; or (II) been previously acquitted by reason of insanity or been previously found incompetent under this chapter with regard to an alleged offense involving actual, threatened, or attempted physical harm to a person; and (B) Found by the court to be not competent; then (C) the court shall order the secretary to place the defendant: (I) At a secure mental health facility in the custody of the department or an agency designated by the department for mental health treatment and restoration of competency. The placement shall not exceed 14 days in addition to any unused time of the evaluation under RCW 10.77.060 (which provides for a period of time not to exceed 15 days for the purposes of a court ordered competency examination).(ii) At the end of the mental health treatment and restoration period...the defendant shall be returned to court for a hearing. If...competency has been restored, the stay entered...shall be lifted. If competency has not been restored, the proceedings shall be dismissed...(B) If the defendant was in custody...at the time of dismissal, the defendant shall be detained and sent to an evaluation and treatment facility for up to seventy-two hours for evaluation for purposes of filing a petition under chapter 71.05 RCW (which relates to the civil commitment of the mentally ill)...(e) If the defendant is charged with a crime that is not a felony and the defendant does not meet the criteria under (d) of this subsection, the court may stay or dismiss proceedings and detain the defendant for sufficient time to allow the county designated mental health professional to evaluate the defendant and consider initial detention proceedings under chapter 71.05 RCW.

state for the additional 14 days and must have the charges dismissed. However, such defendants may also be evaluated to determine the appropriateness of civil commitment.

Defendants who, at the end of this period, are restored to competency are rescheduled to appear in Mental Health Court to decide upon participation in its program. Defendants who are still found to be incompetent at the end of the statutory treatment period must have their criminal charges dismissed. They must also be referred to the county-designated mental health official for evaluation to determine the appropriateness of involuntary civil commitment. At this stage, the focus of the inquiry will be on whether the defendant poses a danger to public safety or security, and will not depend upon whether or not the defendant was charged with a felony.[16] In the past, the court lost jurisdiction over misdemeanor cases once the defendant was found incompetent to stand trial.

Once the threshold question relating to competency is resolved, the judge decides whether to accept the case and determines whether the defendant wishes to participate in the program based on the input from the Mental Health Court team and on consideration of the monitor's report and treatment plan. In the cases of defendants who are competent but unstable, the judge's next concern is to determine the nature of treatment and support Health Coftilableeorlj0nHeale ohe fnt dtt ior mentae offirlved,f the statuttion oveine tir

In the experience of the King County Mental Health Court so far, it appears that few defendants refuse the treatment option once the preliminary matters are completed. Even so, most candidates who wish to enter the program are released pending adjudication under the terms of the service plan for an initial period of a week or two. During this period of provisional participation, defendants are given the opportunity to become familiar with the aspects of the proposed treatment regimen under the supervision of the court monitor before they are returned to court to make a decision about whether they wish to continue. Upon return to the Mental Health Court, if a defendant should decide to opt out of the program, the criminal case is simply listed in the normal fashion for adjudication. Defendants may occasionally prefer going to adjudication because they do not agree that they have a serious mental health problem or because they believe that they have a good chance of a favorable outcome at trial.[17] Under the original program design, defendants who choose adjudication were not eligible to return to Mental Health Court upon conviction. This policy was recently revised to allow a defendant who requests a trial to continue to attend the treatment program to which they were provisionally assigned on their own, whether they are ultimately convicted or not. Should they be found guilty at trial, the defendants are now eligible to return to treatment court program.

Defendants who decide to enter the Mental Health Court treatment program must address their charges first, either by entering a plea of guilty or no contest to the misdemeanor charges, petitioning for a deferred prosecution,[18] or entering an agreement with the prosecutor for a deferred sentence. Statute governs the deferred prosecution in Washington, where it is considered a pre-arraignment disposition. No finding of guilt is entered for the defendant and upon successful completion of the program the defendant is eligible to have his charges dismissed. The defendant must petition for the deferred prosecution, which may be granted by the judge over the objection of the District Attorney. The deferred sentence generally comes about as a result of plea negotiations between the prosecutor and the defense attorney. While there is an initial finding of guilt, defendants who successfully complete the program are eligible to have their charges

[17]This may be based on the assessment and advice of counsel or despite it. Some defendants may simply decide that the penalty, such as time served, will be minimal and that they would rather be at liberty without the constraints associated with the treatment plan.

[18]Deferred prosecutions can be used for misdemeanor charges, but there was some confusion about whether a defendant would be limited to only one such disposition in a lifetime. The public defenders would be reluctant to make use of the deferred prosecution option for a mental health court charge. If they believed that the defendant was likely to be arrested in the future for a DUI charge, they did not want to take such an opportunity on a less serious offense.

dismissed. A disposition can be granted by the judge over the objection of the prosecutor. In most cases, the defendant will be placed on probation in the Mental Health Court for up to 2 years or will receive a suspended sentence of up to 1 year while participating in the program. For individuals pleading guilty to driving-under-the-influence charges, pleas are accepted and a sentence of up to 5 years' probation may be imposed. In some instances, persons charged with domestic violence misdemeanors are determined to be eligible for the court. In these cases, defendants are granted a "stipulated order of continuance." In it they waive the right to a jury trial and agree that if they do not comply with the conditions of release to the Mental Health Court treatment program the judge can find him guilty on the basis of the facts in the police report without taking any testimony.

In appropriate domestic violence cases, successful completion of the Mental Health Court treatment program results in dismissal of the charges (and no record of conviction), following procedures often employed in misdemeanor domestic violence cases in regular court. This permits an opportunity in cases of mentally ill defendants who have been charged with domestic violence-related offenses to begin and complete treatment without being required to plead guilty. The matter is handled in this way in order to assure that these defendants are not penalized for trying to address their illness by opting to enter treatment court.

From February through December 1999, 54 defendants (27 percent) of the 199 defendants referred decided not to enter the King County Mental Health Court treatment program and were transferred back to normal criminal calendars. Dispositions for the remaining 145 defendants included the following: 69 defendants (48 percent) chose to participate and an additional 33 (23 percent) remained undecided as of December 31, 1999. Of the remaining 43 defendants, 6 cases had been closed, 17 cases were dismissed by the prosecutor, 13 cases were screened out as being inappropriate for mental health court, and the prosecutor elected not to file charges in District court in 7 cases. Of the 69 defendants who entered mental health court, 35 pled guilty, 8 received stipulated orders of continuance, and 6 were granted deferred prosecution status. The 20 remaining participants were referred from other courts, either having already been placed on probation, or having pled and had the sentencing transferred to mental health court. As of the end of the year, 63 participants were on active probation.

Once the candidate opts in or formally enters the Mental Health Court, a probation officer is appointed to supervise the participant. The probation officer works as part of the Mental Health Court team and maintains close contact with the participant, whether in custody or in the community. The probation officer coordinates and communicates with the caseworker at the treatment facility handling the defendant's care and the Mental Health Court case manager. Once the treatment plan is put into effect, the probation officer and the case manager check on the participant's progress and ensure that court-ordered treatment is being provided.

Participants are required to return to King County Mental Health Court for review hearings at regular intervals—or when the judge determines that it is necessary—to assess whether they are complying with the requirements of the treatment process or there are any difficulties that need to be addressed. One of the most common issues for supervision surfacing at the review hearings involves the participant's failure to take the prescribed medication. In cases in which the participant appears to be having great difficulty in complying with the treatment process, a hearing may be scheduled and the defendant may be taken into custody if found to be in violation of the terms of probation, and such a sanction is deemed appropriate. In rare instances, failure to take medication may mean that the participant can become a threat to himself or others. In such cases the court may refer the defendant to the state hospital to determine whether temporary involuntary civil commitment is necessary. The use of jail to motivate the participant to take the program seriously is rare (usually jail is what the Mental Health Court is seeking to avoid). When it occurs, it usually is for short periods of no more than a few days detention. Defendants who are purposefully noncompliant and who do not respond to repeated counseling by team members and the judge in court appearances may have their probation or suspended sentences revoked and be ordered to serve their sentences in jail.

The Treatment Approach in the King County Mental Health Court

King County Mental Health Court supports its participants in treatment by drawing on an array of treatment programs and ancillary services available through the county's existing community mental health system. The community mental health network of services includes 17 treatment facilities at locations throughout the county. Although the geographic coverage offered by these programs is an asset to the Mental Health Court, the size of the county and the number of treatment services involved initially posed a challenge to the Mental Health Court in coordinating services, communication and procedures.

The King County Mental Health division has contracted with United Bevision has contract.76 m564no mo

Participants are assigned to programs based upon their individual needs, and at locations as near to their living situations as possible to facilitate attendance in treatment. The types of services provided vary depending on the particular problems of the participants, but may include medical evaluation, monitoring of medications, psychotherapy, supervised living situations, and other relevant social services. In addition, vocational preparation and an educational component are available to defendants who have the ability to benefit from them. Most of the defendants are placed in community-based, out-patient programs, unless acute care or more intensive services are needed. When in-patient or residential treatment is recommended, participants must specifically consent before they can be placed in a program. Participants who refuse the structure, support and supervision of in-patient programs may be held in jail for lack of other sufficiently secure options. Jail is used as a last resort, in part because services provided there are not as comprehensive and are by nature short-term, and in part because the Mental Health Court seeks as one of its primary goals to move mentally ill individuals out of jail into community treatment.

The participants entering the King County Mental Health Court present a variety of challenges for treatment services. One of these challenges is the large number of participants dually diagnosed with substantial substance abuse problems as well as serious mental illness. Given the nature of the criminal justice-based population of participants entering the treatment process, the King County Mental Health Court has discovered in its early stages of development that services for the dually diagnosed are insufficient. Unfortunately, only eight providers in the county network are able to treat dually diagnosed participants on an out-patient basis. In addition, only two programs, one run by the county, and the other by the state, are available to provide MICA services on an in-patient basis for these participants, and there is a long waiting list at both facilities. Thus, there is a shortage of treatment resources available to deal with this commonly encountered type of participant. There are also special programs available in King County to address problems such as anger management or domestic violence issues.

The Mental Health Court experience in the early stages has also shown that a majority of participants require assistance in finding appropriate living arrangements. Resources are very limited for patients requiring residential programs and structured living arrangements. The need for structured living situations varies on a case-by-case basis. For some participants who are in immediate crisis, special housing to support stabilization of their mental health symptoms is an urgent requirement. Others homeless participants may have been accustomed to living in makeshift living arrangements and now resist any type of structured living arrangement. Although a variety of programs are utilized to try to address these needs, the county is not well funded to meet the needs of the mental health defendants for structured residential care. To make up for the lack of

availability of structured care situations, the Mental Health Court attempts to supplement the support and supervision it provides with "wrap around" services. Through these services the defendant is engaged in some sort of structured treatment or activity from morning to night each day, with specialized case managers who visit the participant daily to monitor compliance with day treatment and medication, and try to respond to problems as they arise.

At this stage of its development, the King County Mental Health Court itself does not have an aftercare program, but seeks to facilitate the participant's transition to full use of community mental health services after involvement with the court. The use of community services is voluntary, of course, so that an aim of the court treatment process is to build strong links to appropriate services for participants so that most will carry on without supervision by the Mental Health Court. In its planned evaluation research, the Mental Health Court intends to track the clients for 3 years after release from probation to see whether they were successful in preparing clients to continue to access the support services.

Success and Failure in the King County Mental Health Court

It is early in the development of the King County Mental Health Court to measure program successes. However, two kinds of measures seem to be available for assessing the realization of the court's goals, short of the longer-term evaluation it has planned. The court's initial aims have included identifying and enrolling (from the jail, other courtrooms, friends, relatives and attorneys) mentally ill persons charged in misdemeanors. In 10 months of operation, the King County court had screened (received and evaluated) 199 referrals and enrolled less than half of them in the court-supervised treatment process. Although Judge Cayce believes there are many more mentally ill misdemeanor defendants in King County who could benefit from participation in the Mental Health Court, the court has already begun to tap a potentially large population and gained some operational experience. It has identified resource and treatment needs in its first months of operation. In addition, the court has revised some of its program requirements, including the policy that required the loss of the treatment court opportunity to defendants who opted to contest their charges at trial, and the requirement that the majority of the defendants plead guilty in order to enter the program. The court is now open to the return to treatment court of defendants who are convicted at trial, and the option of deferred prosecution or deferred sentencing dispositions, with the likelihood of a dismissal of the charges upon successful program completion, is being more liberally granted. These adjustments will result in expanded opportunities for defendants to enter into the treatment court program without necessarily being penalized with a criminal conviction.

According to the Mental Health Court's mission, the principal measures of success are to place participants in appropriate medical, behavioral health treatment and related services, and to monitor, case manage and supervise them through their involvement with the Court. With rare exceptions, the terms of probation extend for 1 year. Thus, a negative measure of the court's performance would be large numbers of participants who violate conditions of probation, or suspended sentences, who then had to serve jail or probation sentences outside of the control of Mental Health Court. These data are not available at the time of this writing, particularly because the court is only about 1 year into its implementation. More difficult interim measures would seek to indicate how well candidates had been placed into treatment, had stabilized and were functioning. Because participants have different problems related to their mental illnesses, an early measure would reflect forward progress in bringing participants into stable settings and more normal life routines. The use of probation as the principal vehicle for supervision by the court will provide data for measures of compliance and progress at a later date. At this stage, with the King County Mental Health Court still adapting and expanding, the most relevant measures of success have to do with implementation of services and reaching the intended target population.

The Anchorage Mental Health Court

Target Problem and Rationale

A 1997 (Care Systems North) study of the incarcerated population in Alaska found that about one-third of inmates suffered from serious mental illness, a rate about twice as high as the estimated national average of 16 percent (Bureau of Justice Statistics, 1999). That group included a large number of persons with developmental disabilities and organic brain injuries. The study noted that the Alaska Department of Corrections had become the largest provider of institutional mental health services in the state. Against the background of efforts to address institutional overcrowding, the challenge facing Corrections to provide services for its mentally ill inmates was extraordinary, particularly in Anchorage, one of the state's largest population centers.

In 1998 the Criminal Justice Assessment Commission, formed to examine jail crowding problems in Anchorage, identified the mentally ill and disabled as a special population presenting difficult problems for the jail and local justice system. One of the recommendations of the Decriminalizing the Mentally Ill Subcommittee was to explore means of identifying mentally disabled offenders for diversion away from the justice system into coordinated community treatment services. A special jail-based program to provide placement in community mental health treatment programs for inmates, the Jail Alternative Services Pilot Program, was instituted during July 1998. The subcommittee also recommended development of a mental health court, referred to as the Court Coordinated Research Project (CCRP), to address misdemeanor defendants and offenders with mental disabilities. During the planning stages, the experiences of the Broward County and King County Mental Health Courts were considered and adapted to the special problems of the local justice system in Anchorage. Circuit Court Presiding Judge, the Honorable Elaine Andrews, signed an administrative order that officially established the Court Coordinated Resources Project in April 1999 and appointed Judges Stephanie Rhoades and John Lohff to preside over the "specialty mental health court."

The two-pronged mental health court initiative went into operation in July 1998. One component, the Jail Alternative Services (JAS) Program, established alternative mental health programming in the community for specially targeted mentally ill inmates. The other, the CCRP, established a court-centered approach to identifying and treating mentally ill persons in the criminal caseload in the Anchorage District Court. The mental health court process is presided over by two District Court judges, the Honorable

John Lohff, Deputy Presiding District Court Judge, and the Honorable Stephanie Rhoades.

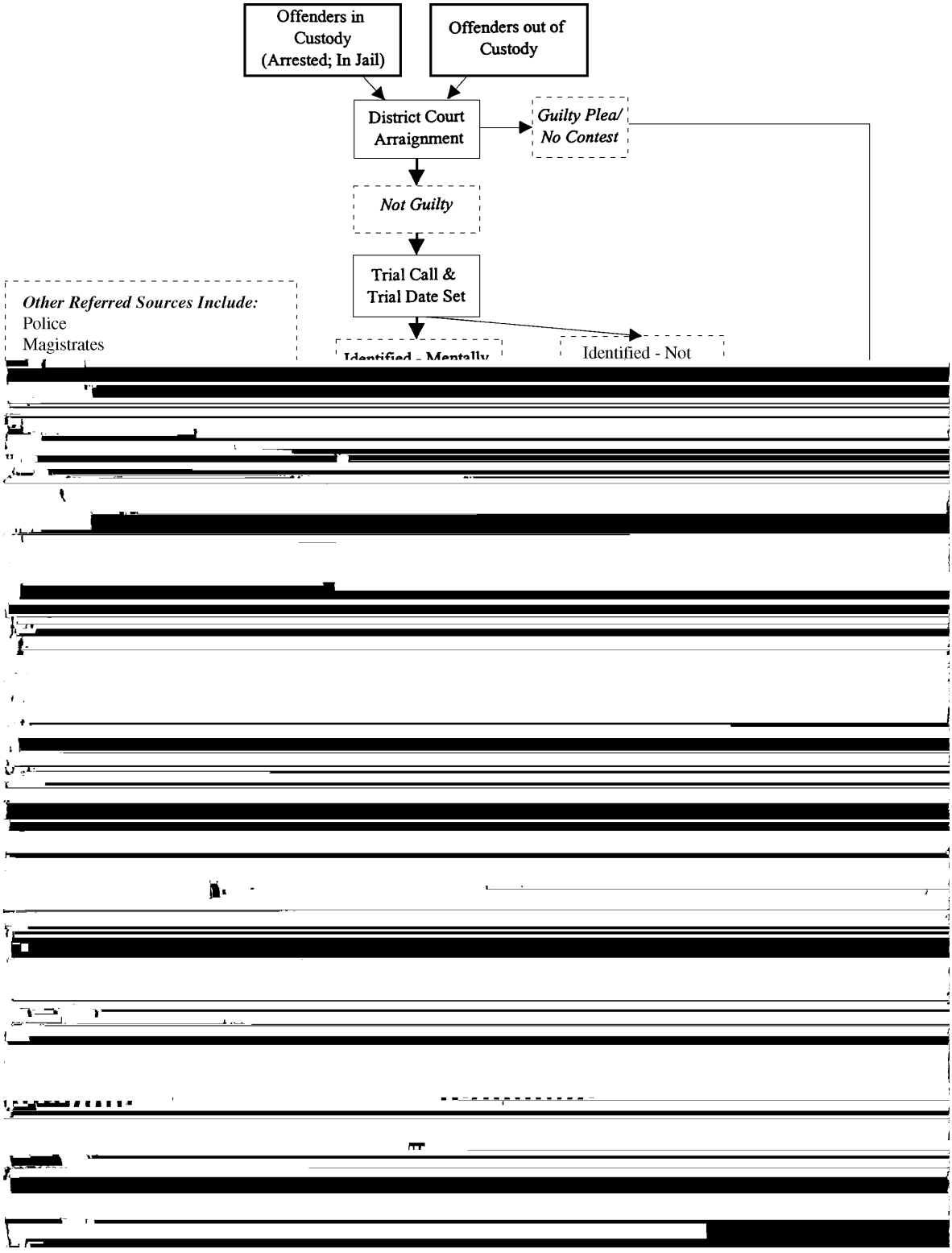
CCRP was designed to provide an alternative to jail and routine adjudication of misdemeanor cases for persons with mental disabilities by instituting special procedures that allow trained judges to address and treat mental illness and create more effective linkages and coordination between the courts, other justice agencies and mental health resources. Although the court-based initiative was motivated by the pressing need to address problems associated with jail overcrowding in Anchorage—hence the special Jail Alternative Services Program initiative for persons in custody—CCRP aims at a broader population. It accepts mentally ill persons in the misdemeanor population whether or not they are confined. Although CCRP places some defendants in the JAS Program, it draws upon a large array of community mental health and other supportive services. While the aims of the Anchorage District Court's CCRP initiative to link mentally ill defendants with community-based mental health services are similar to those of other mental health courts, the court chose not to call itself a "mental health court" to avoid the stigma that might be associated with participation in a court designed to respond to the mentally ill.

Target Population

The jail-based component of the mental health court initiative, the JAS Program, began on July 6, 1998 as a pilot project operated by the Alaska Department of Corrections and funded through the Alaska Mental Health Trust Authority. To be eligible for the JAS Program, defendants must be confined in the Anchorage jail on misdemeanor charges (punishable by a statutory maximum of 1 year in jail) and be found to suffer from a major mental illness with a history of psychosis or an organic brain injury. Prior records of convictions are anticipated by the mental health court. These restrictive criteria ensure that the JAS Program is very selective. It is limited to 40 participants, 5 of which are to be defendants suffering from organic brain impairments.

Eligibility criteria for participation in the District Court's mental health court program (CCRP) also begin with the limitation that defendants—in or out of custody—must be charged with misdemeanor offenses and defendants with prior records are not excluded. Beyond these threshold criteria, CCRP criteria are less restrictive than those that apply to JAS participants. Defendants diagnosed with or showing obvious signs of mental illness, developmental disability, or organic brain syndrome are considered appropriate candidates for the mental health court program. However, there is no requirement of a history of psychosis, as in the JAS Program, and the defendant need not have been in custody, a JAS eligibility requirement as well. CCRP has not attempted to limit enrollment to a

Figure 3. Anchorage County Mental Health Court Referral Process



evaluation.[19] If the defendant is found to be incompetent by the state medical staff, the court must hold a hearing at which evidence is presented on the issue of incompetence.

If the defendant is found, by a preponderance of the evidence, to be incompetent, the criminal proceeding will be stayed, and the defendant may be committed to the hospital for treatment for a period of 90 days. In those cases, at the end of the 90-day period, a hearing must be held before the mental health court judge to determine whether competency has been restored. If the defendant is still incompetent, he or she may be returned to the hospital for treatment for an additional 90-day period. A defendant who remains incompetent at the expiration of the second treatment period has the charges dismissed without prejudice; unless they involved force against a person, the defendant is a danger to others, or there is a substantial possibility that he will regain competence within a reasonable period of time. If these conditions are met, the defendant's commitment may be extended for an additional 6 months. At the end of this period, defendants whose competency has not been restored will have all charges dismissed without prejudice.[20]

At the first mental health court hearing, in cases when defendants are competent and stable, the judge determines whether the candidate understands what the mental health court (CCRP or JAS) treatment options involve and asks whether the defendant wishes to participate. The defendant makes this decision with the assistance of counsel and the court ensures that the decision to participate is voluntary. To enter the program, in most cases, the defendant is required to enter a plea of guilty or no contest to his misdemeanor charge in exchange for a plea agreement that the sentence will not involve jail. In rare cases involving very minor offenses and no prior criminal records, participants enter the mental health court via deferred disposition, which involves court-ordered conditional release of the defendant to community treatment prior to adjudication with court monitoring for compliance. Defendants who successfully complete the court program under these terms may be eligible to have their charges dismissed.

Once the plea has been entered and accepted, a sentencing hearing is scheduled. Ideally, if an acceptable treatment plan has already been prepared and approved and the participant is already in treatment and in an acceptable supportive living situation, the sentencing may be held immediately after the plea of guilty is accepted. If the defendant is assigned to the JAS Program, he will be sentenced and released as soon as the appropriate interviews are completed and the treatment plan set up. Due to a

[19]See Alaska Statutes, Code of Criminal Procedure, Section 12.47.100.

[20]See Alaska Statutes, Code of Criminal Procedure, Section 12.47.110.

lack of separate funding available to support treatment services in the mental health court, CCRP participants may wait longer than JAS candidates before their treatment plan is prepared and approved because they have to make arrangements for services themselves through their attorneys and community mental health services.

Defendants who are in custody remain there until a satisfactory treatment plan has been approved by the judge, unless a reliable third party who is acceptable to the judge steps forward to take on the responsibility of providing supervision in the community during this interim period. When prospective participants are in jail awaiting approval of their treatment plans, the court tries to expedite the sentencing hearing so that the defendant can be released as soon as possible. Typically, the adjudicated defendant receives a probationary term with a suspended sentence, with treatment through CCRP as a condition of probation. Although the probationary term for a misdemeanor conviction in Alaska can extend up to 10 years, the probation sentence in mental health court is usually between 3 and 5 years. Unlike the few deferred disposition defendants, these defendants are not eligible to have their charges dismissed upon successful program completion. Because many would have been subject to jail time in normal court, the suspended sentence is thought to provide an incentive to encourage participation in the mental health treatment process.

In the event that a defendant wishes to pursue pretrial issues or motions before making a decision about entering CCRP, the motions may be heard before one of the mental health court judges, Rhoades or Lohff, or may be heard by another judge in the normal district court process. If a defendant is successful, the charges may be dismissed. A defendant who wishes to litigate a pretrial issue and loses may still decide to enter the mental health court treatment process. Defendants who wish to proceed to adjudication, in the belief that they will be found not guilty, may or may not have their cases heard before either of the mental health court judges (both judges also preside over a normal criminal caseload). Mentally ill defendants assigned to other criminal judges and found guilty, may or may not be sent by the trial judge to the mental health court judges for sentencing.

In the event that a defendant qualifies for the selective Jail Alternative Services Program, the JAS coordinator, who also is the caseworker, is assigned to link the defendant to community treatment, to oversee and facilitate the treatment process and to report progress and potential violations to the court. The coordinator/caseworker monitors the defendant to be certain that their living situation is stable and that the participant is complying with court-ordered conditions of probation. This involves meeting with the participant on a regular basis; the frequency of the meetings varies from case to case, from twice a week to once every 4 to 6 weeks. A status hearing before the judge is scheduled after the defendant's release, with additional dates scheduled on an as-needed basis.

Minor violations of conditions of program participation generally result in adjustments being made in the participant's treatment plan to better meet his needs and to prevent future violations. Participants in the JAS Program who have difficulty complying with program conditions or who pose higher risks of violation may be scheduled for regular monthly status hearings at which they are required to explain problems to the judge. If the defendant appears not to be interested in cooperating after numerous chances, the caseworker may file an affidavit of noncompliance and petition to revoke probation. The defendant must then return to the CCRP court to answer for the noncompliance. As a last resort, the order may be vacated and the defendant may be sentenced on his original charges, with credit given for time served should the court determine that jail time is appropriate. Participants who decide that the program is not working for them have the option to drop out of the program. In such an instance, the JAS coordinator will recommend to the judge that the JAS order be vacated and the offender sentenced by the CCRP court.

Mental health court candidates not qualifying for JAS, but qualifying for treatment through the CCRP program, will be released on probation to follow the court-approved treatment plan as a condition of release. Due to lack of sufficient resources, CCRP participants are not supervised by a caseworker. The participant is required to sign a release of information document that permits the judge and the prosecutor to receive reports about compliance with program conditions from the mental health facility or program to which the defendant has been assigned. If violations occur, the prosecutor will file a petition, and a status hearing will be scheduled. In addition, compliance is monitored through regularly scheduled review hearings.

Unfortunately, as of this writing, there is no separate funding available to hire a court monitor or a caseworker to support the CCRP program. As a result, the burden of coordinating services falls mainly upon the judge, who recommends programs for the defendant and his attorney to explore, but who relies heavily upon the defense attorney for developing suitable treatment options. In addition, there is no staff person assigned to supervise or case manage the participant once he is released on an acceptable treatment plan. Supervision is accomplished by the monitoring of the prosecuting attorney and the court through regular review hearings.

CCRP participants who violate conditions of their participation in the treatment process while on probation may be assigned sanctions that range from counseling by the judge at the hearing and threats of jail time, to revocation of probation and imposition of portions of the suspended sentence, to termination from the program and imposition of the full suspended sentence. Judge Rhoades notes that, for lack of compliance with program conditions, the court will not penalize defendants for participating in CCRP and not employ sanctions for noncompliance more severe than the standard sentence would be if the case had been adjudicated

through the normal misdemeanor court process. When a mentally ill participant fails in the CCRP program, and ends up receiving a "normal" sentence and then is rearrested, the new case will be flagged to return to mental health court. At that time, depending on the seriousness of the new charge (it must be a misdemeanor) the defendant may be given another opportunity to enter the treatment services provided by the CCRP program. Readmission can occur after careful evaluation by the court team to determine whether circumstances or attitudes have changed and the candidate would be more amenable to treatment this time.

The Treatment Approach in the Anchorage Mental Health Court

program. In the courtroom, the prosecutor supports the treatment process, while considering the implications for public safety. The defense attorney is also more flexible in mental health court than in traditional misdemeanor court, allowing direct dialogue between the defendant and the judge after the fashion of the drug court model. In addition, much more

a day treatment program on a daily basis. Only the state hospital, with limited capacity, is available to meet the needs of participants requiring inpatient treatment services. For JAS mental health court participants, an important aim is to reduce the level of supervision and structure provided to the clients over time as their level of independence increases, and to develop strong links to treatment so that treatment will continue after the probationary period and mental health court involvement.

Very few of the defendants have a place to live when they are placed in the Anchorage CCRP or JAS Program. Most need assisted living with varied levels of structure and support to enable them to function appropriately in the community, ranging from 24-hour staff availability to apartment settings with staff available to look in on them once a day. Chronically ill and/or personality-disordered defendants or those with ongoing substance abuse problems are more difficult to place in available programs. Some programs are reluctant to accept JAS participants because of the risk they pose to other clients or the potential to be disruptive to the overall treatment programs. Unfortunately, for such individuals there are few resources available to provide the living situation and services needed. Instead, JAS participants are forced to make use of two unsupervised shelters in the Anchorage area; or they are placed on the "hotel plan" under which they are placed in an inexpensive hotel, and closely monitored by the caseworker and the staff at the day treatment center they attend. They are essentially "wrapped" in services that take them through the weekdays from morning until night, and provided with assisted living as needed for their day-to-day functioning (preparing meals, buying groceries, managing money).

Staff views these housing arrangements as less than ideal. Staff have no control over other potential residents who tend to frequent these living quarters. Neither the unsupervised shelters nor the inexpensive hotels are viewed as desirable settings for JAS participants, who require supportive services. Attempts are made to compensate for the poor housing situations by providing JAS participants with day treatment services, an aggressive outreach component, and case managers who check in on them and respond to their needs on a daily basis. A small percentage of JAS clients have supportive home situations and do not require structured housing.

Day treatment is supplied to the JAS program mainly by the South Central Counseling Center, which provides substance abuse treatment, training in social and independent living skills, daily medication dispensing, and vocational training. Each defendant is assigned to a team based upon individual treatment needs. Most of the JAS defendants require an intensive level of treatment accompanied by an aggressive outreach component. (Staff will go out in the community to look for them if they fail to appear for group sessions or medication.) The JAS program also contracts with the South Central Foundation in Anchorage, which works primarily with the

native Alaskan population. That program provides day treatment programs as well as cultural links and activities, some outreach, and limited housing. While most JAS clients require day treatment, at least at first, some are stable enough, or become stable enough, to be placed in vocational programs or to take on part-time jobs. Unfortunately, only a small percentage of JAS clients have the ability to ever hold a job.

At least in its initial stages, the JAS program has not been able to draw on good options for placing dually diagnosed participants in treatment. Substance abuse is common among the mentally disabled JAS participants, with an estimated 82 percent having significant substance abuse issues.[21] With only 2 facilities and a combined capacity of 25 beds, this lack of treatment resources is most acutely felt when dealing with clients with personality disorders or who display severe symptoms of mental illness, and who need, but are unable to function in, the available in-patient programs. When their criminal histories are also taken into consideration, this type of participant is not usually eligible for most treatment programs. As a result they are placed in out-patient MICA groups with regular monitoring and drug screening, supplemented by day treatment with "aggressive" outreach activities. JAS staff believe that this approach is unlikely to address the treatment needs of the dually diagnosed participants.

JAS clients who have organic brain impairment are placed with agencies specifically dedicated to addressing their problems, some of which are permanent in nature and do not respond to treatment. These agencies provide services including daily living assistance and maintenance. The clients are assisted, for example, in getting their food and cooking meals. Daily activities are structured to meet their levels of functioning. These placements are intended to be permanent in that the clients can stay there even after the jurisdiction of the court has ended.

In contrast to the more structured approach of the selective JAS Program available to some mental health court participants, CCRP participants do not enter a structured program, staffed and supervised by the court. Rather, candidates must set up their own treatment plans through their attorneys. This task is difficult and time-consuming, and results in different arrangements for different participants based on the attorney's ability to pull together an effective treatment plan, and the defendant's financial situation. However, there is no accessible, integrated mental health treatment network for defense attorneys to draw on in designing an appropriate treatment plan for their clients and some attorneys do not have experience in developing such a plan. As a result, treatment plans for their mentally disabled clients vary in scope and potential effectiveness, ranging

from simply attending AA meetings for substance-abusing mentally ill, to

percent decided to enter the treatment program, however. This low rate of enrollment initially was apparently due to the large number of eligible defendants who were sentenced or released before they could be assessed for the program and processed by the JAS coordinator. As of February 2000, there were 49 participants, of whom 71 percent are male and the average age is 31. The population is composed mainly of native Alaskans (39 percent), Caucasians (39 percent), and African-Americans (20 percent). Most have co-occurring substance abuse problems. JAS participants have fairly extensive prior criminal histories, averaging 7 prior convictions, and almost all have a history of psychiatric hospitalization, averaging nearly 10 prior admissions. Early program information suggests that about half of the JAS participants, like those sentenced in the normal fashion, were rearrested for new offenses during the recent 12 months. Of the 49 individuals who have entered the JAS Program since its inception, 17 individuals have been rearrested on new misdemeanor charges, and only one has been rearrested on a felony charge.

The San Bernardino (California) Mental Health Court

Target Problem and Rationale

In California, as in other places, deinstitutionalization of the mentally ill from state institutions and the inability of the community-based mental health system to provide sufficient resources to meet treatment needs has contributed to more mentally ill persons being found among the homeless, drug-addicted and criminal justice populations (Whitmer, 1979). San Bernardino's Mental Health Court was established to respond to the large numbers of mentally ill persons found in the local jail population, recently estimated by corrections officials to account for 12 percent of the inmate population. At the same time, the Honorable Patrick Morris recognized the challenges posed for treatment by substance-abusing offenders with mental illness as a co-occurring disorder through his experience presiding over San Bernardino's drug court. In 1998, a health and justice system task force was formed of representatives from the justice system, the mental health system, and city council to examine the problems of the mentally ill offender. As a result of its recommendations and with initial funding from the Department of Behavioral Health, the Mental Health Comprehensive Offender Umbrella for Release and Treatment (MH COURT) began as a pilot program in the San Bernardino Superior Court in January 1999, with the Supervised Treatment After Release (STAR) Program as its principal component.

Target Population

The San Bernardino Mental Health Court differs from the other mental health courts in its admission of defendants charged with nonviolent lower level felonies, punishable by up to 6 years in prison, as well as defendants facing misdemeanor charges, punishable by up to 1 year in jail. Some defendants charged with violent offenses may be considered for the program, on a selective, case-by-case basis, if it is clear from an examination of the facts that it was not a truly violent incident, despite the seriousness of the charge, and that the offense was linked to mental illness. Because one of its aims is to address the jail-based or jail-bound population of mentally ill offenders, all candidates are in custody at the time of their referral to the Mental Health Court. In addition, the San Bernardino court limits eligibility for the STAR Program to defendants with previously diagnosed and persistent mental illness and a history of recidivism that would make jail

terms likely. Candidates for Mental Health Court must live in the San Bernardino area and be eligible for SSI benefits or be employed, so some contribution to the costs of treatment is possible. To date, few participants have been employed and most have been eligible for SSI benefits because of their previous diagnoses. Participants who are not receiving benefits at the time of admission to Mental Health Court are supported in treatment until their benefits are applied for and received.

San Bernardino Mental Health Court Procedure

Most potential candidates are identified for the San Bernardino Mental Health Court while in detention in the West Valley Detention Center by jail mental health staff, subsequent to arraignment, which must occur within 48 hours of arrest. (For an overview of the San Bernardino Court procedure, see Figure 4.) The staff consists of two clinicians with PhDs in psychology, and one licensed clinical social worker. These clinicians also function as case managers, who provide supervision for the participants who are admitted into the program. At that time, they are interviewed and screened by a mental health clinician who explains the Mental Health Court program and confirms that the defendant has been diagnosed as having a history of an Axis I category of mental illness.[22] Candidates who appear eligible for the Mental Health Court sign a waiver permitting information to be conveyed to the court relating to the mental illness and indicate they wish to participate in the treatment process. Once candidates request admission to the program, screening information is passed on to the probation officer, the prosecutor and the public defender assigned Mental Health Court duties. The practice of considering only candidates who have requested admission to the treatment program helps ensure that resources are focused on persons who will enter the program and engage in treatment once admitted.

The defendant-candidate will make a first appearance in Mental Health Court about 2 or 3 weeks after arraignment. The period between referral (after arraignment) and first hearing in Mental Health Court is used to develop background information about the candidate's mental health and criminal history and to stabilize the individual on medication, if necessary. This is done so that participation is meaningful in the first hearing, and the candidate can comprehend the proceedings and make an informed acceptance of the program conditions. Because the Mental Health Court purposely targets persons who would be spending time in jail upon conviction, the criminal histories of participants are often significant, although violent prior offenses might preclude participation in the program.

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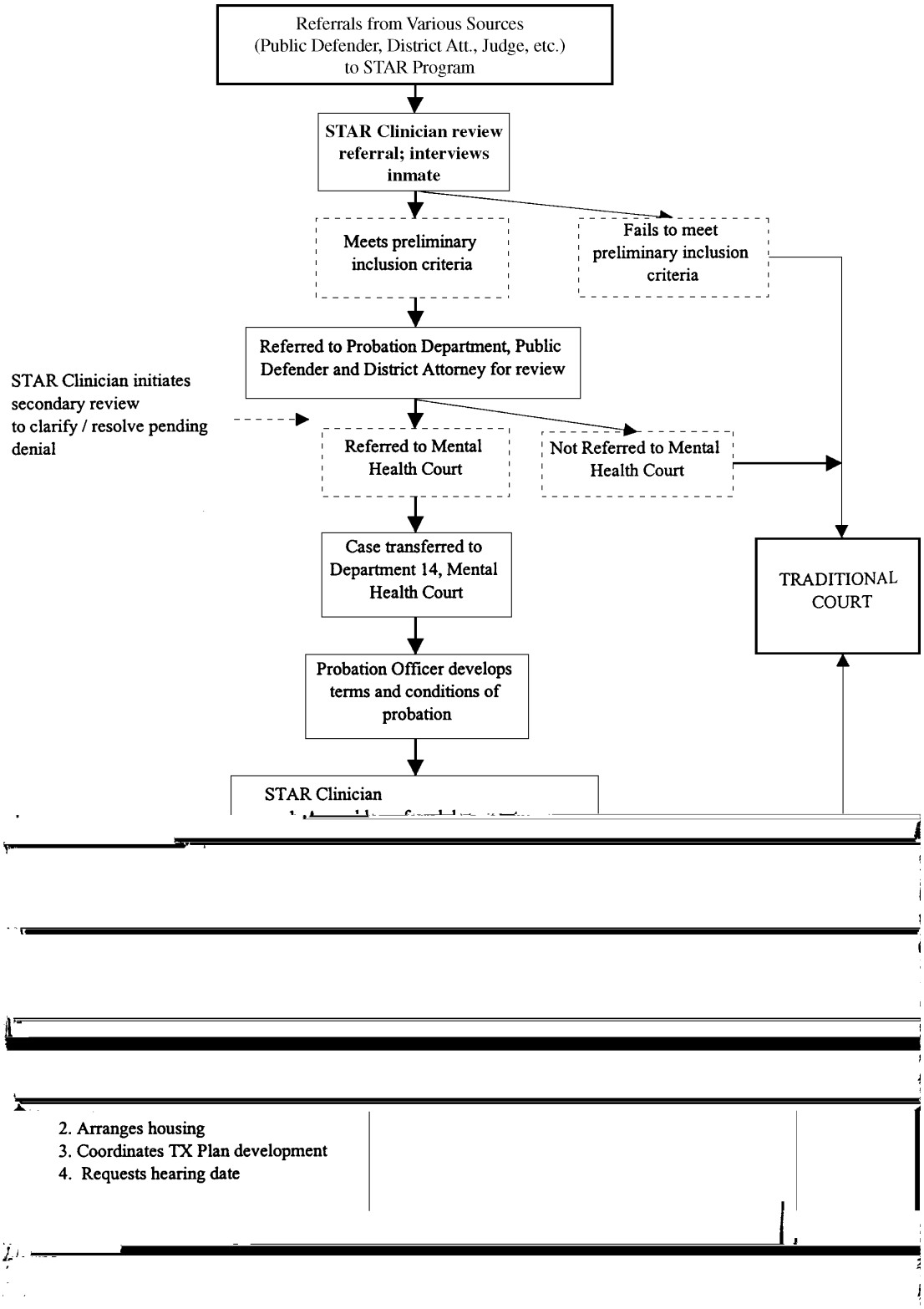
Figure 4. San Bernardino County Mental Health Court Referral Process



Admission to the Mental Health Court requires consensus of all members of the court team. If any member of the team, including the defender, the prosecutor, the mental health caseworker, or the judge objects, the defendant will not be accepted into the program. The probation officer performs an intensive interview of the defendant and reviews his prior criminal record. If the defendant is believed to be appropriate for the program, the probation officer will complete a pre-sentence investigation and prepare written terms and conditions that outline specific requirements that the defendant must adhere to for his treatment to be effective. The prosecutor also checks into the defendant's criminal history. Crimes of violence are checked to ascertain their actual circumstances and seriousness. True violent offenders are not eligible for the program. If a consensus is reached and the defendant is approved, the case is listed for Mental Health Court. Prior to the hearing, the prosecutor and the defense attorney engage in plea negotiations, so that they are prepared to present an agreement to the court at the defendant's first appearance, assuming the defendant is competent.

San Bernardino Mental Health Court hearings are held once a week on Wednesdays. The court team meets to discuss the case prior to the hearing, as well as any issues that should be addressed in court. As in the other courts, the first issue addressed in the San Bernardino court is competency. Felony defendants who are thought to be incompetent are returned to the jail and the court will order that they be assessed by a licensed psychologist or a psychiatrist for competency. A hearing on the issue will then be held. Defendants found to be incompetent are examined by a therapist from the county Department of Mental Health to determine appropriate placement. If hospitalization is deemed appropriate, the defendant may remain in the hospital while steps are taken to restore competency. In fact, that process may take up to 3 years, or the statutory maximum associated with the crime charged, whichever is less. In misdemeanor cases, the court will attempt to avoid hospitalization, which can cost approximately $350 per day. It is more likely that the misdemeanor defendant will be placed in a public or private treatment facility approved by the Department of Mental Health or in a community-based program, in an attempt to restore competency. The criminal proceedings are suspended pending the restoration of competency, up to a period not to exceed the statutory maximum.[23] Defendants who are unstable when they enter the jail are generally stabilized during the 2- to 3-week detention period while being considered for treatment court. Unstable defendants must consent to treatment while in jail in order to qualify for Mental Health Court, so that while they are housed in the psychiatric wing, they can be stabilized with therapy and medication. Most unstable defendants are ultimately denied program admission due to

[23]See the California Codes, Penal Code Sections 1367-1375.5.

their inability to cope with the highly structured nature of the treatment program.

Assuming that a defendant is competent, he or she enters a guilty plea as a condition of entry into the program. The defendant is placed on probation for a period of 2 years in misdemeanor cases or 3 years in felony cases, with participation in Mental Health Court treatment ordered as a condition of probation. Each participant must also sign an individualized treatment contract that specifies the mental health services to be provided, the frequency of those services (and the required attendance), and any other activities required of the participant. Upon successful completion of the program, the plea may be withdrawn, the charges against the defendant may be dismissed, and the participant may also petition the court to have the record expunged.

Once the treatment plan has been agreed to, most participants are released into an augmented board-and-care residential treatment facility. (There are presently 24 beds allotted to the Mental Health Court program.) The case managers transport the participant to the facility and then visits the client several times a week to ensure compliance, providing intensive supervision to assure that he is attending psychiatric counseling, stabilizing on medication and abiding by the terms of his probation. Upon request, the probation officer will intervene if the client becomes disruptive or uncontrollable at the facility, and will arrange for transport back to court for a hearing before the judge. Clients who fail to cooperate or comply with program standards, or who otherwise are in violation of probation, will have sanction recommendations made for them by the mental health clinicians.

A small number of participants may have the family support and stability to allow them to be supervised from their homes. The case manager will conduct home visits two times per week, to determine that the living conditions are appropriate, and that clients are not in possession of any illegal or inappropriate items that would impede their progress in treatment, and to perform urine analysis testing for illegal substances. When the conditions in the residence are found to be unsuitable, the officer will find new arrangements for the participant. When a participant is found to be in violation, the officer will recommend sanctions.

Status hearings are held every 3 to 4 weeks to track the level of compliance by the participant and to address any problems that may arise. Noncompliance sanctions range from an in-court reprimand from the judge and loss of privileges, to increased restrictiveness of placement that includes more meetings with the case manager and more meetings in the 12-step program, or community service, and even jail time (usually a weekend, or more for continued violations). The noncompliant participant will also be reevaluated to ascertain if changes in treatment and/or living arrangements are necessary to aid them in attending to program rules. Serious and

willful recurring violations may result in program termination and a return to traditional court. San Bernardino differs from the other early mental health courts in its close adaptation of the drug court model to the mental health court treatment process, including the use of jail as a sanc-

Because this type of care is expensive, the number of beds allotted to the treatment program is limited to 24 beds. As clients progress and become more stable, they are moved to one of the six regular licensed board-and-care facilities with which the court has contracted, and finally to basic room and board or other independent living situations. Only very stable clients are initially released into a regular, licensed board-and-care facility, where, in contrast to the augmented-care facilities supportive services, day treatment and dispensation of medications are not included in facility services (and the educational level required for staff is not as high). A small number of participants may be released directly to their family when family support is sufficient to facilitate the treatment process.

San Bernardino Mental Health Court participants generally receive day treatment from the Pegasus program which was run by Mental Health Systems, Inc., and tailored to fit the needs of the Mental Health Court. Pegasus began servicing the Mental Health Court in February 1999. Although Pegasus also takes referrals (of mainly individuals with some form of criminal justice involvement) from the other courts and agencies, the majority of its clients are participants in the Mental Health Court.

Defendants attend the day treatment program 5 days per week, from 8:30 a.m. until 1:00 p.m. The services provided include anger management, socialization skills, psychotherapy, medication therapy, and chemical dependency treatment, which includes a "12 + 5" step program specifically geared toward the dually diagnosed client, as well as drug testing. (Most San Bernardino Mental Health Court participants also have serious substance abuse and self-medication problems.) Pegasus also provides prevocational training, which is meant to prepare participants for educational or work programs. Participants also receive individual case management; regular conferences are held to discuss client needs and progress. The program will transport participants to scheduled doctor's appointments.

The day treatment component is intended to last for 1 year, at which point participants who have made satisfactory progress will be considered for vocational or educational training, or full- or part-time employment. Participants are referred to the state vocational rehabilitation department to receive training. Court (STAR) participants move from one level of care to another as a result of recommendations made by clinicians to the judge and the attorneys at periodic treatment meetings.

The mentally ill offenders grant is being used to fund two new programs: STAR LITE and SPAN. STAR LITE is an intermediate level treatment program designed to cover a similar mentally ill population to the one covered by STAR, but with *Less Intensive Treatment Episodes*. It offers services and case management for defendants who have less need for supervision; however, these participants will still be on supervised probation and be subject to specific medication and treatment requirements. They are also required to meet regularly with their case managers. Review hearings will

be held approximately every 3 months. SPAN, which stands for San Bernardino Partners for Aftercare Networking, was designed to provide case management and augmented services to in-custody defendants who had not been previously diagnosed, but rather were diagnosed with an Axis I illness in jail,[24] and who are not chronic offenders. Lower level services are offered to these defendants, and only regular board-and-care referrals are available for homeless participants. SPAN participants may not have probation terms and conditions relating to taking medications and treatment. There are no regularly scheduled review hearings required for them. Rather, they are tracked through brief meetings with a case manager and a counselor who will check in on them to assure that they are stable.

From the San Bernardino Mental Health Court's inception in January 1999 through November 16, 1999, 181 referrals were made to the Court. Of these, 106 were actually evaluated, resulting in the acceptance of 25 participants and the rejection of 81 candidates. The majority of the rejections came from the office of the District Attorney. Most of those accepted were placed in the Pegasus program, with the majority of these housed in augmented board-and-care facilities. Sixty percent of entering participants were remanded to jail at least once during their treatment period, with 40 percent remanded more than once. Six participants were terminated from the Mental Health Court program, half due to AWOL status, and half due to serious or persistent violation of terms and conditions. Nineteen participants were active in the program as of November 19, 1999.

Success and Failure in the San Bernardino Mental Health Court

The San Bernardino Mental Health Court accepts participants facing misdemeanor or felony charges who have serious mental health problems based on past history and current diagnosis of Axis I conditions. All participants plead guilty and are sentenced to probation for 2 or 3 years, depending on the offense. The STAR Program aims to place mentally ill offenders in appropriate services and to move them to different and less intensive levels of care when success is demonstrated in various stages. An overriding goal is to place participants in treatment programs and to link them with the appropriate services so that, when their participation is concluded, they continue to make use of these resources, which will assist them to function normally and not to return to the criminal justice system. A related goal is to maintain the mentally ill offenders in the community and to avoid their confinement in the local correctional facility. Participants who are successful move from intensive services to more independent and self-sufficient living situations, complete probation successfully

[24]For an expanded definition of Axis I, please see footnote 10.

and have their pleas withdrawn, their charges dismissed, and their arrests expunged. The program's first graduation is expected to occur in June 2000, when it is anticipated that up to six participants will have successfully completed the program.

After entering the Mental Health Court, participants who cannot comply with the requirements of the treatment process are sanctioned, much as in Judge Morris' drug court. They often receive stern lectures and reprimands, sometimes resulting in sitting in the jury box during the court proceedings, possibly being placed in a more restrictive and structured treatment setting, and, occasionally, being returned to jail until further plans can be made. Court staff considers the use of the jail appropriate in a therapeutic not a punitive sense, helping some participants see the consequences of their actions and encouraging them to refocus their efforts. Unsuccessful participants may be terminated from the Mental Health Court, have probation revoked and face serving terms of confinement in jail or a state prison facility.

Early Mental Health Court Initiatives: Common Themes

including fines that would never be paid and time served for days already spent in jail.

A very clear aim in each site was to devise an alternative to holding and treating mentally ill defendants in jail. Although each jail was attentive to the issues of the mentally ill offender, the jails faced serious crowding problems and were ill-equipped to provide more than temporary care for the mentally ill. Resources were too scarce, facilities were inadequate, and the numbers of inmates were too great. Moreover, each mental health court strategy was premised on a belief that, in most cases, jail was the last method that should be employed to address the problems of the mentally ill offender. Not only were jails generally unable to provide adequate care, confinement was often a stressful ordeal for the mentally ill, causing crises and a variety of problems that might otherwise be avoided. The designers of these mental health court innovations saw the growing problem of the mentally ill in jails as evidence of the failure of mental health treatment and other social service systems in the community.

The early courts also share common origins and aims because they draw on the example and experience of the nation's first mental health court in Broward County. Each of the succeeding efforts has considered and adapted the pioneering Broward County Mental Health Court model in some fashion. Once established, the early mental health courts have shared lessons and challenges among themselves and—as communication and geography would permit—have continued to learn from their different experiences. Moreover, each of the early courts now receives visitors from other courts interested in addressing the problems of the mentally ill in their justice systems.

Common Features

The mental health courts we examined share a number of common attributes, some adapted from the earlier models of problem-solving courts, some unique to the mental health populations they address.

Target Problems and Populations

The early mental health courts focus their efforts on the relatively low-level mentally ill offender who is found in the criminal justice population. All of the courts place a primary emphasis on the mentally ill defendant or offender held in jail, seeking ways to find supportive treatment in the community as an alternative to confinement. The courts differ slightly in their criminal justice and mental health eligibility criteria. Each of the courts accepts misdemeanor defendants but has a varying period of court supervision. The Broward County Mental Health Court is limited to 1 year of supervision of participants, the extent of misdemeanor jurisdiction in cases that are sentenced. (Broward defendants are not on probation during their

Figure 5. Four Pioneering Mental Health Courts: Descriptive Summary

Defining Features	*Broward County (FL) Mental Health Court*	*Anchorage, Alaska*	*King County, Washington*	*San Bernardino, California*
Court start date	June 6, 1997	July 6,1998	February 17, 1999	February 17, 1999
Supervising Judge	Honorable Ginger Lerner Wren, Criminal Division,17th Judicial Circuit, County Court.	Honorable Stephanie Rhoades, Honorable John Lohff, Third Judicial District Court Judge.	Honorable James Cayce, Presiding Judge, District Court.	Honorable Patrick Morris.
Mental Health Court Goals	Expedite case processing, create effective interactions between mental health and criminal justice systems, increase access to mental health services, reduce recidivism, improve public safety, reduce length of confinement of mentally ill offenders.	Expedite case processing, improve access to community health resources, relieve jail overcrowding, reduce clinical and legal recidivism, improve public safety and order.	Expedite case processing, create effective interactions between mental health and criminal justice systems, improve mental health and well being of participants, protect public safety, reduce clinical and legal recidivism, improve access to mental health resources, improve monitoring of mentally ill offenders.	Provide mental health services to eligible defendants to improve their community functioning, reduce rate of reincarceration and recidivism, maintain defendants in least restrictive mental health environment.
Stage of intervention	Post arrest.	Plea/sentencing hearing.	Plea/sentencing hearing.	Plea/sentencing hearing.
Method of entry	Diversion program; entry prior to disposition of charges.	Plea required prior to program entry; a few deferred dispositions are allowed.	Plea required for official program entry; stipulated order of continuance possible for domestic violence; some deferred prosecutions allowed.	Plea required prior to program entry.
Eligible criminal offenses	Misdemeanors, excluding DUI and domestic violence, battery eligible with victim consent only.	Misdemeanors.	Misdemeanors.	Misdemeanors and low-level felonies.
Eligible criminal history	Misdemeanors, and felonies allowed; with careful screening of violent offenses.	Misdemeanors and felonies allowed with careful screening of violent offenses.	Misdemeanors and felonies allowed; violent priors accepted on case by case basis.	Prior record required for admission misdemeanors; felonies allowed with careful screening of violent offenses.
Mental health eligibility requirements	Axis I serious mental illness, organic brain impairment, developmental disability.	CCRP-diagnosis or obvious signs of serious mental illness, developmental disability or organic brain syndrome that was contributing factor in commission of crime charged. JAS: major mental illness with history of psychosis.	Serious mental illness or developmental disability that triggers crime charged.	History of severe and persistent Axis I mental illness; previous diagnosis required.

Figure 5. Four Pioneering Mental Health Courts: Descriptive Summary (cont.)

Defining Features	*Broward County (FL) Mental Health Court*	*Anchorage, Alaska*	*King County, Washington*	*San Bernardino, California*
Frequency of court sessions	Court convenes daily at 11:30 a.m.; review hearings held on Thursdays at 1:30 p.m.	Court operates on part time, as-needed basis.	Court convenes daily at 1:00 p.m. for first appearances, and Thursdays at 2:00 p.m. for status and review hearings.	Court in session every Wednesday.
Courtroom team	Judge, prosecutor, public defender, court monitor, court clinician, case manager, mental health court liaison.	Judge, prosecutor, public defender, JAS case coordinator.	Judge, prosecutor, public defender, program manager, court monitor, jail psychiatric liaison, probation officer.	Judge, prosecutor, public defender, mental health court administrator, case managers, probation officer.
Stage of identification	Within 24 hours of arrest, from magistrate/bond hearing.	Within 24 hours of arrest, during jail screening prior to arraignment.	Within 48 hours of arrest during jail screening prior to first court appearance.	Within 48 hours of arrest, during jail screening prior to arraignment.
Defendant in custody	Most are in custody, but not required for admission to program.	CCRP: most are in custody, but not required; JAS: defendant must be in custody to be eligible for program.	Most are in custody, but not required for admission to program.	Defendant must be in custody to be eligible for program.
Referral source	Primary source: magistrate, county jail; others-attorneys, family.	CCRP-county jail, Mental Health providers, family, attorneys, magistrate; JAS: county jail.	Primary source: county jail; others magistrate, attorneys, family, police, Mental Health caseworker.	Primary source: county jail.
Initial screening	Magistrate court, county jail.	County jail.	County jail.	County jail.
Time from referral to Mental Health Court appearance	Often within hours of the referral.	24–48 hours.	Usually 24 hours.	2–3 weeks.
Competency evaluation	Private psychiatrists generally perform evaluation at detention facility; if defendant is incompetent, will be conditionally released or given temporary housing while attempts are made to restore competency; state maintains criminal jurisdiction for 12 months.	If defendant in custody, referred to state hospital for evaluation; if not in custody, independent evaluation is scheduled; 90 days to restore competency, then court reevaluates if defendant civilly committed, may dismiss charges.	Evaluation done by state hospital psychiatrist in county jail unless the defendant requires hospitalization; evaluation held within 14 days; 29 days total allowed to restore competency if violent charge or history; if not restored, charges dismissed without prejudice.	Evaluation conducted in psychiatric wing of county jail by state hospital psychiatrist; if defendant found incompetent, statute allows up to 3 years, or the statutory maximum to restore competence.
Final eligibility decision	Judge decides eligibility with input from court team.	Judge decides eligibility with input from dedicated court team.	Judge decides eligibility with input from court team.	Admission requires consensus of all members of court team.
Treatment begins	Treatment plan is to be completed prior to resolution of charges.	Treatment plan is ordered as a condition of probation at conclusion of sentencing hearing.	Interim treatment plan begins prior to resolution of charges, generally released at first appearance; defendant returns to court 2–3 weeks later to resolve charges.	Treatment plan begins in jail; defendant released to treatment program at first appearance or within 1 week thereof.

Figure 5. Four Pioneering Mental Health Courts: Descriptive Summary (cont.)

Defining Features	*Broward County (FL) Mental Health Court*	*Anchorage, Alaska*	*King County, Washington*	*San Bernardino, California*
Length of Mental Health Court treatment	Defendant may be monitored for up to 1 year while charges are held in abeyance.	Typical treatment probationary term: 3–5 years; misdemeanor probation may last up to 10 years.	Treatment probationary period: typically 2 years; for DUI charge, term is extended to 5 years.	Treatment probationary term: 2 years for misdemeanors, 3 years for felonies.
Disposition of charges	Disposition conclusion of treatment; in most cases adjudication withheld, no conviction ever entered; in serious cases guilty plea with credit for time served.	Most defendants have convictions at conclusion of treatment and their sentence is suspended; deferred dispositions result in dismissal of charges upon successful completion.	Most defendants have convictions at the conclusion of treatment, sentence is suspended; the few with deferred dispositions are eligible to have their charges dismissed upon successful program completion.	Charges are dismissed upon successful completion; defendant may petition for expungement.
Effect of request for trial	Defendant will be transferred to traditional court for trial, but can access community-based treatment and services through the Mental Health Court team.	Defendant may still be eligible for treatment court; trial may proceed before Judge Rhoades, who also maintains a criminal calendar.	Defendant no longer eligible for treatment court; case referred to traditional court.	Defendant may still be eligible for treatment court; considered on case-by-case basis.
Supervision	Court monitor supervises with assistance from case managers and program staff; probation officer rarely used because most defendants are not on probation.	CCRP: no outside supervision, court and prosecutor monitor; JAS: caseworker with small caseload provides close supervision up to several times weekly, as needed.	Probation officer and Mental Health staff at assigned treatment facility closely monitor the defendant; court monitor supervises provisional treatment plan.	Probation officer and case manager with limited case-load oversee client on as needed basis, up to several times weekly.
Frequency of status and review hearings	Hearings held at regular intervals and as needed.	One hearing scheduled after release; thereafter on as-needed basis unless high risk defendant-hearings every 30 days.	Hearings held at regular intervals and as needed.	Hearings held every 3–4 weeks.
Sanctions for noncompliance	Hearings before judge; change in treatment, support and encouragement; use of jail as sanction extremely rare.	Minor violations: adjustments made in treatment; jail used as threat; jailed after repeated attempts at counseling.	Jail used sparingly if defendant noncompliant after repeated counseling and court hearings.	Sanctions range from reprimands by judge to stricter treatment conditions, community service, and jail, which are used liberally.
Successful termination from Mental Health Court	Most cases: deferred prosecution, withdraw guilty plea, no conviction on record; serious cases: guilty plea entered, credit given for time served.	Few deferred prosecutions may withdraw plea; most cases, credit given for time served, conviction remains on record.	Deferred prosecution; defendant may withdraw plea; most cases, credit given for time served in program, guilty plea remains on record; may dismiss charges on District Attorney recommendations.	Charges dismissed; defendant may petition for expungement.

Figure 5. Four Pioneering Mental Health Courts: Descriptive Summary (cont.)

Defining Features	*Broward County (FL) Mental Health Court*	*Anchorage, Alaska*	*King County, Washington*	*San Bernardino, California*
Unfavorable termination from Mental Health Court	Defendant commits serious new crime, repeated willful violations, or wants to get out of program, adjudication may be withheld or plea taken; judge has full array of sentencing options.	Defendant commits serious new crime or repeated willful violations, original charges referred to criminal court.	Defendant commits serious new crime or repeated willful violations, original charges referred to criminal court.	Defendant commits serious new crime or repeated willful violations, original charges referred to criminal court.

also differ slightly from court to court. In Broward County, candidates must be diagnosed with an Axis I mental illness,[25] have an organic brain injury or head trauma, or be developmentally disabled. In King County, misdemeanor candidates must be found to suffer from a significant mental illness, organic brain impairment, and/or a developmental disability that is directly or indirectly connected to the crime charged, and for which the person is in need of treatment and that, unless treated, greatly increases the probability of future criminal recurrence. The JAS Program in Anchorage and the STAR court in San Bernardino have the strictest mental health criteria. In Anchorage, the JAS Program deals with defendants who have a major mental illness with a history of psychosis. (Eligibility requirements for CCRP are less stringent, requiring serious mental illness, developmental disability or organic impairment, but not psychosis.) The San Bernardino Court requires that participants have been previously diagnosed with one of the six Axis I illnesses. The defendant must have a documented history of mental illness to be eligible for treatment through the STAR Program. Both of these programs are relatively low volume, having access to a small number of treatment beds, and both focus on confined defendants who are seriously mentally ill.

Judge-Centered Court Treatment Process

Each of the mental health courts is built around the main feature of the problem-solving court strategy pioneered by the Miami Drug Court and carried over into other substantive areas, such as community courts and domestic violence courts. Under this approach, the judge sits at the center of the court treatment process and plays a variety of roles, formal and informal. The judge represents authority and has responsibility for all actions of both legal- and treatment-related natures to be taken. The judge presides formally over any legal matters at the entry and completion stages of the process and may adjudicate cases of participants who opt out or fail in the program. Perhaps most importantly, the judge plays a hands-on, therapeutically oriented and directive role at the center of the treatment process. The judge deals with problems, encourages progress and responds to poor performance by participants. The judge deals and interacts with the participant directly, and assigns rewards and sanctions as may be appropriate, including selective use of jail or changes in placement options.

[25]For an expanded definition of Axis I, please see footnote 10.

New Working Relationship Between the Court and Mental Health Services

The new, multifaceted role of the judge and other courtroom actors is premised on the development and implementation of a new working relationship between the criminal court and mental health treatment and related support services. To the mental health court, the presence in criminal justice (and particularly in jail) of large numbers of mentally ill and disabled defendants is evidence that, on their own, community mental health services have failed to engage citizens in the treatment process. If they were effective in treating this population, such large numbers would not be in the criminal justice system. Following the drug court model, the mental health court redesigns the working relationship between the court and treatment services, brings the redesigned partnership into the courtroom and holds it accountable to the judge. The new working relationship is seen in the special teams of courtroom personnel dedicated to staffing the mental health courts, including the judge, probation officers, clinical supervisors or coordinators, case managers, defense attorneys, prosecuting attorneys, jail liaisons and other service providers dealing with the court participants. The new relationship is reflected in the pre-court case staffing discussions and the in-court collective problem-solving that assist the judge in directing appropriate actions in individual cases. The authority and final decision making responsibility of the judge holds the treatment process, as well as the participant, accountable and requires continual communication between members of the mental health court staff.

Special Courtroom Procedures, New Roles for Courtroom Staff

The special use of the courtroom associated with the early mental health courts is reminiscent of the drug court conceptualization of the courtroom as part of the therapeutic environment (a “theatre in the square”) (Goldkamp, 1994a, 1994b;, Goldkamp et al., 2000; Hora et al., 1999). The courtroom environment differs in style in each of the settings studied, ranging from the full and busy meeting room with many consultations going on in Broward County, to the quieter and slower proceedings in King County, to the drug-court style of proceedings in San Bernardino. Each of the courtrooms shares in common the attempt to present a supportive environment in which participantsa, 19XTDpemence that, hey wec Beeciaknd

The tempo of proceedings differs markedly from other courts. The mental health court judge allows time for participants to speak; in some instances, defendants may ramble and get confused in addressing the court, sometimes causing proceedings to progress slowly. The style of the courtroom varies as well in the size and nature of the audience, often including people at various stages of treatment and processing who may be experiencing a variety of problems. The mental health court courtroom is intense, emotional and demanding of all staff, as problems are identified and solu-

each of the strategies is multiagency and systemwide support in both planning and operation. This is reflected in the planning task forces producing the recommendations for the mental health courts and in the collaboration required in the day-to-day operation of the court and the work of the court team. In Broward, the Public Defender's office, State Attorney's office, Broward County Sheriff's Office, community treatment providers, and the local hospital have supported the development and operation of the mental health court. In King County, the court operates with the support and cooperation of the Prosecuting Attorney's office, the Public Defender's office, the Probation Department, the King County Jail, and United Behavioral Health, which provides case management. In San Bernardino, participating agencies include the Department of Behavioral Health, the Public Defender's office, the District Attorney's office, the Probation Department, and private providers. In Anchorage, the court draws on the cooperation and support of the Department of Corrections, the Alaska Mental Health Trust Authority, the Municipal Prosecutor's office, the Public Defender's office, and treatment providers and is seeking to broaden its base of support and cooperation.

Differences in the Approaches of the Four Mental Health Courts

Although the four mental health courts we describe share common elements, they also differ in their adaptation of a problem-solving court model to their particular systems. These differences include the timing and method of resolving the underlying criminal charges, the responses to noncompliance by participants, and the effect of a defense request for a trial.

Stage of Intervention

As the first site to design a special court approach addressing the mentally ill and disabled in the criminal justice population, the Broward County Mental Health Court laid the groundwork for the efforts that followed. One of the features of the Broward court that none of the other sites chose to adopt was its pre-adjudicatory emphasis. Defendants who choose to enter the Broward program are not required to answer to their charges until their treatment is completed. Criminal charges are held in abeyance for a period of up to a year, while the participant's mental health needs are addressed. At the conclusion of the treatment period, the defendants' adjudication is often withheld, depending on the seriousness of the charges and their criminal histories. This approach was adopted in Broward County based upon a therapeutic rationale that the mental health court should be as nonthreatening and nonpenal as possible. In addition, the Broward model seeks to divert the mentally ill person from the formal adjudication process. Other jurisdictions adopted a conviction-based approach, partly because of prosecutorial preferences and partly because of constraints of criminal procedure.

Mental Health Court Versus Normal Trial: Second Chances?

In each of the jurisdictions, a candidate's participation in the mental health court is based on a voluntary decision. The courts differ in their policies regarding mentally ill defendants who decline to enter mental health court and choose to have their charges adjudicated instead of either entering treatment prior to adjudication or pleading guilty and being placed on probation in the mental health court. In King County, defendants must waive their rights to a trial in return for admission to the mental health court treatment process. Defendants who choose to go to trial and are then found guilty are not accepted back into the mental health court. None of the other sites has a strict policy against accepting individuals who have declined the program, chosen adjudication, been convicted and then requested admission to the mental health court. However, admission is far from ensured and is decided on a case-by-case basis. The San Bernardino, Anchorage and Seattle Mental Health Courts operate as sentencing courts, or at least as courts dealing with persons serving sentences but not as trial courts for practical and philosophical reasons. (They were seeking to concentrate resources on mental health treatment.) Thus, they may have little control over adjudication and sentencing in other courts, should candidates select the normal adjudication route.

Methods of Case Disposition

The four mental health court sites also differed in their methods of resolving the criminal charges. Successful participants in the Broward Mental Health Court may, as a result of withheld adjudication or an outright dismissal of charges with the consent of the prosecutor, have no conviction on their records. In King County, there is an increasing likelihood that charges will be resolved through deferred prosecution or deferred sentence, resulting in a dismissal of the charges upon successful program completion. In Anchorage, however, the requirement of a guilty plea (or of a nolo contendere plea) ensures that a conviction generally results, whether or not the participant is successful. Withheld adjudication or deferred prosecution dispositions are only rarely employed in this location. In San Bernardino, where a plea is also required, successful completion may result in withdrawal of the plea and dismissal of charges. Because many of the mentally ill or disabled persons who enter the mental health courts may have fairly extensive records of prior convictions, the question of whether or not a conviction is recorded for the current offense may be of little practical significance. Defense counsel, especially in King County, have expressed discomfort with the policy requiring conviction and suggested that the guilty plea requirement might serve as a disincentive to some eligible defendants wishing to enter treatment.

Use of Sanctions for Participant Noncompliance

The four mental health courts appear to differ as well in the way they respond to noncompliance by participants in the mental health treatment process. In designing its approach, each court has recognized the challenges associated with engaging and maintaining the target populations in the treatment process. Thus, while each court expects problems with compliance in its client population, they vary in the way they impose sanctions, a basic element of the drug court model adapted by each type of problem-solving court. Short of termination from the program (with the attendant legal consequences), one of the most severe sanctions is the imposition of jail confinement. The use of jail as a sanction seems least common in the Broward County Mental Health Court and the Anchorage Mental Health Court, and somewhat more likely in the King County Court. It is used most common in the San Bernardino Mental Health Court, which operates most closely to a drug court model.

This difference in the use of sanctions generally, and of jail in particular, is not explained mainly by judicial philosophy—which likely accounts for some differences—but may be linked instead to differences in the type of candidates admitted to the courts. For example, in contrast to its peer courts, the San Bernardino Mental Health Court focuses on felony defendants as well as misdemeanants and deals with serious substance abuse as a co-occurring disorder in most of its cases. Differences in target populations notwithstanding, officials interviewed in the King County and San Bernardino Mental Health Courts acknowledge that the threat of jail may serve as an important motivator for candidates considering whether to enter the mental health court and a useful tool for ensuring compliance among participants.

Emerging Issues

Early Identification of Mental Health Court Candidates

Problem-solving courts of different types share the need to identify their target population candidates as early in criminal processing as possible. The original drug court model was premised on the assumption that intervention with addicted offenders should occur shortly after arrest when individuals may be most open to the possibility to maximize the opportunity to begin treatment. In domestic violence courts, there is urgency to correctly assess the risks posed to victims and implement options for treating or otherwise dealing with the offenders before further harm can occur. To be effective, mental health courts share that critical need to identify mentally ill or disabled candidates at the earliest possible stages of processing to avoid the damaging experience of arrest and confinement, to intervene medically to stabilize offenders and then to situate them in an appropriate placement process.

Like the other types of courts, however, the mental health court model faces serious challenges in identifying appropriate candidates early through appropriate and effective screening and evaluation procedures. Collectively, the early mental health courts employ informal and formal methods for identifying possible candidates and assessing them in some depth before detouring them from the normal adjudication process. These methods may include informal referrals at arrest, arraignment or jail admission of persons appearing to suffer from mental illness or disabilities. They are followed by more in-depth clinical interviews at the jail or in court to assess the eligibility of defendants for the mental health court programs.

Fair, appropriate and effective screening procedures face three principal challenges: timeliness, accuracy, and confidentiality. Each of the courts has established procedures that identify mentally ill or disabled candidates as early as possible in the criminal process to maximize the opportunity to intervene and assist. The need to identify and assess the conditions of candidates quickly potentially conflicts with the need to conduct the thorough clinical assessment required for a reliable diagnosis on the basis of which processing in the mental health court can begin. To put it simply, it is hard to rush such an assessment and still have it be accurate and complete. This may be particularly true because of the difficulty associated with communicating with some mentally ill defendants.

Early intervention by the mental health court depends on timely and accurate information about the defendants' criminal justice and mental health backgrounds. However, the goal of early intervention and prompt treatment conflicts in part with the need for confidentiality and for consent by the defendants to share the mental health information with the court staff. Devising workable procedures that both enhance early intervention and enrollment of mentally ill offenders in the mental health courts and respect confidentiality pertaining to sensitive personal information represents one of the difficult challenges facing the mental health court approach.

Voluntariness

Some observers see special courts as vehicles for "coerced treatment," a term with favorable and unfavorable connotations. The favorable use of the term suggests that the judicial role and application of sanctions and rewards contribute a valuable tool for keeping participants in treatment and increasing the chances of successful outcomes (Anbullja(i23 a)Tj0 -1.1r coiotentially con

example, when substance abuse treatment professionals might stress tolerance for relapse and erratic performance (or a positive drug test) by drug abusers as part of the therapeutic process, criminal courts might normally be inclined to revoke conditional release (probation) and impose sanctions. While the criminal process may need to proceed expeditiously to adjudicate criminal charges, mental health professionals require sufficient time to diagnose the mentally ill defendant's condition, take immediate steps to stabilize the defendant and then to place the defendant in appropriate supportive services so that treatment could then proceed. From the perspective of mental health treatment, potentially the worst experience for many mentally ill persons would be arrest, jail and formal proceedings in the criminal court. In short, these conflicts in method, aims, values and style pose a particular challenge in the emerging mental health court initiatives to produce a hybrid model that attends to the basic requirements of each.

Defining Success

Favorable progress in the drug court treatment process is measured by completion of successive phases of treatment by participants on their way to graduation. In the drug court instance, requirements for graduation were clearly specified and typically included minimum periods of testing negatively for drugs of abuse, completion of all treatment activities, payment of fees, etc. Drug court participants therefore were able to chart their progress against clear expectations and rules for completion of the program. When applying this kind of framework of favorable progress to the mental health court approach, however, setting a standard for success in treatment is more complex.

Participants may suffer from a variety of symptoms and illnesses and, thus, lack a common starting point. The steps necessary to stabilize participants and to situate them in living situations that will maximize their effective functioning are likely to differ considerably from individual to individual. While a goal for substance abusers can clearly and measurably be abstinence within the timeframe of the drug court treatment program, such a practical framework is not so readily available in the treatment of mental illness. Courts cannot say, "be cured within 12 months." They can expect that participants successfully follow the steps to improved functioning outlined in a treatment plan agreed upon by the participant and the mental health participants. Thus, the challenge for setting achievable milestones for mental health court professionals is more complex and the functional equivalent of graduation may differ considerably from individual to individual.

Range of Responses to Participant Behavior/ Performance

To an observer of other problem-solving courts, particularly drug courts where some of the in-court techniques were first developed, the mental

health court model faces special challenges in devising responses to participant performance in treatment. One might argue that the experience of drug courts in the United States suggests that drug abusers respond well to a very structured system of incentives and sanctions when moving through the treatment process toward sobriety and improved functionality. These approaches are crafted based on assumptions about the behaviors of addicted persons, including a belief that very basic lessons and behaviors may have to be taught and retaught for substance abuse treatment to be successful. Many drug courts have devised a rich range of responses rewarding participants for forward progress through treatment stages (until graduation). When these elements of the drug court model are applied to the mentally ill and disabled in the criminal justice system, the translation of the "rewards and sanctions" approach to mental health courts raises some difficult challenges.

To promote progress through treatment, the drug court model rewards good behavior and discourages poor performance by participants through the use of various types of sanctions. It is apparent that, because of the nature of mental illness (as compared to substance abuse or domestic violence), judicial responses have to be more generally encouraging and supportive as the court process seeks to move mentally ill and disabled participants into treatment and supportive services. Thus, depending on a defendant's illness, the judge's repertoire may need to draw on a wider range of incentives and supportive responses to participant progress than other problem-solving courts.

The notion that mental health courts should also call upon sanctions for poor performance is more difficult. In some cases, it may be clinically appropriate to employ the kinds of sanctions employed by drug courts in responding to noncompliance in treatment, including returning participants to earlier and more restrictive treatment stages or, even, making use of jail in selective instances. In others types of cases, however, it may be questionable as to whether sanctions (based on assumptions of deterrence) are at all appropriate to produce the improved mental health outcomes desired. Real questions, therefore, are raised about how the coercive power of the courts can be channeled to promote the goals of mental health treatment. Can a court sanction a defendant who fails to take meciprsiribt sanctiso08s1.1891 TD(applied sanction a d

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premised on a working relationship as represented by the dedicated team approach that facilitates ongoing supervision and case management. Courts considering a mental health court approach face two important problems.

First, if it is true that the court system finds itself having to address the needs of the mentally ill population, it is at least partly because existing institutions and services in the community (at least outside of criminal justice) have failed to serve this population. There is some irony, then, in designing a program that uses the court to place mentally ill and disabled participants in those very systems. Secondly, if the rationale for making use of these existing services is that the mental health court creates a new, synergistic relationship that improves both the court and treatment approaches, then the actual availability of these services and the resources to support them becomes a critical concern. A mental health court approach with a large population of persons in need of treatment but few services available in the area may have great difficulty in delivering treatment. Moreover, even when services are available and enthusiastic about the court-based mental health treatment approach, effective identification of candidates in the criminal justice population risks placing a new and large demand on existing treatment resources.

Each of the mental health courts described in this report has identified a potentially large population of mentally ill and disabled defendants who are in need of mental health and treatment-related supportive services. Each has also found that treatment resources and funding are insufficient for the populations they are serving and plan to serve in the near future. When resources exist, they do not adequately provide the type or range of services the mentally ill and disabled persons in the criminal justice population require.

Mental Health Courts as a Community Justice Initiative

The mental health court strategy shares with prior problem-solving court undertakings the fact that a difficult problem has not been adequately dealt with through community institutions and services. Presumptively, effective community interventions could prevent the need to find and treat mentally ill citizens in the criminal justice system. The crime behaviors of the mentally ill range from nuisance and quality-of-life levels to more serious offenses that endanger themselves or others. Although there are a range of behaviors associated with the mentally ill and disabled, it is highly unlikely that they have gone unnoticed in the community until their encounters with the criminal justice system.

Because other community networks or institutions have not effectively treated and supported the mentally ill—due to the failure of community-based safety nets—they enter the justice system, usually involved in

minor, nuisance, and quality-of-life offenses. Often, by then, they have other serious problems—such as alcohol or other drug addiction, housing, employment and physical health problems—that also have not been addressed. In many instances, the mentally ill or disabled find themselves in criminal justice primarily because of their mental illness and their inability to connect with or stay in supportive community-based treatment services.

Like the other special court approaches, the mental health courts described in this report attempt to address the problems of their target populations on two levels:

- By dealing with their problems in the criminal justice system.
- By building linkages to community services and support structures that have for a variety of reasons failed to reach them prior to their criminal justice involvement.

Each of the mental health courts discussed has developed strategies for identifying mentally ill and disabled offenders at the earliest stages of processing, sometimes involving contacts from police officers at the arrest stage. Each jurisdiction has taken steps to implement early screening procedures to evaluate candidates for the court treatment process as soon as possible so that unnecessary delay, criminal justice processing, and jail confinement can be avoided. Each of the courts began with a primary focus on defendants entering the criminal process shortly after arrest and being

Mental health courts, in this regard, represent important court-based community justice initiatives. They are strengthening the effectiveness of community mental health treatment approaches by offering their close attention and supervision. They are returning mentally ill persons from custody and processing in the criminal justice system to the community to function there. They are encouraging community-based justice and health approaches that would prevent mentally ill and disabled individuals from entering the justice system in the first place. Thus, successful court strategies would ideally put themselves out of business: they would find far fewer mentally ill persons in criminal justice, because such persons would be more effectively and appropriately dealt with through improved community intervention, services and support mechanisms.

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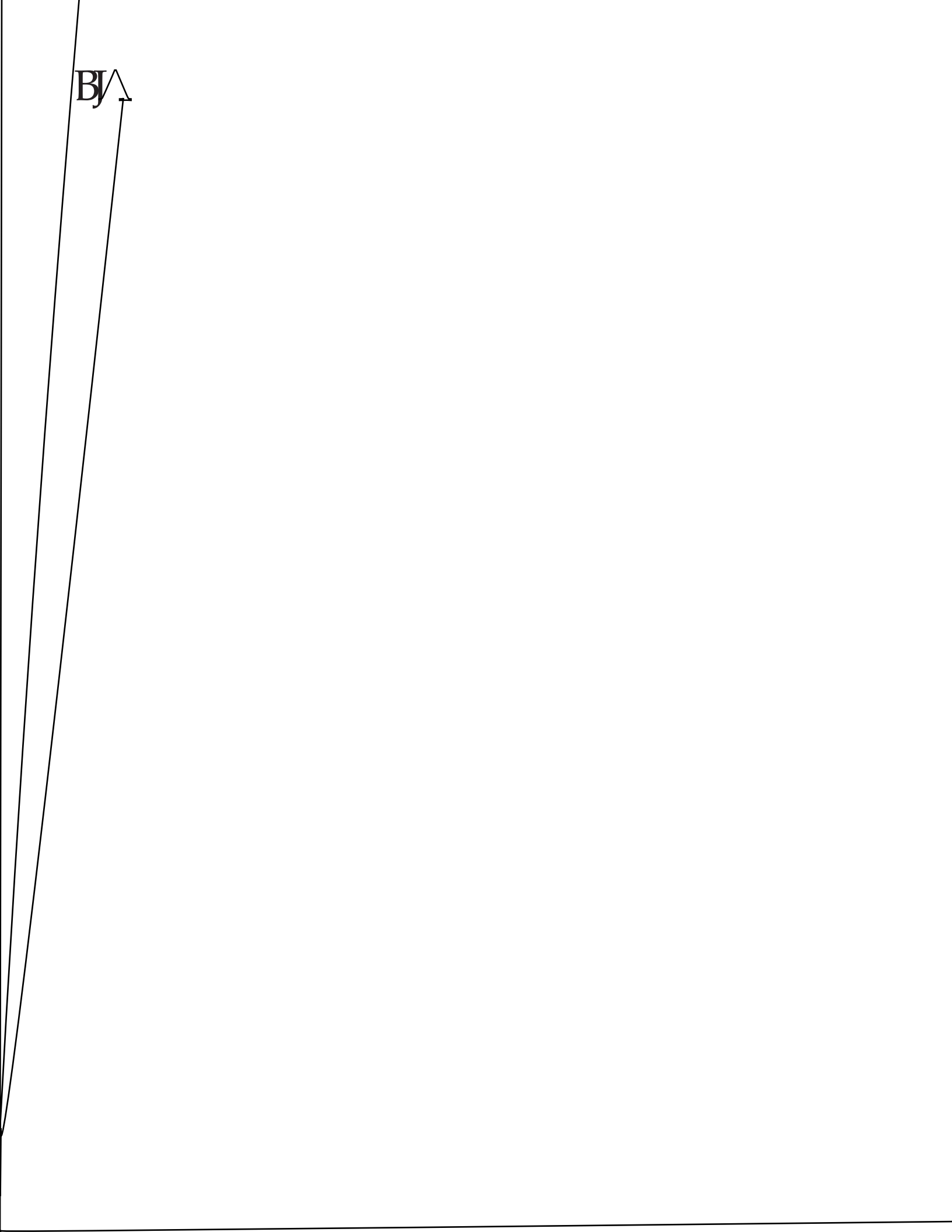
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