

Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders

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I. INTRODUCTION

In Florida, a mentally ill homeless man was arrested for shoplifting an ice cream sandwich that cost \$1.16. He was imprisoned because he lacked the \$25 bail necessary for release.¹ Laurie Flynn, Executive Director of the National Association for the Mentally Ill (NAMI) notes, "Prisons and jails have become the mental hospitals of the 1990s."² One observer states, "Our jails, whether we like it or not, are becoming our largest mental-health facilities."³ Another comments, "Most of the people I see [in jails] don't belong here. Many of these people would have been in a state hospital years ago."⁴ This Article advocates the creation of mental health specialty courts in

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1. See Bob LaMendola, *South Florida Hospital Aims to Break Crime Cycle of Mentally Ill Homeless*, SUN-SENTINEL (Ft. Lauderdale), Nov. 24, 1998, at B3.

2. *Mentally Ill Need More Than Cells: Jails and Prisons are Ill-Equipped to Help Disturbed Inmates*, DAYTON DAILY NEWS, July 18, 1999, at 12B.

3. Aimee Howd, *Trapped Between Law and Madness*, 14 INSIGHT MAG., Sept. 14, 1998, available in 1998 WL 9105794 (noting that while Washington D.C.'s law enforcement has an operative jail service program for mentally ill patients, once jail inmates are released, there is no adequate system for ensuring continuation of needed medication). See also Henry J. Steadman, *Diversion of Mentally Ill Persons from Jails to Community-Based Services: A Profile of Programs*, 85 AM. J. PUB. HEALTH 163 (1995) ("[I]t is clear that there are far fewer public sector mental health beds available across the United States and that there are large numbers of persons with mental illnesses in US [sic] jails who require appropriate treatment.").

4. Jacqueline Marino, *Warped Justice: Jails Have Become Our New Mental Hospitals*, CLEV. SCENE, Aug. 12, 1999, at 1.

order to divert mentally ill offenders from the criminal justice system (i.e., prisons, jails) into treatment, consistent with the principles of therapeutic jurisprudence.

Mentally ill offenders are often inextricably trapped in a “revolving door” of petty crime, incarceration, release, homelessness, and reimprisonment.⁵ NAMI reports “at least seven percent of all jail inmates and 14 percent of all prison inmates suffer from schizophrenia, bipolar disorder, or major depression. On any given day, there are roughly 210,000 persons with severe mental illnesses incarcerated in federal and state jails and prisons.”⁶ Furthermore, about 40–50% of the estimated two million homeless Americans—often an “invisible” and abandoned element of society—are severely mentally disordered.⁷ In contrast, only one-fourth of the nation’s mentally ill

5. David Fleshler, *Jenne: Treat the Mentally Ill, Don't Jail Them*, SUN-SENTINEL (Ft. Lauderdale), Jan. 30, 1998, at 1B, available in 1998 WL 242972. See also *Good Morning America: Efforts to Keep the Nonviolent Mentally Ill Out of Jail* (ABC television broadcast, Jan. 26, 2000) [hereinafter *Good Morning America I*]. Mrs. Raphael is the mother of Jamie DiMarco, a schizophrenic patient who “has been in and out of prison for the last 25 years,” and “shuttled from doctors to judges to jails and back again for nonviolent crimes like trespassing and disturbing the peace.” *Id.* She says “[Jamie’s] life has been so terrible and tormented that at times he must feel like dying. . . . When they release you back on the street, you’re again homeless, and without treatment.” *Id.* See also Leona L. Bachrach, *What We Know About Homelessness Among Mentally Ill Persons: An Analytical Review and Commentary*, in *TREATING THE HOMELESS MENTALLY ILL: A REPORT OF THE TASK FORCE ON THE HOMELESS MENTALLY ILL 11* (H. Richard Lamb ed., 1992). Bachrach quotes an anonymous chronic mentally ill woman who states,

Someone who has been on the streets and is homeless and jobless and who has a disability, who doesn’t have a car or food or a friend, and doesn’t know what to do about the situation, is in pain. . . . If you talk to people who have been there, they will tell you they were alone and afraid. So afraid that help doesn’t look like help, but like more torture.

Id.

6. National Alliance for the Mentally Ill (NAMI), *The Criminalization of People with Mental Illness—NAMI’s Position* (visited Oct. 15, 2000) <<http://www.nami.org/update/unitedcriminal.html>> [hereinafter NAMI, *Criminalization of Mentally Ill*].

7. See National Coalition for the Homeless, *NCH Fact Sheet #2: How Many People Experience Homelessness?* (last modified Feb. 1, 1999) <<http://nch.ari.net/numbers.html>>. In 1999, the National Law Center on Homelessness and Poverty noted that “over 700,000 people [are] homeless on any given night, and up to 2 million people . . . experience homelessness during one year.” *Id.* (citation omitted). The Clinton Administration’s Priority Home! The Federal Plan to Break the Cycle of Homelessness estimated that a median of 7 million homeless Americans existed in the U.S. from 1985–1990. *Id.* This figure is based on Dr. Bruce Link’s 1990 national telephone survey. *Id.* Dr. Link’s subsequent 5-year survey enumerated that 12 million adults had experienced homelessness at some point in their lives. *Id.* The widely varying estimates in the number of homeless Americans can be explained by differences in both the methodology used and the populations measured. *Id.* See also H. Richard Lamb, *Involuntary Treatment for the Homeless Mentally Ill*, 4 NOTRE DAME J.L. ETHICS & PUB. POL’Y 269, 277 (1989) (observing that “the estimates of the seriously mentally ill in the urban homeless population range from 25 to 50 percent, and that the true percentage is most likely in the upper end of that range.”). See generally *TREATING THE HOMELESS MENTALLY ILL* (H. Richard Lamb ed.,

(about 70,000 persons) currently reside in public psychiatric hospitals.⁸

Thus, crowded jails and prisons are often utilized by society as “surrogate mental hospitals” to house nonviolent mentally ill offenders and the distraught homeless population, often convicted of nuisance crimes such as “urinating in alleys, sleeping at airports, [or] harassing people in front of convenience stores.”⁹ Ostensibly, this situation is the result of a backlash created by nationwide attempts to remove mental patients from institutionalization.¹⁰ More insidiously, Reagan Administration cutbacks resulting in loss of Supplemental Social Security Income benefits have contributed to the homelessness dilemma, indirectly leading to the increased criminalization of the mentally ill.¹¹ Jails have been criticized as being called “high-expense

1992); Bruce Link et al., *Life-Time and Five-Year Prevalence of Homelessness in the United States*, AM. J. PUB. HEALTH, Dec. 1994; Bruce Link et al., *Life-Time and Five-Year Prevalence of Homelessness in the United States: New Evidence on an Old Debate*, 65 AM. J. ORTHOPSYCHIATRY 347-54 (1995); Felicity Barringer, *U.S. Homelessness Is Far Below Estimates*, N.Y. TIMES, Apr. 12, 1991, at A11 (noting underestimates of homelessness because of difficulties in enumerating this population); *Wrong Answer*, L.A. TIMES, Dec. 4, 1987, at 6.

8. Kim Barker, *New Court Tries Prevention*, SEATTLE TIMES, Feb. 21, 1999, at B1, available in 1999 WL 6258310 (Ron Honberg, NAMI Legal Affairs Director, commenting on the plight of the mentally ill offender).

9. *Id.* (observing that mentally ill offenders frequently leave jail without treatment). See also John Monahan, *The Scientific Status of Research on Clinical and Actuarial Predictions of Violence*, in MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY § 7-2.2.2 at 315 (D. Faigman ed. 1997); MICHAEL L. PERLIN, THE HIDDEN PREJUDICE 40 (2000) (noting “[n]inety percent of persons with mental disabilities are not violent.”); John Monahan, *Mental Disorder and Violent Behavior: Perceptions on Evidence*, 47 AM. PSYCHOL. 511, 519 (1992) (“Clearly, mental health status makes at best a trivial contribution to the overall level of violence in society.”); Jeffrey Swanson et al., *Violence and Psychiatric Disorders in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761 (1990); E. Fuller Torrey, *Editorial: Jails and Prisons—America’s New Mental Hospitals*, 85 AM. J. PUB. HEALTH 1611 (1995); NAMI, *Criminalization of Mentally Ill*, *supra* note 6, at 2.

10. Marino, *supra* note 4, at 1. See also Torrey, *supra* note 9, at 12-13. E. Fuller Torrey observed,

Deinstitutionalization of seriously mentally ill individuals has been the largest failed social experiment in twentieth-century America. It has failed not because the vast majority of released individuals cannot live in the community, but because we did not ensure that they receive the medications and aftercare that they need to do so successfully. The fact that we need jail diversion programs for these individuals is yet one more reminder of how badly we have failed them.

Id.

11. MICHAEL L. PERLIN, LAW AND MENTAL DISABILITY 390 (1994) (noting that the Reagan Administration cutbacks “resulted in over 350,000 people losing their [SSI] benefits since the fall of 1981” and stating that “there is no question that the reduction of disability benefits was a significant factor in the increase in the number of homeless persons.”). See also Harold E. Shabo, *Proposals for Working Group Regarding Adult Offenders with Mental Illness 1* (Jan. 1, 2000) (unpublished manuscript). Judge Shabo noted,

Upon discharge [from incarceration], individuals with mental illness are released gen-

facilities that deal with . . . social problems." The Bazelon Center for Mental Health Law states that "[b]etween 600,000 and one million men and women jailed each year have a mental illness[,] many [are] arrested for nonviolent misdemeanors or 'crimes of survival,' such as stealing food or trespassing[,] . . . [or] in 'mercy arrests' by police officers who find the public mental health system unresponsive and the process of accessing its emergency services cumbersome."¹² Similarly, one California county jail reported 250,000 new bookings and the service of 21 million meals each year because local government was purportedly "overwhelmed with [the] unmet needs of the poor and mentally ill."¹³ Senator Mike DeWine maintains, "Law enforcement agencies and correctional facilities simply do not have the means, or the expertise, to properly treat mentally ill inmates."¹⁴ The National Council on Disability (NCD), a federal agency authorized by Congress and the President, emphasizes that "the manner in which American society treats people with psychiatric disabilities constitutes a national emergency and a national disgrace."¹⁵

The United States Bureau of Justice reported that the nationwide cost of housing a prisoner in a state correctional facility is about \$20,100 per year, or about \$55 a day.¹⁶ Similarly, the cost of incar-

erally without any appropriate linkage to mental health care in the community, income supports such as SSI, and provisions for basic needs. Under these circumstances, recidivism, violation of conditions of release (probation or parole), and lack of consistent, effective mental health treatment in the community make return to jail and prison virtually inevitable.

Id. The National Working Group on Adult Offenders with Mental Health Needs is an organization comprised of legislators, judges, corrections administrators, mental health service directors, victim advocates, prosecutors, public defenders, law enforcement, jail administrators, public policy experts, and academic policy experts.

12. Judge David L. Bazelon Center for Mental Health Law, *Civil Rights and Human Dignity 1998-1999 Annual Report* 6 (Jan. 2000) <<http://www.bazelon.org/bazanrpt.pdf>> ("[I]ncarceration is not cost effective or just or humane for [mentally ill] people who have committed minor offenses essentially associated with systemic neglect. By definition, a penal institution is a non-therapeutic environment.")

13. Bill Boyarsky, *Budget Hearings Shift Emphasis to Plight of Homeless Mentally Ill*, L.A. TIMES, June 12, 1986, at 1 (quoting Los Angeles Sheriff Block's comments on crowded, expensive jails).

14. Mike DeWine, *Treatment for Mentally Ill Inmates*, Congressional Press Releases (Federal Document Clearing House), Oct. 20, 1999, at 1.

15. Judge David L. Bazelon Center for Mental Health Law, *The National Council on Disability Releases Report on People with Psychiatric Disabilities* 2 (posted Feb. 7, 2000) <<http://www.bazelon.org/interest.html#NCD%20report>>. The executive summary of the NCD report notes that drastic changes in the "mental health system, . . . criminal and civil justice systems, housing, income supports, education, job training and many others . . . [are needed] so that people with psychiatric disabilities are guaranteed their fundamental right as American citizens."
Id.

16. James J. Stephan, *Bureau of Justice Statistics, State Prison Expenditures 1996* (visited Aug. 25, 1999) <<http://www.ojp.usdoj.gov/bjs/pub/ascii/spe96.txt>> (reporting 1996 statistical

ceration for federal inmates is estimated at \$23,500 per year.¹⁷ These per capita expenditures rapidly approach astronomical figures: In 1996, annual state and federal prison expenditures were \$22 billion and \$2.5 billion respectively.¹⁸ Regarding the composition of prisoners in correctional facilities, a 1999 United States Department of Justice statistical report revealed that “[a]bout 10% of prison and jail inmates reported a mental or emotional condition”; this number amounts to about a quarter of a million inmates nationwide.¹⁹ Some view incarceration of the mentally ill as a societal injustice. Judges presiding over hearings involving misdemeanors committed by mentally ill defendants state that “[t]hese inmates should be in treatment, not in and out of jail.”²⁰

Furthermore, the impact of imprisonment on the personal lives of the disenfranchised, politically powerless, and often “invisible” mentally disordered offenders may be devastating.²¹ NAMI notes that correctional facilities are ill-equipped to provide adequate mental health care to mentally ill inmates with severe psychiatric illnesses.²² Mentally ill inmates are frequently punished, physically restrained, or secluded in isolation cells because of the correctional staff’s lack of understanding regarding the nature of mental illness. Such prisoners lack access to expensive, state-of-the-art medications and are not provided with rehabilitative services to facilitate their transition back to the community.

This Article explores the establishment of mental health courts as a partial solution to the perplexing societal problem that relegates mentally ill offenders to a “revolving door” existence in and out of prisons and jails.²³ This inescapable situation results from a paucity of

survey results).

17. *Id.*

18. *Id.*

19. Paula M. Ditton, *U.S. Department of Justice Bureau of Justice Statistics, Mental Health and Treatment of Inmates and Probationers*, 1-2 (last modified July 11, 1999) <<http://www.ojp.usdoj.gov/bjs/pub/ascii/mhtip.txt>> (noting about 280,000 prison and jail inmates are mentally ill; convicted criminals with histories of mental health treatment comprise 16% of the prison population, about double the rate of mental illness in the general population); Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000) (stating that these Department of Justice statistics are probably gross underestimates of the number of mentally ill offenders because such figures are primarily based on self-reports of mental illness by clients).

20. *Therapy Instead of Jail*, PALM BEACH POST, Apr. 19, 1999, at 18A.

21. See PERLIN, *supra* note 9, at 40. Professor Perlin comments, “People with mental disabilities have largely been invisible and without political power. Hidden for decades in large, remote institutions, their ‘stories’ have never been incorporated into our social fabric or consciousness.” *Id.* (footnotes omitted).

22. NAMI, *Criminalization of Mentally Ill*, *supra* note 6, at 2.

23. MONAHAN, *supra* note 9, at 315 (“None of the data give any support to the sensationalized caricature of the mentally disordered served up the by media, the shunning of former

effective humanitarian policies, laws, and procedures for treating such medically disordered defendants. The establishment of mental health specialty courts is investigated as a potential means of addressing the complex legal issues and psycho-sociological problems faced by the judicial system in dealing with mentally ill offenders.

Part II of this Article discusses basic principles of therapeutic jurisprudence and preventative law: two critical concepts applicable to just adjudication of cases involving mental health law. Part III briefly chronicles the historical currents of underlying policies and the general public's misguided, stereotypical attitudes, which have engendered laws unfavorable to the just treatment of mentally ill offenders. Part IV examines the successes of state and federal specialty courts in focusing upon and resolving unique problems similar to those faced in cases involving mental health issues. Two types of state specialty courts—drug and family courts—will be examined as examples of workable models from which to construct a corresponding mental health specialty court system.

Part V advocates the establishment of mental health specialty courts, discussing the following major topics: the general need for such specialized state courts; the effectiveness of court reform; the unique qualifications and role of the mental health court (MHCT) judge; the promotion of a cooperative, nonadversarial justice system within MHCTs; a mentally ill defendant's initial exposure to court hearings, with interactions with defense and prosecution attorneys, psychiatric medical experts, and other staff; the establishment of a treatment plan with objectives for a "client's"²⁴ rehabilitation back to the social community; and contingency plan management for potential relapses among clients.

Part VI presents a proscriptive MHCT action plan to enable states, courts, hospitals, correctional facilities, national support organizations, community service organizations, and others to reduce societal

patients by employers and neighbors in the community, or 'lock 'em all up' laws proposed by politicians pandering to public fears.").

24. Mentally ill defendants are sometimes referred to generically as "clients" by legal and medical staff. While courts traditionally address mentally disordered inmates as "defendants," the term "client" might be preferable in some contexts because it emphasizes a therapeutic focus on diagnosing and treating the underlying mental illness. Similarly, Protection & Advocacy defense attorneys, patients' rights advocates, and the Department of Justice express a preference for the less stigmatizing phrase "persons or individuals with mental disabilities." While the Author prefers this denotative phrase, until this cumbersome terminology becomes widely promulgated in American society and its statutes, the more commonly utilized terms "mentally ill" or "mentally disordered" "defendant" or "offender" will be used for convenience herein, notwithstanding some unavoidable negative connotations. See JESSE DUKEMINIER & STANLEY M. JOHANSON, *WILLS, TRUSTS, AND ESTATES* 38 (2000) (noting that Jeremy Bentham observed, "Error is never so difficult to be destroyed as when it has its root in language.").

costs through the treatment and rehabilitation of mentally ill offenders. This action plan includes the following: projected financial savings to the community resulting from implementation of specialized MHCTs; the predicted impact of MHCTs in reducing criminal recidivism rates; the visible role of MHCT judges in the news media as advocates of treatment of mental illness as a disease; support for concomitant passage of laws promoting treatment and rehabilitation of mentally ill offenders back into productive society; and model legislation for the establishment of pilot state mental health courts (see Appendix A). Current Congressional and state proposed legislation is discussed, including the recently enacted progressive law for a federal mental health diversionary court program entitled "America's Law Enforcement and Mental Health Project," codifying Congressional companion bills H.R. 2594 and S. 1865.²⁵

Finally, Part VII concludes with a return to the fundamental therapeutic jurisprudence and preventative law principles underlying the advocacy of the establishment of state mental health courts.

II. THE CONCEPT OF THERAPEUTIC JURISPRUDENCE AND PREVENTATIVE LAW AS APPLIED TO MENTAL HEALTH LAW

Professor David B. Wexler has been a pioneer in promoting the general concept of therapeutic jurisprudence—a theoretical framework that is invaluable in the analysis of society's role in the adjudication and treatment of mentally ill offenders. Therapeutic jurisprudence probes the role of the law itself as a social and economic force in producing both beneficial "therapeutic" and detrimental "antitherapeutic" effects upon individuals such as those with mental disabilities; these effects result from the application of laws, rules, and procedures upon societal institutions such as courts, correctional institutions, and treatment facilities.²⁶

25. See H.R. 2594, 106th Cong. § 1 (1999) (bill establishing mental health courts); S. 1865, 106th Cong. (1999) (noting companion bills to provide grants to create twenty-five state experimental mental health courts).

26. David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, in *ESSAYS IN THERAPEUTIC JURISPRUDENCE* 3, 8 (David B. Wexler & Bruce J. Winick eds., 1991). Wexler states:

Therapeutic justice is the study of the role of the law as a therapeutic agent. It looks at the law as a social force that, like it or not, may produce therapeutic or antitherapeutic consequences. Such consequences may flow from substantive rules, legal procedures, or from the behavior of legal actors (lawyers or judges). The task of therapeutic jurisprudence is to identify—and ultimately to examine empirically—relationships between legal arrangements and therapeutic outcomes. The research task is a cooperative and thoroughly interdisciplinary one. . . . Such research should then usefully inform policy determinations regarding law reform.

Id. See also David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 *PSYCHOL.*

The theory of therapeutic jurisprudence maintains that the law asserts beneficial therapeutic or detrimental antitherapeutic psychological or other consequences upon individuals²⁷ that are often minimized by the legal community.²⁸ Concerned judges, attorneys, law enforcement personnel, hospital administrators, and members of the psychiatric or medical community possess a humanitarian responsibility to fully analyze and comprehend potential therapeutic and antitherapeutic consequences of the law.²⁹ These various decision-makers—knowingly or not—participate in molding the application of legal rules and procedures to make such rules either more beneficial or more detrimental to the treatment of the individuals impacted.³⁰

Closely related to therapeutic jurisprudence is the concept of preventative law.³¹ Advocates of preventative law support the objective of obtaining just resolution of cases through nonadversarial means. Proponents of both preventative law and therapeutic jurisprudence note that a reliance upon the American adversarial system for justice may sometimes yield unsatisfactory results.³² Our contentious culture often promulgates an attitude that "litigation is war." Critics observe that "the American legal system is a prime example of trying to solve problems by pitting two sides against each other and letting them slug it out in public."³³ Commentators denigrate the "psychological brutality of the adversary system,"³⁴ leading advocates of preventative law to maintain that attorneys and judges possess the opportunity to make major societal contributions by preventing or circumventing costly, acrimonious litigation³⁵ that often upsets the

PUB. POL'Y & L. 220 (1995).

27. See generally David B. Wexler & Bruce J. Winick, *Introduction to LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* at xvii (David B. Wexler & Bruce J. Winick eds., 1996).

28. See Stephen H. Behnke & Elyn R. Saks, *Therapeutic Jurisprudence: Informed Consent as a Clinical Indication for the Chronically Suicidal Patient with Borderline Personality Disorder*, 31 LOY. L.A. L. REV. 945, 978 (1998).

29. Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, in *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* 646 (David B. Wexler & Bruce J. Winick eds., 1996).

30. See Dennis P. Stolle et al., *Integrating Preventative Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering*, 34 CAL. W. L. REV. 15, 33, 37 (1997). See also David B. Wexler, *Applying the Law Therapeutically*, 5 APPLIED & PREVENTATIVE PSYCHOL. 179 (1996).

31. See Dennis P. Stolle, *Professional Responsibility in Elder Law: A Synthesis of Preventative Law and Therapeutic Jurisprudence*, 14 BEHAV. SCI. & L. 459, 469 (1996).

32. See Stolle et al., *supra* note 30, at 36.

33. DEBORAH TANNEN, *THE ARGUMENT CULTURE: MOVING FROM DEBATE TO DIALOGUE* 131 (1998).

34. Ellen A. Waldman, *The Evaluative-Facilitative Debate in Mediation: Applying the Lens of Therapeutic Jurisprudence*, 82 MARQ. L. REV. 155, 160 (1998).

35. See, e.g., LOUIS M. BROWN, *LAWYERING THROUGH LIFE: THE ORIGIN OF PRE-*

defendant's psyche, depletes financial resources, and prolongs judicial resolution of matters.³⁶ Courts and legislatures considering a preventative law approach toward mentally ill defendants might consider the creation of a less adversarial and more supportive system of justice.

Supporters of both therapeutic jurisprudence and preventative law recognize a common objective in promoting the psychological health of clients involved in the legal process, thereby minimizing the detrimental effects of the law.³⁷ Dennis Stolle suggests, "If more than one legal tool is available to achieve the [client's] intent, the role of the integrated framework is to choose the most therapeutic, or, at minimum, the least antitherapeutic alternative."³⁸ Lawyers, whether in private practice or public service, have the unique opportunity to become "helping professionals," preserving the psychological well-being of clients in a manner consistent with notions of fairness and justice.³⁹ Rather than giving attorneys, judges, and other legal actors a novel role, therapeutic jurisprudence and preventative law provide "merely a sharper conceptualization of and focus on work that a number of us . . . had been engaged in earlier."⁴⁰ Since existing ethics codes of professional responsibility for attorneys and judges lack a specifically defined role in the representation of mentally ill clients, this "sharpened focus" of legal professionals necessarily fills a gap in the law.⁴¹

VENTATIVE LAW (1986). *But see, e.g.*, John Scott Hoff, *Attorneys as Warriors*, DEC NEBRASKA LAWYER 16 (1998) (noting nonadversarial approaches may contradict an attorney's education, personality, or financial interests).

36. See Edward D. Re, *The Lawyer as Counselor and the Prevention of Litigation*, 31 CATH. U. L. REV. 685, 695 (1982).

37. See Dennis P. Stolle & David B. Wexler, *Therapeutic Jurisprudence and Preventative Law: A Combined Concentration to Invigorate the Everyday Practice of Law*, 39 ARIZ. L. REV. 25, 27 (1997).

38. Stolle et al., *supra* note 30, at 24.

39. See Scott E. Isaacson, *Preventative Law: A Personal Essay*, UTAH B. J., Oct. 1996, at 14, 17. See also Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL. PUB. POL'Y & L. 193 (1995). Judge Re comments,

A good lawyer must be more than a passionate advocate for a specific client and must consider more than merely the specific case or issue presented. In the role of counselor, whose goal is the prevention of litigation and the settlement of disputes, lawyers fulfill their classic role as healers and peacemakers rather than promoters of litigation and strife.

Stolle & Wexler, *supra* note 37, at 33 n.12 (citing Edward D. Re, *The Causes of Popular Dissatisfaction with the Legal Profession*, 68 ST. JOHN'S L. REV. 85, 116 (1994)).

40. David B. Wexler & Bruce J. Winick, *Professionals, and the Path of Therapeutic Jurisprudence: A Response to Petrila*, 10 N.Y.L. SCH. J. HUM. RTS. 907, 909 n.9 (1993), reprinted in *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* 707 (David B. Wexler & Bruce J. Winick eds., 1996).

41. Janet B. Abisch, *Mediational Lawyering in the Civil Commitment Context: A Therapeutic Jurisprudence Solution to the Counsel Role Dilemma*, 1 PSYCHOL. PUB. POL'Y & L. 120, 138-39

Applying therapeutic jurisprudence principles to legal practice concerning the mentally ill, research by the MacArthur Network on Mental Health and the Law revealed that patient perceptions of coercion in the mental hospital admission process (e.g., in civil commitment) were highly correlated with patient views of provided procedural justice.⁴² A significant finding of the MacArthur study was that clients who are given baseline procedural justice in civil commitment proceedings feel an absence of coercion if judges, attorneys, clinicians, law enforcement, and ancillary staff are perceived as having benevolent intentions, treating clients with dignity, compassion, fairness, and respect.⁴³ Sometimes seemingly inconsequential courtroom conduct, such as a judge's permission to permit a patient to appear in the courtroom in business dress rather than in a hospital gown or prison garb, may prove significant in preserving a client's dignity, which correspondingly may impact treatment outcome.⁴⁴ The MacArthur study validates principles of cognitive and social psychology that indicate that choice and coercion have diametrically opposed consequences.⁴⁵ Research suggests that mentally ill offenders who freely choose to obtain treatment, rather than being forced into treatment against their will, may be more committed to treatment objectives, thus benefiting more consistently from it.⁴⁶ Thus, thera-

(1995). *But see Thoughts from the Peer/Self Advocacy Unit*, 68 PROTECTION & ADVOCACY, INC. NEWSLETTER, Summer 1999, at 13. Clients have formed self-advocacy units in reaction to perceived deficiencies of the legal system. *Id.* For example, clients at Protection & Advocacy run the Peer/Self Advocacy Unit, started in 1989. *Id.* Another client-run advocacy program is the California Network of Mental Health Clients, founded in 1986. *Id.* Client advocates "speak in favor of a cause" in asserting their own legal mental health rights. *Id.*

42. *See generally* Nancy S. Bennet et al., *Inclusion, Motivation, and Good Faith: The Morality of Coercion in Mental Hospital Admission*, 11 BEHAV. SCI. & L. 295 (1993); Kirk Heibrun & Gretchen White, *The MacArthur Risk Assessment Study: Implications for Practice, Research, and Policy*, 82 MARQ. L. REV. 733 (1999); Steven K. Hoge et al., *Perceptions of Coercion in the Admission of Voluntary and Involuntary Psychiatric Patients*, 20 INT'L J. L. & PSYCHIATRY 167 (1997).

43. *See generally* Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433 (1992). *But see* Ronald Diamond, *Coercion in the Community: Issues for Mature Treatment Systems*, NEW DIRECTIONS FOR MENT. HEALTH SERVICES, Summer 1995, at 3, 16 (noting that community-based mental health systems may employ coercive tactics to control "the client's money, influence access to housing, or use contact with family or probation officers to increase adherence to treatment regimens").

44. *Id.* *See also* Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMPORARY LEGAL ISSUES 37, 42 (1999) (noting "[c]ivil commitment proceedings are often extremely informal, sometimes occurring in courtrooms set up at the hospital in which patients appear in hospital garb rather than street clothes," possibly resulting in devaluation of the clients' rights).

45. *See generally* Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis*, 17 INT'L J. L. & PSYCHIATRY 99 (1994).

46. Alexander Greer et al., *Therapeutic Jurisprudence and Patients' Perceptions of Procedural*

peutic jurisprudence and preventative law principles may provide a constructive contextual framework in which to implement the formation of specialized mental health courts. Within this theoretical structure, judges, attorneys, medical experts, hospital administrators, law enforcement personnel, and other legal system participants necessarily focus upon the maximization of the therapeutic consequences upon individuals through application of substantive and procedural rules.

III. HISTORICAL BACKGROUND SURROUNDING POLICY AND LAWS AFFECTING THE MENTALLY ILL

A. *The Case of Miss Louisa Nottidge*

In 1849, the Lord Chief Baron of the Court of the Exchequer and a special jury heard the case of *Nottidge v. Ripley*.⁴⁷ Miss Louisa Nottidge's trial has since been immortalized as a harbinger of change in legal policies concerning the mentally ill.⁴⁸ In this case, the judge awarded Louisa fifty pounds and court costs against two of her family members for wrongfully imprisoning her in an insane asylum.⁴⁹ At trial, it was revealed that, upon her father's death, Louisa and her spinster sisters became captivated with an amoral religious cult led by a man named "Prince."⁵⁰ The four women moved to the remote "Abode of Love" country house location of Prince's Lampeter Brethren religious cult. Three of the sisters lost their worldly possessions in marriages to penniless men of the sect.⁵¹ Louisa lived for six weeks in the cult, "dazzled by its luxury, charmed with its games and pastimes, and sustained by glorious assurances of judgment being past, and heaven to come."⁵²

Due Process of Civil Commitment Hearings, in *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* 923, 930 (David B. Wexler & Bruce J. Winick eds., 1996). Greer's study notes that angry, sad, displeased, or confused patients who feel "coerced by the [civil commitment] process . . . may [adversely] affect the course and conduct of their treatment in the hospital." *Id.* However, further scientific investigation is necessary to determine if these general principles also apply to clients with severe mental illness.

47. Andrew Scull, *The Theory and Practice of Civil Commitment*, 82 MICH. L. REV. 793, 793 (1984) (citing *TIMES* (London), June 25, 1849, at 7, col. 4; *TIMES* (London), June 26, 1849, at 7, col. 2; *TIMES* (London), June 27, 1849, at 7, col. 4).

48. See generally *id.* (reviewing *THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW* (Carol A.B. Warren ed., 1982), and recounting the calamitous story of Louisa Nottidge).

49. *Id.* at 793 (citing *TIMES* (London), June 30, 1849, at 5, col. 1).

50. *Id.*

51. *Id.* at 794 (citing *TIMES* (London), June 30, 1849, at 5, col. 1).

52. JOHN CONOLLY, *A REMONSTRANCE WITH THE LORD CHIEF BARON, TOUCHING THE CASE OF NOTTIDGE V. RIPLEY* 16 (1849).

Louisa's mother was shocked and appalled by her daughter's life of degradation and debauchery, and she sent Louisa's brother and brother-in-law to rescue Louisa from a life of sin. The two men physically dragged her from the house, screaming and struggling.⁵³ Louisa's family then recruited medical doctors to deem her mentally delusional and insane simply because of her immoral and financially irresponsible lifestyle. Louisa was then committed to Dr. Stillwell's madhouse, where she was confined for over a year. In the insane asylum, Louisa's delusions continued with thoughts that Prince was "God manifest in the flesh" and that she was immortal and would soon be "taken up to heaven in the twinkling of an eye." She was diagnosed as a religious fanatic. Still under the cult's influence, upon one brief escape from the asylum, Louisa returned to the "Abode of Love," transferring all her life savings to Prince.⁵⁴

While medical experts testified that Louisa was insane and should be recommitted to a mental institution, the sage Lord Chief Baron disagreed.⁵⁵ In a key victory for mental health patients, the judge radically instructed the jury, "It is my opinion that you ought to liberate every person who is not dangerous to himself or others . . . and I desire to impress that opinion with as much force as I can."⁵⁶ The *London Times* newspaper noted the court's explicit underlying policy: "We must not stretch a harmless hallucination into legal insanity. . . . The shades and gradations of error and folly are so insensibly blended that we could not incarcerate and coerce such [a] . . . one without danger to others."⁵⁷ Thus, public awareness was brought to the plight of sane persons who were, like Louisa Nottidge, improperly committed to the madhouses of the nineteenth century.⁵⁸

John Conolly, renowned psychiatric commentator of his time, noted:

If the liberty of an insane person is inconsistent with the safety of his property or the property of others; or with his preservation from disgraceful scenes and exposures; or with the tranquility of his family, or his neighbors, or society;—if his sensuality, his disregard of cleanliness and decency, make him offensive in private and public, dishonoring and injuring his children and his name;—if his excessive eccentricity or extreme feebleness of

53. *Id.*

54. *Id.*

55. *Id.*

56. Scull, *supra* note 47, at 794 (citing *TIMES* (London), June 27, 1849, at 7, col. 4).

57. *Id.* at 794 (citing *TIMES* (London), June 30, 1849, at 5, col. 1).

58. See John McCandless, *Liberty and Lunacy: The Victorians and Wrongful Commitment*, in *MADHOUSES AND MADMEN* 339 (A. Scull ed., 1981).

mind subject him to continual imposition, and to ridicule, abuse, and persecution in the streets, and to frequent accidents at home and abroad;—his protection and that of society demands that he should be kept in a quiet and secluded residence, guarded by watchful attendants and not exposed to the public.⁵⁹

Conolly maintained that some men and women, lacking societal homeostatic mechanisms keeping them in conformity with the orderly day-to-day workings of society, should be sequestered from society.⁶⁰ Accordingly, out-of-control persons who exhibit public explosions of anger, lack of personal hygiene, drunkenness, or other conduct disruptive to the smooth functioning of society should be placed in protective treatment facilities.⁶¹ Conolly advocated sequestering these individuals commenting, "People of this kind may not endanger their lives or those of others, but their being at large is inconsistent with the comfort of society, and their own welfare."⁶²

B. Transition into the Twentieth Century

As England and the United States entered the twentieth century, the mentally ill were assigned to treatment facilities (mental institutions, for example), an action consistent with the suggestions of Conolly and other reformers. This policy was reflected by the enactment of laws that generally permitted psychiatrists to delineate the fine dividing line between sanity and insanity.⁶³ While the treatment objectives were commendable, mental institutions failed to carry out their mandates. Thus, in the 1950s, studies showed that public attitudes towards the mentally ill remained unenlightened, with most American citizens espousing the stereotypical viewpoint that mentally ill persons were unpredictable, threatening, and potentially violent.⁶⁴

59. Scull, *supra* note 47, at 795 (citing CONNOLLY, *supra* note 52, at 5).

60. *Id.* (citing CONNOLLY, *supra* note 52, at 5).

61. CONNOLLY, *supra* note 52, at 9-10.

62. *Id.* at 9. Conolly further observed that Louisa Nottidge suffered from "feebleness and unsoundness of mind," preventing her from properly caring for herself and guarding her financial assets. *Id.* at 21. He noted Louisa's civil commitment humanely protected her "from legalized robbery, and her person from the possibility of legalized prostitution." *Id.* at 18.

63. *But see* Scull, *supra* note 47, at 796 (citing McCandless, *supra* note 58, at 339-62 (indicating the widespread distrust of the objectivity and reliability of psychiatric evaluation of patient competency, with Sir Frederick Pollock urging limitations in the criteria for civil commitment)).

64. *See generally* ANTHONY COLOMBO, UNDERSTANDING MENTALLY DISORDERED OFFENDERS: A MULTIAGENCY PERSPECTIVE (1997); ELAINE CUMMINGS & JOHN CUMMINGS, CLOSED RANKS: AN EXPERIMENT IN MENTAL HEALTH EDUCATION (1957); JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH (1961). *See also* Ron Schraiber, *Stereotyping Mental Illness*, L.A. TIMES, Apr. 3, 1995, at 3. Schraiber observes that dehumanizing media stereotypes create a hostile world for those unfortunately afflicted with mental disorders. *Id.* This patient rights advocate noted "perhaps, the award for

Dr. Shirley Star of the National Opinion Research Centre at the University of Chicago discovered that the general public's reaction to the mentally ill was to view such persons with "fear, distrust, suspicion, and apprehension derived primarily from the assumption that the person could not really be cured."⁶⁵

Similarly, the Joint Commission on Mental Illness and Health, founded in 1955, published a report concluding that American society tended to place negative stereotypical labels upon the mentally ill, often punishing them for their illness.⁶⁶ As a consequence of these views, in the mid-1950s, it was estimated that "there were approximately 565,000 people with severe mental illnesses in state psychiatric hospitals." Hospital institutional conditions were deplorable, as depicted in the film classic "One Flew Over the Cuckoo's Nest."⁶⁷ In 1955, the use of mental hospitals was so prevalent that the number of patients—estimated at 819,000—exceeded the number of inmates incarcerated in prisons.⁶⁸ Newspaper reporters and social commentators published accounts of the horrifying conditions at mental institutions, called "snake pits," in the early 1950s.⁶⁹ Overcrowded and deteriorating buildings were viewed as fostering mental deteriora-

the most stereotypical statement goes to *The Times* [sic] when it proclaimed . . . , 'A mentally disturbed person with only the thinnest streak of violence can produce disaster at any time, any place.'" *Id.* Moreover, the University of Pennsylvania's Annenberg School for Communication conducted a study of network dramas spanning 25 years and found that "mentally ill" characters were "the single most violent group on TV." *Id.*

65. COLUMBO, *supra* note 64, at 10 (citing Shirley Star, *What the Public Thinks About Mental Health and Mental Illness*, Paper Presented at the Annual Meeting of the National Association for Mental Health 23 (Nov. 19, 1952) (available on microfilm at the University of Chicago).

66. JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH 100-01 (1961).

67. Claudine Chamberlain, *Out of the Cuckoo's Nest: Court Ruling Supports Community Care*, 2-3 (visited on Oct. 28, 2000) <http://abcnews.go.com/sections/living/InYourHead/allinyourhead_49.html> (citing ONE FLEW OVER THE CUCKOO'S NEST, a movie dramatically but accurately portraying some of the abuses of mental institutions). Chamberlain notes that state hospitals have progressed substantially in quality of care-taking, away from the "Nurse Ratchet" approach of the 1950s and the cruel treatment of mental health patients by infliction of overmedication, neglect, and abuse. *Id.* The current challenge is to transfer mentally ill patients from state hospitals to superior, high quality community care treatment programs. *Id.* The National Mental Health Association hopes to utilize the \$245 billion that states will receive over the next 10 years from tobacco lawsuit settlements for community mental health programs. *Id.*

68. See C.A. KIESLER & A. SIBULKIN, MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS (1987). See also J.Q. LA FOND & M.L. DURHAM, BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW AND POLICY IN THE UNITED STATES (1992).

69. See generally ALEX DEUTSCH, THE MENTALLY ILL IN AMERICA: A HISTORY OF THE CARE AND TREATMENT FROM COLONIAL TIMES (2d ed. 1949); MARY JANE WARD, THE SNAKE PIT (1949).

tion and dependency among clients.⁷⁰ The courts responded by striking down state commitment statutes as unconstitutional because the statutes authorized involuntary hospitalization of mentally ill individuals who were not dangerous.⁷¹ Moreover, excessive periods of involuntary commitment and detention were held to interfere with a patient's constitutional right to a jury trial.⁷²

In the 1960s and 1970s, court intervention led to a reduction of the average duration of hospitalization and the closing of state institutions by officials.⁷³ Yet, even after civil liberty reforms, involuntarily committed patients in state hospitals consisted primarily of the poverty-stricken and uneducated—individuals lacking the socio-economic resources sufficient to provide them with less drastic alternatives.⁷⁴ However, promised replacement community mental health centers “never materialized,” forcing America's homeless mentally ill into the streets or correctional institutions.⁷⁵ During the 1980s, the number of homeless citizens needing food, shelter, and clothing grew rapidly, with a large percentage of these individuals suffering from mental disorders.⁷⁶ The American Psychiatric Association's Task Force on the Homeless Mentally Ill reported that the increase in the homeless mentally disordered population was caused by society's failure to implement deinstitutionalized, community-based substitutes.⁷⁷ Current estimates are that approximately 40% to

70. See generally E. GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* (1961).

71. See *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972), *vacated and remanded*, 421 U.S. 957 (1975), and *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

72. See *id.*

73. See generally KIESLER & SIBULKIN, *supra* note 68. See also P. LERMAN, *DEINSTITUTIONALIZATION AND THE WELFARE STATE* (1982).

74. See generally R.A. Nicholson, *Correlates of Commitment Status in Psychiatric Patients*, 100 *PSYCHOL. BULL.* 241 (1993).

75. *Wrong Answer*, *supra* note 7, at 6. See E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* 8-9 (1997) (“In effect, approximately 92 percent of the people who would have been living in public psychiatric hospitals in 1955 were not living there in 1994. . . . [A]pproximately 763,391 severely mentally ill people . . . are living in the community today who would have been hospitalized 40 years ago.”); Benton McFarland, *Investigators' and Judges' Opinions About Civil Commitment*, 17 *BULL. AM. ACAD. PSYCHIATRY & L.* 15 (1989). Similarly, the Oregon Task Force on Civil Commitment reported that investigators found community resources were lacking, preventing the diversion of clients from involuntary civil commitment into treatment.

76. See generally LA FOND & DURHAM, *supra* note 68. See also Lamb, *supra* note 7, at 276 (noting that the American Bar Foundation reported that many laws permit “involuntary hospitalization of mentally ill persons who are incapable of providing for their basic necessities, such as food, clothing, and shelter.”) (footnote omitted).

77. See generally E. FULLER TORREY, *NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL* (1988); H.R. Lamb & J.A. Talbott, *The Homeless Mentally Ill: The Perspective of the American Psychiatric Association*, 256 *J. AM. MED. ASSOC.* 498 (1986);

50% of the homeless are seriously mentally ill, with half suffering from treatable schizophrenia.⁷⁸

Recent studies have investigated the public's continued irrational rejection and fear of mentally ill offenders, as well as its lack of sympathy toward them, both of which may interfere with the assimilation of these individuals back into the community.⁷⁹ For example, in 1998, Dr. Bruce Link commented,

to date, nearly every modern study indicates that public fears are way out of proportion to the empirical reality. The magnitude of the violence risk associated with mental illness is comparable to that associated with age, educational attainment and gender [for these offenders].⁸⁰

Misguided public opinion has resulted in laws and social policies that are detrimental to the well-being of mentally ill offenders,⁸¹ often leading to inescapable imprisonment and homelessness rather than to the provision of humane diagnosis, treatment, and rehabilitation.

AMERICAN PSYCHIATRIC ASS'N TASK FORCE REPORT NO. 26, INVOLUNTARY COMMITMENT TO OUTPATIENT TREATMENT 1 (1987) ("The purported effectiveness of deinstitutionalization was predicated both on the availability of effective treatment in the community, and on the willingness of patients to accept treatment voluntarily. . . . Many of these patients responded well to treatment when hospitalized, but rapidly relapsed after discharge, leading to the 'revolving door' syndrome of repeated brief hospitalizations followed by relapse after discharge.").

78. See PERLIN, *supra* note 11, at 389 n.62; *Wrong Answer*, *supra* note 7, at 6. While the 1990 United States census noted that approximately 230,000 citizens were homeless—with 180,000 residing in shelters and 50,000 living on the streets—the Census Bureau considers these numbers low, with more reliable estimates counting in excess of one-half million—and perhaps as many as two million or more—homeless Americans. See PERLIN, *supra* note 11, at 389. Professor Perlin estimates the number of homeless who are mentally ill to be between 10% and 90%, with surveys reporting that one-third, one-half, or three-quarters of homeless persons are mentally ill. *Id.*

79. See generally COLOMBO, *supra* note 64, at 30-31; B.M. Murphy et al., *Attitudes Toward the Mentally Ill in Ireland*, 10 IRISH J. PSYCHOL. MEDICINE 75 (1993); George Wolff et al., *Community Attitudes to Mental Illness*, 168 BRITISH J. OF PSYCHIATRY 183-90 (1996); George Wolff et al., *Community Knowledge of Mental Illness and Reaction to Mentally Ill People*, 168 BRIT. J. OF PSYCHIATRY 191 (1996).

80. Vicki Fox Wieseltheier & Michael Allen, *Don't Scapegoat People with Mental Illness*, ST. LOUIS POST-DISPATCH, Sept. 5, 1999, at B3 (noting Dr. Link's comments in the Archives of General Psychiatry).

81. CENTER FOR MENTAL HEALTH SERVICES, NATIONAL INSTITUTES OF HEALTH, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 4 (1999) (stating, "mental illness is the second leading cause of disability and premature mortality."). See generally Robert C. Kessler, *Lifetime and 12 Month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey*, 51 ARCHIVES OF GENERAL PSYCHIATRY 8-19 (1992) (noting that 22% of adults and 20% of children suffer from mental disorders each year).

C. *Current Laws and Policies Concerning Imprisonment, Commitment, and Treatment of Mentally Ill Offenders*

This section will provide a brief overview of current laws and social policies concerning the imprisonment, commitment, and treatment of mentally ill offenders.

1. United States Department of Justice Bureau of Justice and NAMI Statistics on Incarcerated Mentally Ill Offenders

A recent survey by United States Department of Justice revealed that about ten percent of prison and jail inmates reported a mental or emotional condition.⁸² Ten percent of these mentally ill offenders indicated they had stayed overnight in a mental hospital or program.⁸³ In 1998, an estimated 283,800 mentally ill patients were incarcerated in the nation's prisons or jails.⁸⁴ Mentally ill inmates comprised sixteen percent of currently incarcerated state prisoners, seven percent of federal inmates, and sixteen percent of those housed in local jails.⁸⁵ For offenders released on probation, another sixteen percent (estimated at 587,800 former inmates) had either been treated for mental illness or stayed overnight in a mental hospital at some time in their lives.⁸⁶

82. Kessler, *supra* note 81, at 1-2.

83. *Id.*

84. Ditton, *supra* note 19, at 1-2 (basing findings on self-reported data on the 1997 Survey of Inmates in Local Jails, and the 1995 Survey of Adults on Probation); *Good Morning America I*, *supra* note 5 ("For a quarter million of America's mentally ill, [the Los Angeles County jail] . . . is as close to a hospital as they'll ever get. . . . It has become, by sheer numbers, the largest mental institution in the United States."). *But cf.* S. 1865, 106th Cong. § 1 (1999) (estimating that "between 600,000 and 700,000 mentally ill persons are annually booked in jail alone, according to the American Jail Association."). It is estimated that 670,000 mentally ill persons were booked in U.S. jails in 1996. Judge David E. Bazelon Center for Mental Health Law, *Criminalization of People with Mental Illnesses* (May 26, 2000) <<http://www.bazelon.org/decrim.html>>. In addition, 40% of all Americans with a serious mental illness were estimated to be in jail or prison at any given time. *Id.* This percentage comprises approximately 10-30% of all inmates. *Id.* See also Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000) (noting that Bureau of Justice statistics are probably gross underestimates of incarcerated mentally ill offenders, since these figures are based entirely on self-reporting by prisoners).

85. Ditton, *supra* note 19, at 2.

86. *Id.* at 2. See also Shabo, *supra* note 11, at 12-13. Judge Shabo notes that correctional institutions often lack a "uniform, effective method of screening inmates for mental illness" perhaps utilizing an "ostrich-like head-in-the-sand" approach, covertly designed to avoid the expense of treatment of these offenders. *Id.* He advocates that the government sponsor the implementation of a universal screening protocol, based on investigations that are not limited to the currently utilized compilation of self-reporting statistics, to identify mentally disordered defendants in custody. *Id.* Thus, Judge Shabo maintains that current statistics, based virtually exclusively upon self-reports, grossly underestimate the number of mentally ill inmates housed in correctional facilities. *Id.*

Bureau of Justice Statistics reported in 1996 reveal that over one-third of jail inmates reported a physical or mental disability, with one in ten jail prisoners reporting a mental or emotional illness.⁸⁷ For many mentally ill offenders, incarceration may lead to victimization by rape and physical assault, solitary confinement for violating rules they are incapable of fathoming, neglect of medical problems, or even suicide.⁸⁸

As a class, mentally ill offenders reported high rates of homelessness, unemployment, alcohol or drug use, and either physical or sexual abuse prior to their imprisonment.⁸⁹ NAMI estimates that "25 to 40 percent of America's mentally ill will come into contact with the criminal justice system."⁹⁰ Dr. E. Fuller Torrey of the National Institute of Mental Health noted that most "seriously mentally ill individuals who end up in jail have been charged with relatively minor offenses," primarily "assault, theft [of] property or services, disorderly conduct, alcohol or drug-related charges, and trespassing."⁹¹ He adds, "common forms of theft for seriously mentally ill individuals are shoplifting and failing to pay for restaurant meals ('dine and dash')."⁹² Some ordinances allow the homeless to be arrested for loitering or panhandling.⁹³ Perhaps surprisingly, it has been reported that as high as "29% of jails sometimes incarcerate mentally ill persons against

87. Bureau of Justice Statistics, U.S. Department of Justice, *Profile of Jail Inmates 1996*, 1, 12 (visited Oct. 15, 2000) <<http://www.ojp.usdoj.gov/bjs/pub/pdf/pji96.pdf>>.

88. See TORREY, *supra* note 75, at 31-35. See also Torrey, *supra* note 9, at 12. Dr. E. Fuller Torrey cites an incident where a mentally ill inmate

was pulled out of line while waiting for a meal in a jail cafeteria. [He] was violating jail rules requiring inmates to remain silent, place their hands in their pockets, and keep their shirts tucked in. He was beaten by the guard so severely that he suffered permanent brain damage. As a mental health official in a California county jail phrased it, "The bad and the mad don't mix."

Id. See also *Good Morning America I*, *supra* note 5. Dr. Milton Miller commented, "To be in jail is a miserable, horrible experience. It's full of shame, it's full of defeat, it's full of hopelessness, it's scary. It would have to be 10 times more difficult for mentally ill offenders than for those without phobias, depression, schizophrenia, or other disorders." *Id.*

89. Ditton, *supra* note 19, at 11.

90. S. 1865, 106th Cong. § 1 (1999).

91. Torrey, *supra* note 9, at 1612.

92. *Id.*

93. CAL. PENAL CODE § 647 (1999) (permitting law enforcement to charge a homeless person with a misdemeanor for disorderly conduct for loitering or "wandering upon the streets or from place to place without apparent reason or business."); D.C. CODE §§ 22-3311-§ 22-3316 (1999) ("Panhandling Control") (considering "continuously asking, begging, or soliciting alms from a person" aggressive behavior and categorizing it as a criminal offense); MASS. ANN. LAWS ch. 272, § 66 (1999) ("[P]ersons wandering abroad and begging, or who go about . . . in . . . public places for the purpose of begging or to receive alms . . . shall be deemed vagrants and may be punished by imprisonment for not more than six months in the house of correction.").

whom *no criminal charges were filed*.”⁹⁴ The cost of incarcerating mentally ill offenders is exorbitantly high. In 1996, Bureau of Justice statistics reported that national spending was \$22 billion for state prisons and another \$2.5 billion for federal prisons, for a total annual expenditure of \$24.5 billion.⁹⁵

Almost half of the states reported per capita correctional facility costs for incarcerating prisoners of between \$20,000 and 30,000 per year.⁹⁶ Considering the high costs of incarcerating mentally ill offenders, advocates of therapeutic jurisprudence and preventative law believe rehabilitation and treatment would reduce the economic costs associated with this class of offenders. Section III of this Article will probe justifications for these viewpoints in some detail.

2. Overview and Assessment of Current Court Criminal Proceedings in Adjudication of Mentally Ill Offenders

This section will discuss commitment and recommitment procedures in generalist courts and the protection of mentally ill offenders’ constitutional rights.⁹⁷

a. Initial Court Civil Commitment Decisions in Generalist Trial Courts

A fundamental principle in criminal proceedings is that a defendant—even one who possesses a mental disorder—is innocent unless proven guilty, with the burden of proof upon the State to prove each and every element of the crime beyond a reasonable doubt. However, under both state and federal laws, the insanity defense must be affirmatively asserted and proved by the defendant.⁹⁸ Commitment laws

94. TORREY, *supra* note 75, at 31-35. Dr. E. Fuller Torrey notes that a 1992 jail survey found that uncharged mentally ill persons are temporarily housed in jails to “await a psychiatric examination, the availability of a psychiatric bed, or transportation to a public psychiatric hospital, which, in rural states, may be many miles away.” *Id.* He observes, “I have personally seen a woman with bipolar disorder who had been in a county jail in Indiana for 4 months, not having been charged with any crime, merely awaiting the availability of a bed in a state psychiatric hospital.” *Id.*

95. James J. Stephan, *Bureau of Justice Statistics, State Prison Expenditures 1996*, at 3 (visited Aug. 25, 1999) <<http://www/ojp.usdoj.gov/bjs/pub/ascii/spe96.txt>> (reporting 1996 statistical survey results).

96. Bureau of Justice Statistics, U.S. Department of Justice, *Criminal Offender Statistics*, 2 (visited on Oct. 15, 2000) <http://www.ojp.usdoj.gov/bjs/crimoff.htm>. Expenditures include costs of operations; employee wages, salary and benefits; food service; medical care; transportation; land and building purchases; utilities; and building construction, renovation, and repair. *Id.*

97. See generally MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* (1998); ROBERT M. WETTSTEIN, *TREATMENT OF OFFENDERS WITH MENTAL DISORDERS* (1998).

98. See, e.g., *United States v. Byrd*, 834 F.2d 145, 146 (8th Cir. 1987); *State v. Marley*, 364 S.E.2d 133, 135 (N.C. 1988); *State v. Moorman*, 744 P.2d 679, 687 (Ariz. 1987). See also *United*

generally require a finding of both mental illness and dangerousness resulting from that mental illness.⁹⁹ The judge, with broad discretionary powers, possesses enormous responsibility to ensure protection of a defendant's constitutional substantive and procedural due process rights before depriving the defendant of his liberty.¹⁰⁰

Courts also have upheld state statutes requiring a defendant's immediate hospitalization following an insanity defense.¹⁰¹ After finding a defendant not guilty by reason of insanity, courts generally schedule a hearing within approximately sixty days to determine the need for hospitalization. Prior to the hearing, the defendant may be hospitalized. Similarly, defendants found incompetent to stand trial may be held involuntarily for evaluation.¹⁰² In justifying these deci-

States v. Cameron, 907 F.2d 1051, 1065 n.26 (11th Cir. 1990) (noting that House Report No. 980577 states "[the definition of insanity in section 17(a)] constitutes the only affirmative defense based on mental disorder that will be applicable in Federal courts.").

99. PERLIN, *supra* note 97, at 44.

100. See *State v. Krol*, 344 A.2d 289, 301-02 (N.J. 1975). In *Krol*, the New Jersey Supreme Court stated,

Dangerous conduct involves not merely violation of social norms enforced by criminal sanctions, but significant physical or psychological injury to persons or substantial destruction of property. Persons are not to be indefinitely incarcerated because they present a risk of future conduct which is merely socially undesirable. Personal liberty and autonomy are of too great value to be sacrificed to protect society against the possibility of future behavior which some may find odd, disagreeable, or offensive. . . . Unlike inanimate objects, people cannot be suppressed simply because they may become public nuisances.

Id. at 301-02.

101. See, e.g., *Jones v. United States*, 463 U.S. 354, 370 (1983); *State v. Huiett*, 394 S.E.2d 486, 489 (S.C. 1990); *People v. Catron*, 246 Cal. Rptr. 303, 309-10 (Cal. Ct. App. 1988). See generally PERLIN, *supra* note 9, at 232. While the public has often expressed the common misconception that criminals may escape punishment for their crimes by deceiving psychiatrists and "faking mental illness," there is no rational basis for this view. *Id.* Professor Perlin notes,

Carefully crafted empirical studies have clearly demonstrated that malingering among insanity defendants is, and traditionally has been, statistically low. Even where it is attempted, it is fairly easy to discover. . . . Clinicians correctly classify 92 to 95% of all individuals as either faking or not faking, especially in cases in which defendants are faking severe forms of mental illness.

Id. (citations omitted).

102. See, e.g., *United States v. Schwar*, 865 F.2d 856, 861 (7th Cir. 1989); *United States v. Waddell*, 687 F. Supp. 208, 209 (M.D.N.C. 1988). See generally Bruce Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921-31 (1985). Winick notes that while incompetency as an issue is raised more often than the insanity defense, courts infrequently find defendants to be incompetent. *Id.* When a seriously mentally disordered defendant will not likely gain competence in the near future, this individual may be committed to a forensic hospital for an indefinite or prolonged stay. *Id.* See also CAL. PENAL CODE §§ 1368-69 (1999). Under §§ 1368-69, the court may begin an incompetency hearing at any time before judgment, suspending criminal proceedings until mental competence is established. *Id.* During an incompetency hearing, the court appoints a psychiatrist to examine the defendant. *Id.* The issue of a defendant's incompetence to stand trial may be raised either by the defense or the prosecution, and a finding of incompetence requires proof by a preponderance of the evidence. *Id.* If a jury, rather

sions, courts often find that the protection of public safety outweighs a brief deprivation of the individual's liberty, and that hospitalization gives psychiatric staff the reasonable opportunity to assess the defendant's mental illness and predilection for recidivism (e.g., violence). Similarly, most states provide for emergency commitment of an individual who is "reasonably believed to be imminently dangerous to himself or others."¹⁰³ After *O'Connor v. Donaldson*,¹⁰⁴ states have instituted laws that require a hearing within three to five days of emergency confinement to ensure that such confinement meets constitutional requirements.¹⁰⁵

Historically, the individual liberty interests of mentally ill offenders were more highly valued than they are today because finite time limits were placed on involuntary commitment terms. More recently, courts have extended the maximum periods of time that these offenders can be confined for treatment against their will.¹⁰⁶ Thus, in *Jones v. United States*,¹⁰⁷ the Supreme Court upheld controversial legislation that permitted insanity acquittees to be involuntarily committed and hospitalized indefinitely beyond the original term of imprisonment.

Similarly, in *Kansas v. Hendricks*,¹⁰⁸ the Supreme Court upheld a Kansas state law that established involuntary civil commitment procedures for mentally ill offenders classified as sexually violent predators (SVPs). Critics of state SVP acts based upon *Hendricks* rationale¹⁰⁹

than a judge, determines incompetency, a unanimous verdict is required. *Id.* A judgment of incompetency may be appealed. *Id.* See also *Medina v. California*, 505 U.S. 437 (1992); *People v. Fields*, 62 Cal. 2d 538 (1960).

103. PERLIN, *supra* note 97, at 500.

104. 422 U.S. 563 (1975).

105. See *Garrett v. State*, 707 So. 2d 273, 275 (Ala. Civ. App. 1997); *Cooper v. Oklahoma* 517 U.S. 348, 368 (1996) (noting that "due process requires at a minimum a showing that the person is mentally ill and either poses a danger to himself or others or is incapable of 'surviving safely in freedom.'").

106. See, e.g., *Jackson v. Indiana*, 406 U.S. 715 (1972).

107. 463 U.S. 354, 370 (1983).

108. 521 U.S. 346, 371 (1997). Because *Hendricks* admitted that he could not control his urge to molest children when he became stressed, the Court held the acknowledged lack of volitional control, when coupled with a prediction of future dangerousness based on past offenses, sufficed to permit *Hendricks*' involuntary civil commitment. *Id.* at 360. See, e.g., *Schweninger v. Minnesota*, 525 U.S. 802 (1998) (following the *Hendricks* rationale).

109. *Hubbart v. Superior Court of Santa Clara*, 58 Cal. Rptr. 2d 268, 279 (Cal. Ct. App. 1996) (noting that the new SVP Act differs from the old Mentally Disordered Offender (MDO) law in that a person may be categorized as a SVP even in the absence of a conviction; the categorization may be based solely on a defendant's history of sexually violent behavior and the diagnosis of a mental disorder that renders that person dangerous to others); *In re Linehan*, 557 N.W.2d 171 (Minn. 1996); *In re Young*, 857 P.2d 989 (Wash. 1993). But see *Garcetti v. Superior Court of Los Angeles*, 80 Cal. Rptr. 2d 724, 727-28 (Cal. Ct. App. 1998) (noting that there are procedural safeguards in the probable cause hearing and at trial that ensure the accused

vehemently argue that these statutes interfere with a mentally ill person's constitutionally guaranteed liberty rights because they utilize overly vague criteria that foster the indeterminate commitment of sexual offenders to potentially lifetime terms.

In contrast to SVP cases, Congress and several states have limited involuntary commitment for other offenses to a period of time equal to a mentally ill offenders' maximum term if the offender is either found not guilty by reason of insanity or determined to be incompetent to stand trial.¹¹⁰ While most courts have upheld these laws,¹¹¹ some courts have interpreted the statutes to permit extended and sometimes indeterminate periods of commitment.¹¹² With such statutes, the risk of unnecessarily prolonged involuntary commitment is high, unless the commitment is periodically monitored by the judiciary in regularly scheduled court hearings.¹¹³

b. *Protection of a Mentally Ill Offender's Constitutional Right to Medical Treatment*

In *Youngberg v. Romeo*,¹¹⁴ the United States Supreme Court cautiously recognized an involuntarily hospitalized patient's constitutional right to "minimally adequate" rehabilitation, training, and treatment; freedom from undue restraint; and the basic necessities of life. Following *Youngberg*, other state courts have examined the care state institutions provided to mentally ill offenders in order to ensure that substantial professional medical judgment was rendered prior to an offender's commitment.¹¹⁵ Critics note that *Youngberg's* "substantial

under the SVP Act is in fact a sexually violent predator).

110. See, e.g., 18 U.S.C. § 4244(d) (1994).

111. See, e.g., *Hickey v. Morris*, 722 F.2d 543 (9th Cir. 1983); *State v. Hungerford*, 267 N.W.2d 258 (Wis. 1978).

112. See generally Marc Miller, *Purposes at Sentencing*, 66 S. CAL. L. REV. 413, 435 n.94 (1992). In indeterminate sentencing, the judge issues a "flexible sentence" whereby the length of imprisonment is given within a minimum-maximum range. *Id.* The actual time served by the prisoner, however, is determined by both evidence of good behavior leading to early conditional release and assessments of the inmate's rehabilitation. *Id.* See also *United States v. Roberts*, 915 F.2d 889 (4th Cir. 1990); *People v. Bolden*, 217 Cal. App. 3d 1591, 266 Cal. Rptr. 725 (Cal. Ct. App. 1990) (noting that the proper inquiry is to determine whether the defendant's present condition represents a substantial danger of physical harm to others).

113. See, e.g., *Dorman v. State*, 457 So. 2d 503 (Fla. Dist. Ct. App. 1984) (upholding a judge's recommendation of a seven year sentence, exceeding Sentencing Guidelines, for long term residential care of a mentally disordered sexual offender).

114. 457 U.S. 307 (1982). See also *County of Sacramento v. Lewis*, 523 U.S. 833, 851 n.12 (1998) (noting that under *Youngberg*, a mentally retarded plaintiff may claim a violation of substantive due process if he is denied training and rehabilitation by mental institution personnel).

115. See, e.g., *United States v. Tennessee*, 925 F. Supp. 1292, 1296 n.3 (W.D. Tenn. 1995). The court in *United States v. Tennessee* noted that the *Youngberg* case stood, inter alia, for the proposition that states must provide "adequate food, shelter, clothing, and medical care" to

professional judgement" standard may prevent inquiry into the adequacy of treatment, halt civil rights litigation, and abandon the values of therapeutic jurisprudence.¹¹⁶

The Americans with Disabilities Act (ADA) has recently been hailed as the most extensive governmental effort to date to correct problems of discrimination against mentally and physically disabled Americans.¹¹⁷ In *Pennsylvania Department of Corrections v. Yeskey*, Justice Scalia pronounced that prisoners are allowed to maintain suits against a state's department of corrections for discrimination on the basis of disability under the ADA.¹¹⁸ Further extending rights of the mentally ill, in *Olmstead v. L.C.*, the Supreme Court found that institutionalized citizens with mental disabilities are entitled to ADA-mandated treatment in an "integrated community setting" rather than the "unnecessarily segregated" conditions in Georgia State Hospital.¹¹⁹ This decision was consistent with Congress's goal "to eliminate the segregation of individuals with disabilities."¹²⁰

Courts also have recognized an unsentenced mentally ill defendant's right to treatment after being found to be either a sexual offender or not guilty by reason of insanity.¹²¹ This right to treatment is derived from the Fourteenth Amendment's guarantee against depriva-

institutionalized patients. *Id.* (quoting *Youngberg*, 457 U.S. at 324). According to *Youngberg*, "[t]he State also has the unquestioned duty to provide reasonable safety for all residents. . . . [Residents enjoy] constitutionally protected interests in the conditions of reasonable care and safety[, and] . . . reasonable non-restrictive confinement conditions." *Id.* (quoting *Youngberg*, 457 U.S. at 324).

116. PERLIN, *supra* note 9, at 115, 122. Perlin notes that in *Wyatt v. Stickney*, the court found that a constitutional right to treatment exists where

[t]he purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment. This is the only justification from a constitutional standpoint, that allows civil commitment to [a state hospital]. . . . To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.

Id. See also *Olmstead v. L.C.*, 527 U.S. 581, 605 (1999) ("Each disabled person is entitled to treatment in the most integrated setting possible for that person—recognizing that, on a case-by-case basis, that setting may be in an institution." (citation omitted)).

117. See generally Michael L. Perlin, *The Americans with Disabilities Act and Mentally Disabled Persons: Can Sanist Attitudes Be Undone?*, 8 J.L. & HEALTH 15 (1993–1994).

118. 524 U.S. 206, 213 (1998).

119. *Olmstead*, 527 U.S. at 602.

120. *L.C. v. Olmstead*, 138 F.3d 893, 898 (11th Cir. 1998), *aff'd in part, rev'd in part*, and *vacated in part*, 527 U.S. 581 (1999).

121. See generally *United States v. Ecker*, 543 F.2d 178, 208 (D.C. Cir. 1976) (emphasizing the importance of a patient's right to treatment and noting that if conditional release is needed to meet treatment objectives, the court should develop criteria for determining conditions under which a defendant may become eligible for such conditional release); *Millard v. Cameron*, 373 F.2d 468 (D.C. Cir. 1966).

tion of life, liberty, or property without due process of law.¹²² Similarly, for sentenced mentally disordered prison inmates, the Eighth Amendment—which bars cruel and unusual punishment—gives inmates the right to treatment,¹²³ including access to psychological or psychiatric services when medically necessary.

Judges may also require that correctional facility treatment plans be implemented to ensure that inmates take their prescribed medications, therapeutic drug blood levels are assessed, patient requests for medical services are timely handled, medications are not discontinued without client interviews, psychiatric decisions are not ignored by nonmedical personnel, individual and group therapy is provided, and regular monitoring of treatment is instituted.¹²⁴

Furthermore, a court may require that states provide the following constitutional protections for mentally disordered inmates in correctional settings: adequate systems for identifying and monitoring mentally ill patients, referral rules that ensure inmates can make their medical needs known to staff, communication procedures that guarantee mental health staff regular access to mentally ill offenders, and promulgation of rules that specifically pertain to management and care of the special problems of mentally ill inmates.¹²⁵

122. See *County of Sacramento v. Lewis*, 523 U.S. 833, 849-50 (1998) (observing that pre-trial detainees retain due process rights under the Fourteenth Amendment that are at least as great as the Eighth Amendment rights granted to convicted prisoners); *Bell v. Wolfish*, 441 U.S. 520, 546 (1979) (noting that “convicted prisoners do not forfeit all constitutional protections by reason of their conviction and confinement in prison.”).

123. See generally *Lewis v. Griffin*, 376 S.E.2d 364 (Ga. 1989); *Villarreal v. Thompson*, 920 P.2d 1108, 1110 (Or. App. 1996) (holding plaintiff may assert a claim against a correctional facility if, under the Eighth Amendment, plaintiff shows a “deliberate indifference to serious medical needs.”).

124. See, e.g., *Belcher v. City of Foley*, 30 F.3d 1390, 1397-99 (11th Cir. 1994) (noting that prison guards will incur legal liability if they exhibit deliberate indifference to the serious medical and psychiatric needs of a prisoner, including indifference to the high probability that a prisoner may commit suicide); *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 n.10 (E.D. Cal. 1995). Courts have focused on six components for evaluating a “minimally adequate prison mental health care delivery system.” *Belcher*, 30 F.3d at 1398. These components are as follows:

(1) a systematic program for screening and evaluating inmates to identify those in need of medical care; (2) a treatment program that involves more than segregation and close supervision of mentally ill inmates; (3) employment of a sufficient number of trained mental health professionals; (4) maintenance of accurate, complete and confidential mental health treatment records; (5) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and (6) a basic program to identify, treat, and supervise inmates at risk for suicide.

Id. at 1398 n.10.

125. See, e.g., *Greason v. Kemp*, 891 F.2d 829, 833-37 (11th Cir. 1990) (noting an established constitutional right to psychiatric care); *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 (E.D. Cal. 1995) (noting that an Eighth Amendment violation occurs when defendants act with “deliberate indifference” to mentally ill offenders’ “serious medical needs”). According to the *Coleman* court, “deliberate indifference is established ‘if the failure to treat a prisoner’s condition

Judges may periodically monitor correctional facility environments to ensure that the conditions of incarceration are conducive to treatment objectives.¹²⁶ Understandably, courts have generally rejected excuses such as a lack of available funding, overcrowding, a need for prison security alone, or even a good faith effort to obtain treatment resources when such excuses are used to justify a correctional facility's decision to withhold necessary diagnosis and treatment from mentally ill inmates.¹²⁷

IV. SUCCESSFUL STATE SPECIALTY COURT EXPERIENCES

Ongoing nationwide discussion of the benefits of state specialty courts has resulted in the successful formation of adult drug courts,¹²⁸ family courts,¹²⁹ juvenile drug courts,¹³⁰ teen courts,¹³¹ domestic violence courts,¹³² and business courts.¹³³ Since state judiciaries histor-

could result in further significant injury or the 'unnecessary and wanton infliction of pain.'" *Id.* See also *Casey v. Lewis*, 834 F. Supp. 1477 (D. Ariz. 1993).

126. See, e.g., *Smith v. Jenkins*, 919 F.2d 90 (8th Cir. 1990); *Coleman*, 912 F. Supp. at 1320 (noting that during incarceration, mentally disordered prisoners are treated punitively without due consideration for their mental illness because custodial staff lack appropriate training in recognizing and handling such disordered inmates); *Casey*, 834 F. Supp. at 1477.

127. See, e.g., *Greason*, 891 F.2d at 836 (noting that the failure of prison staff members to notify officials of a mentally disordered person's suicidal state of mind can constitute "deliberate indifference" resulting in liability, perhaps constituting an Eighth Amendment violation); *Camilo-Robles v. Zapata* 175 F.3d 41, 44 (1st Cir. 1999) ("[L]iability attaches if a responsible [correctional facility] official supervises, trains, or hires a subordinate with deliberate indifference toward the possibility that deficient performance of the task eventually may contribute to a civil rights violation."); *Cortes-Quinones v. Jimenez-Nettleship*, 842 F.2d 556 (1st Cir. 1988).

128. See generally James R. Brown, *Drug Diversion Courts; Are They Needed and Will They Succeed in Breaking the Cycle of Drug-Related Crime?*, 23 NEW ENG. J. OF CRIM & CIV. CONFINEMENT 63, 84, 93-98 (1997) (describing drug court objectives and the functioning of two courts in Miami and Boston); John S. Goldkamp, *The Drug Court Response: Issues and Implications for Justice Change*, 63 ALB. L. REV. 923 (2000).

129. See Monrad G. Paulson, *Juvenile Courts, Family Courts, and the Poor Man*, 54 CAL. L. REV. 694, 701 (1966) (emphasizing that the poor disproportionately flood family and juvenile courts, indicating that poverty is accompanied by societal maladaptations that necessitate judicial intervention); Paul A. Williams, *A Unified Court for Missouri*, 63 UMKC L. REV. 383, 383-84 (1994) (describing one state's attempt to build a unified family court). See also AMERICAN BAR ASSOCIATION CENTER ON CHILDREN AND THE LAW, *A JUDGE'S GUIDE TO IMPROVING THE LEGAL REPRESENTATION OF CHILDREN* 1, 2-3 (Kathi L. Grasso, ed., 1998). This project of the American Bar Association focuses on "how courts can better access, utilize, and support lawyers appointed to represent children." *Id.* Judges and attorneys may participate in an e-mail discussion group regarding ABA National Court Improvement Activities through the e-mail address: markhardin@abanet.org. It would be a worthwhile endeavor to develop a corresponding publication designed to aid judges in improving the legal representation of the mentally ill.

130. See Marily Roberts et al., *The Juvenile Drug Court Movement, Fact Sheet* 59 (Office of Juv. Just. and Delinquency Prevention), Mar. 1997 at 1,2 (describing juvenile drug courts).

131. See Allison R. Shiff & David B. Wexler, *Teen Court: A Therapeutic Justice Perspective*, 4 CRIM. L. BULL. 342, 343 (1996) (noting the existence of over 150 teen courts designed to hear misdemeanor cases as an alternative to juvenile court).

132. See Art Barnum, *DuPage Total Crimes Drop, But Robberies Increase 49%*, CHI. TRIB.,

ically have had greater experience with family and drug courts than with mental health specialty courts, these two courts will be introduced as potential models for establishment of the more novel mental health specialty courts.¹³⁴

A. State Drug Courts

State drug courts were instituted as part of a nationwide program known in the media as the "War on Drugs," a term popular in the 1980s to describe the governmental response to America's drug crisis. Alarming statistics revealed that although the United States possessed only 4.5% of the global population, 60% of illegal drugs were consumed and sold here.¹³⁵ Notwithstanding an acknowledged link between drugs and crime, the federal government and drug courts recognized that it was cost effective to direct nonviolent drug offenders away from incarceration and toward treatment programs, with the goal of reintegrating treated drug addicts into society.¹³⁶ Drug courts were created "out of a sense of frustration that law enforcement and imprisonment policies were not having the impact on drug supply or demand that proponents of the war against drugs of the 1980s had hoped for."¹³⁷ These courts have received tremendous public support, and there are over 425 drug courts in operation in the United States today.¹³⁸

The United States government's initial response in its "War on Drugs" was to invest considerable financial resources in law enforcement, arresting and imprisoning offenders. This approach initially appeared successful in controlling drug crimes, with an investment of

Apr. 27, 1997, at 1 (documenting the creation of a unique domestic violence court to handle these cases).

133. See generally Ad Hoc Committee on Business Courts, *Business Courts: Towards a More Efficient Judiciary*, 52 BUS. LAW. 947, 961 (1997) (suggesting the creation of additional business courts, building on successes experienced with previously established business courts); Margaret M. Eckenbrecht, *A Commercial Venture*, A.B.A.J., Jan. 1996, at 35 (noting fifteen states either possess or plan to establish business courts).

134. See Brown, *supra* note 128, at 99 (maintaining that drug courts may also serve as prototypes for domestic violence courts that also provide intensive client treatment).

135. See Panel Discussion, *The Drugging of the Courts: How Sick Is the Patient and What Is the Treatment?*, 73 JUDICATURE 314 (1990).

136. See Brown, *supra* note 128, at 66 n.21 (citing BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, FACT SHEET: DRUG-RELATED CRIME 1, 5 (1994)) (noting that an estimated 17% of state prison inmates reported committing offenses to finance their drug habits); Roberts et al., *supra* note 130, at 6. As many as 50% of prison inmates reported use of drugs one month prior to the offense. See U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, DRUGS AND CRIME FACTS 1993 5 (1994).

137. Roberts et al., *supra* note 130, at i.

138. Goldkamp, *supra* note 128, at 923 (noting the existence of over 425 established drug courts, with other drug courts currently in the planning stage).

\$1.5 billion in 1981 expanding to \$13.1 billion in 1995.¹³⁹ As a direct result of these expenditures, over one million drug arrests were made in 1993, compared to less than 700,000 in 1983.¹⁴⁰

However, imprisonment of drug offenders has contributed to overcrowding the prison system,¹⁴¹ and the federal system is now operating at 125% of capacity. Forty-one state systems operate at or above capacity.¹⁴² As a direct result of state prison overcrowding, inmates are often transferred to local jails.¹⁴³ In accepting inmate transfers, jails often must either release previously held offenders or reduce incarceration rates of minor offenders, actions that both have unavoidable adverse repercussions.

Unfortunately, the imprisonment of drug offenders, while resulting in about a one-third increase in arrests, has not reduced the incidence of drug-related crime.¹⁴⁴ For example, from 1980 to 1990, California's prison population grew by 450%, with no significant impact on the number of crimes committed.¹⁴⁵ While incarceration temporarily deters an imprisoned inmate from recommitting a drug-related offense, statistics show that untreated drug addicts generally continue to commit an enormous number of crimes to support their habits, such as robbery, assault, burglary, auto theft, and shoplifting.¹⁴⁶ One commentator noted, "without treatment, 90% of incarcerated drug offenders will renew a career of addiction and crime within three years of release. . . ."¹⁴⁷ Since the War on Drugs has cost over \$300 billion dollars to date¹⁴⁸ and has not had a major impact on

139. See BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, FACT SHEET: DRUG DATA SUMMARY 5 (1995).

140. See FEDERAL BUREAU OF INVESTIGATION, U.S. DEP'T OF JUSTICE, CRIME IN THE UNITED STATES 1994 tbl. 1 (1995) (noting 1,126,300 arrests for drug abuse in 1993, compared to 661,400 in 1983).

141. See ALLEN J. BECK & DARRELL K. GILLIARD, U.S. DEP'T OF JUSTICE, PRISONERS IN 1994 4 (1995).

142. See *id.* at 8.

143. See *id.* at 6.

144. See generally Steven Belenko et al., *The Effects of Legal Sanctions on Recidivism in Special Drug Courts*, 17 JUST. SYS. J. 53, 57 (1994); Jeff Potts, *American Penal Institutions and Two Alternative Proposals for Punishment*, 34 S. TEX. L. REV. 443, 457 (1993).

145. See David C. Leven, *Curing America's Addiction to Prisons*, 20 FORDHAM URB. L.J. 641, 649 (1993) (noting that index crimes reported by California police almost doubled in the 1980s, with a corresponding population increase of only 25%).

146. See NATIONAL INSTITUTE OF JUSTICE, U.S. DEP'T OF JUSTICE, SEARCHING FOR ANSWERS, ANNUAL EVALUATION REPORT ON DRUGS AND CRIME: 1992 54 (June 1993) (noting a 1980s study showed "573 substance abusers in Miami committed 6,000 robberies and assaults, 6,700 burglaries, 900 auto thefts, and 25,000 acts of shoplifting.").

147. Brown, *supra* note 128, at 81 n.180 (citing Fred Settleberg, *Oakland Tries a Carrot and Stick Approach to Keeping First Time Drug Offenders Out of Jail*, CALIF. LAW., May 14, 1994, at 93).

148. See Mathea Falco, *Toward a Rational Drug Policy, Toward a More Effective Drug*

the incidence of drug-related crime, treatment of drug abusers has been advocated as a logical, cost-effective alternative.¹⁴⁹

Moreover, prison drug rehabilitation programs have lacked the intensity of treatment required for success, providing a token "few hours per week" of actual treatment, which has been deemed grossly inadequate.¹⁵⁰ In addition, the commitment of financial resources to prison treatment programs has not been commensurate with the flood of drug offenders coming into correctional facilities.¹⁵¹

Thus, in the 1980s, states experimented with the concept of drug courts to manage the increasing number of drug abuse cases and place offenders in effective drug treatment programs.¹⁵² Drug courts have promoted a reduction of the financial and societal costs of incarceration through the monitoring of nonviolent drug abusers. Proponents of these courts predict that rehabilitation results in lowered recidivism or reconviction crime rates for these offenders, reducing court case-loads and correctional facility costs.¹⁵³

A primary goal of drug courts is to monitor the appropriate treatment and rehabilitation of drug abusers, accelerating their recovery.¹⁵⁴ After successful completion of an individual's treatment, the drug court possesses the authority to dismiss or mitigate charges and sentences; this serves as an added motivation for addicts to comply with

Policy, 1994 U. CHI. LEGAL F. 9, 9 (1994) (stating that 375,000 newborn babies were adversely affected by exposure to their mother's use of illegal drugs). See also Elaine R. Jones, *The Failure of "Get Tough" Crime Policy*, 20 U. DAYTON L. REV. 803, 804 (1995) (commenting that the average cost of housing an inmate is \$23,000 per year); Carol Vance, *To Achieve Law and Order, People Must Be Changed*, PROSECUTOR, May/June 1995, at 28 (noting prison facility construction costs and costs of housing an inmate for a 30 year period are approximately \$1 million per inmate).

149. See Falco, *supra* note 148, at 16. See also JEAN WELLISCH ET AL., U.S. DEP'T OF JUSTICE, DRUG ABUSING WOMEN OFFENDERS: RESULTS OF A NATIONAL SURVEY 1, 5 (1994) (noting intensive treatment of female drug abusers).

150. See WELLISCH ET AL., *supra* note 149, at 5 ("[T]he effectiveness of many surveyed programs that provide treatment of relatively short duration to a population with multiple needs, particularly programs that provide only a few hours per week is questionable.").

151. See Brown, *supra* note 128, at 82 n.184 (citing Gregory P. Falkin et al., *Drug Treatment in the Criminal Justice System*, 58 FED. PROBATION 31, 32 (1994) (observing that the number of cocaine abusers who need treatment is 16 times greater than the number of abusers who are actually being treated)).

152. See Brown, *supra* note 128, at 83-84 (citing Robert C. Davis et al., *Court Strategies to Cope with Rising Drug Caseloads*, 17 JUST. SYS. J. 1, 2 (1994)). See also CAROLYN S. COOPER & JOSEPH A. TROTTER, JR., THE AMERICAN UNIVERSITY DRUG CASE MANAGEMENT AND TREATMENT INTERVENTION STRATEGIES IN THE STATE AND LOCAL COURTS 20 (1994).

153. See Brown, *supra* note 128, at 84 n.206 (citing JAMEY H. WEITZMAN, DRUG COURTS: A MANUAL FOR PLANNING AND IMPLEMENTATION (Robin J. Kimbrough ed., 1995)).

154. See COOPER & TROTTER, *supra* note 152, at 21.

treatment programs.¹⁵⁵ Proponents optimistically maintain that drug tribunals have successfully reduced the incidence of drug abuse reoffenses, lowered drug-related criminal activity, diminished the number of prisoners incarcerated in prisons and jails, reduced court caseloads, and obtained considerable cost reductions throughout the criminal justice system.¹⁵⁶ However, independent investigation is necessary to determine whether drug courts have fulfilled these expectations.

B. State Family Courts

State family courts first originated in the United States at the turn of the nineteenth century, about the same time as juvenile courts, but long before drug courts.¹⁵⁷ Like drug courts, family courts created a nontraditional, nonadversarial tribunal to resolve a family's legal issues efficiently and quickly, with a minimum of trauma to children and families in crisis.¹⁵⁸ As a result of relatively recent support by the American public, specialized family courts or divisions are now used in diverse forms in several states. In 1996, the American Bar Association funded a two-year project designed to facilitate the establishment of unified family courts in six cities.¹⁵⁹ A recent conference of bar presidents also advocated the establishment of these courts.¹⁶⁰

At present, five states utilize a separate family court for family law cases,¹⁶¹ five other jurisdictions employ separate trial divisions for these matters,¹⁶² and one state possesses a family department within the trial court.¹⁶³ In order to handle cases in different parts of their

155. See Peter Finn & Andrea K. Newlyn, *Miami Drug Court Gives Drug Defendants a Second Chance*, 77 JUDICATURE 268, 269 (1994).

156. See generally JAMEY H. WEITZMAN, *DRUG COURTS: A MANUAL FOR PLANNING AND IMPLEMENTATION* (Robin J. Kimbrough ed., 1995).

157. See Leonard P. Edwards, *The Juvenile Court and the Role of the Juvenile Court Judge*, 43 JUV. & FAM. CT. J. 1 (1992) (documenting the history, laudable objectives, and evolution of juvenile courts); Herma Hill Kay, *A Family Court: The California Proposal*, 56 CAL. L. REV. 1205 (1968).

158. See H. TED RUBIN & VICTOR EUGENE FLANGO, *COURT COORDINATION OF FAMILY CASES* 64-65 (1992).

159. See R. William Ide III, *ABA News Center—From the Chair*, UNIFIED FAM. CHRON., May 1997, at 2. See also Patricia G. Barnes, *It May Take a Village . . . or a Specialized Court to Address Family Problems*, A.B.A.J., Dec. 1996, at 22.

160. See Mary Wechsler, *Unified Family Courts*, THE CONFERENCE CALL, Summer 1995, at 1. The A.B.A.'s two-year project is entitled *Communities, Families, and the Justice System*. *Id.*

161. States that have separate family courts include Delaware, New York, Rhode Island, South Carolina, and Vermont. See, e.g., DEL. CODE ANN. tit. 10, §§ 901-973 (1974 & Supp. 1996); N.Y. FAM. CT. ACT § 111-1211 (McKinney 1987 & Supp. 1997).

162. These states are Florida, Hawaii, New Jersey, Washington, and the District of Columbia. See, e.g., WASH. REV. CODE ANN. §§ 26.12.010-26.12.240 (West 1997).

163. Massachusetts utilizes this unique approach. See MASS. GEN. LAWS. Ch. 211B, § 1

respective states, fourteen states place geographical restrictions on family courts or court divisions¹⁶⁴; nine other states plan to or will experiment with family court programs in the near future.¹⁶⁵ Two other states have received legislative approval to establish these courts,¹⁶⁶ leaving fourteen states that continue to handle family law cases solely within general trial court proceedings.

A judge's term within a family court may vary significantly. While some states' family court judges receive lifetime appointments,¹⁶⁷ other states permit temporary judicial assignments of limited duration. Detractors maintain that these rotating judges possess less knowledge of this specialized area of law than is necessary for just and efficient adjudication of cases.¹⁶⁸

Criticisms of the traditional trial court forum include the following: (1) family matters are often burdensomely expensive and time-consuming; some disputes are tried more than once, or are tried before different judges—or even different courts—in a fragmented, rather than unified, approach, (2) children may be inadvertently subjected to trauma, (3) judges hearing family law cases may lack understanding, interest in a given dispute, or the temperament to hear these cases, and (4) courts inadequately address needs of the poor, who lack financial resources to hire an attorney and must represent themselves.¹⁶⁹ Court reform has established state family courts that specifically address some of these disadvantages of traditional trial court fora. Thus, both family and drug specialty courts provide successful foundational models on which to build the bases of mental health courts.

V. CREATING AN EXEMPLARY WORKING MODEL OF NOVEL MENTAL HEALTH SPECIALTY COURTS

Although there has been a paucity of published information on the operations of the handful of newly established state mental health

(1989 & Supp. 1996).

164. These states are Alabama, Colorado, Kansas, Louisiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, and Wisconsin. *See, e.g.*, OR. REV. STAT. § 3.405 (1995).

165. These states are California, Georgia, Illinois, Kentucky, Maine, Maryland, Michigan, New Hampshire, and Virginia. *See, e.g.*, CAL. FAM. CODE §§ 2000-20043 (West 1994 & Supp. 1997).

166. These are Michigan and Virginia. *See, e.g.*, MICH. COMP. LAWS ANN. § 600.1001 (West Supp. 1997).

167. Judges in Massachusetts and Rhode Island serve life terms. *See, e.g.*, R.I. GEN LAWS § 8-16.1-7 (Supp. 1996).

168. In the District of Columbia, judges remain in the Family Division for nine months.

169. *See* ROBERT C. MURPHY, REPORT OF THE FAMILY DIVISION REVIEW COMMITTEE 6-7 (1993) (describing results of a study of Maryland's family law court system).

courts (MHCTs) in the United States,¹⁷⁰ more detailed information regarding the function of specialized courts has been generated in the context of drug and family courts. News analysts have noted that recently established MHCTs have been "loosely modeled" after drug courts or other specialty courts.¹⁷¹ However, Judge Harold E. Shabo, Supervising Judge of the Mental Health Departments of the Superior Court of Los Angeles (referred to as "Department 95"¹⁷²) and supervisor of associated Los Angeles County court staff, has provided invaluable information regarding the operation of this California court, the oldest and most established existing independent MHCT in the United States.¹⁷³ In addition, Judge Ginger Lerner-Wren of Florida's Broward County MHCT has recently received prominent news media coverage for pioneering what has been publicized as another "one-of-a-kind court" designed to "steer[] nonviolent mentally ill defendants into care rather than jail."¹⁷⁴ The Florida MHCT now hears cases involving 450 defendants annually.¹⁷⁵ Thus, this Article's advocacy of the establishment of mental health specialty courts will rely heavily upon analogies to existing state specialty courts (e.g., fam-

170. *But see* CAROL A.B. WARREN, *THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW* (1982); Debra Baker, *A One-of-a-Kind Court May Offer the Best Hope for Steering Nonviolent Mentally Ill Defendants into Care Instead of Jail*, A.B.A.J., June 1998, at 20.

171. *Mental Health Courts Worth a Look*, THE DESERT NEWS (Salt Lake City), Aug. 31, 1999, at 1.

172. *See* Raj Kamal Jha, *Murderers' Psychiatrist Says Everyone Can Get the Urge to Kill*, L.A. TIMES, Oct. 29, 1989, at 2 (noting that until the late 1960s, Department 95 of the Los Angeles County MHCT "had its offices in the psychiatric ward at County-USC."). The Los Angeles MHCT, with a supervising judge and other bench officers holding hearings in three courtrooms, is at least thirty years old, making it the first MHCT in the nation. Dr. Ronald Markman's experiences in the Los Angeles MHCT as Southern California's most renowned forensic psychiatric expert is recounted in RONALD M.D. MARKMAN & DOMINIC BOSCO, *ALONE WITH THE DEVIL* (1989).

173. *See generally* WARREN, *supra* note 170. Warren documented some of the historical operations of the Los Angeles County MHCT from sociological and philosophical viewpoints, with data collections over a period of seven years. She states,

Metropolitan Court [(now known as the Los Angeles County MHCT)] stands alone in a dingy, dirty part of town next to the railroad tracks. It was once a [pickle factory] warehouse; it still looks like one. Into the court annually come thousands of persons, most of them seeking release from involuntary confinement in mental hospitals, but some of them involved in narcotic hearings, mentally disordered sex offender misdemeanor hearings (MDSO), not guilty by reason of insanity hearings (NGI), and other matters at the intersection of the mental health and criminal justice systems.

Id. at 122. Recently, the Superior Court considered constructing a new building to house the L.A. MHCT. However, funding cutbacks and the San Fernando Valley earthquake consumed monies allocated for this project. The Edelman Court in Monterey Park was recently constructed for a specialized juvenile court, however, leading some to believe that a new MHCT structure will also be built someday.

174. Baker, *supra* note 170, at 1.

175. *See* Bill Douthat, *Group Weighs Need for Court for Mentally Ill Defendants*, PALM BEACH POST, June 22, 1999, at 2B.

ily and drug) and on supplemental information derived from the Los Angeles and Broward County MHCT experiences.

A. *The General Need for Specialized State Courts Such as Mental Health Courts (MHCTs)*

Court reformers often justify the compelling need to establish specialized courts by noting "it is clear that in almost every field of endeavor and in every profession, the need to master a body of knowledge and to gain experience in working with that body of knowledge has created a narrower focus over time for those who work within more broadly defined fields."¹⁷⁶ At times, society has criticized specialized judges as being less adaptable and perhaps less qualified than generalist judges.¹⁷⁷ However, this criticism is generally unfounded. The specialist judges' knowledge of the depth and complexity of difficult areas of law makes them uniquely trained and qualified to resolve these issues efficiently and judiciously.

Permanent assignments of judges to specialty courts (e.g., family courts or MHCTs), rather than utilizing temporary rotating generalist judges in these courts,¹⁷⁸ permits specialist judges to master the nuances of a complex body of law.¹⁷⁹ When these judges "see the same issues repeatedly and thus have both the time and the motivation to do the research and thinking needed to resolve them accurately,"¹⁸⁰ cases may be rightly decided more often. A specialized MHCT judge may avoid the criticism of being overly myopic by keeping lines of communication open with generalist colleagues who may provide him or her with more panoramic viewpoints.¹⁸¹ Specialist judges must vigilantly guard against any tendency to dismiss the due process rights of litigants out of an insensitivity to a client's right to his day in court; judges must also watch that they do not give inflexible responses to some parties who repeatedly appear before the court.¹⁸² Specialist

176. Ad Hoc Committee on Business Courts, *Business Courts: Towards a More Efficient Judiciary*, 52 BUS. LAW. 947, 948 (1997).

177. See Jeffrey W. Stempel, *Two Cheers for Specialization*, 61 BROOK. L. REV. 89, 89-91 (1995).

178. See *id.* at 127.

179. See Rochelle C. Dreyfuss, *Specialized Adjudication*, BYU L. REV. 377, 378, 409 (1990) ("The more intricate the law, the more likely it is that a generalist will get things wrong, confuse matters, and encourage additional litigation. The more complicated the facts of a case, the more the judge must master before the case can be decided at all.").

180. See Rochelle C. Dreyfuss, *Forums of the Future: The Role of Specialized Courts in Resolving Business Disputes*, 61 BROOK. L. REV. 1, 16 (1995).

181. See *id.* at 17.

182. See *id.* at 21 ("[R]epeat players have an advantage over one-time litigants. This problem is exacerbated on a specialized bench, where repeaters sometimes know all the judges, are well-acquainted with the eccentricities of the court's local rules and specialized law. . . . One-

judges should guard against even the appearance of unfairness by ensuring that the constitutional rights of defendants are constantly monitored and preserved in all judicial proceedings.

B. General Evaluation of the Effectiveness of Court Reform

A specialty court's success may be measured by examining its decision-making quality, judicial efficiency, and retention of due process rights.¹⁸³ Decision-making quality may be assessed objectively by determining whether the court in question is consistent and accurate in its decisions, including policy determinations, when the facts and law of cases present similar circumstances.¹⁸⁴

Judicial efficiency and economy may be evaluated using such factors as the length of litigation and the court's docket clearance rate, with consideration given to the number of judges and court appearances required for case resolution.¹⁸⁵ Due process requirements may be monitored to determine whether proper notice, an opportunity to be heard, and a neutral adjudicator are provided to defendants.¹⁸⁶ Objective public opinion polls may be taken to assess whether the specialty court is viewed as having achieved societal objectives and met the therapeutic needs of mentally disordered offenders; polls may also be used to determine whether the court is held in high esteem by lawyers, academics, and members of the judiciary.¹⁸⁷

C. Critical Role of the Mental Health Court (MHCT) Judge

Debra Baker describes the plight of mental health offender Tracey Harris, a misdemeanor charged with loitering in front of a convenience store near his group home residence.¹⁸⁸ Tracey entered Judge Ginger Lerner-Wren's Florida mental health courtroom one day "fighting off the sheriff's escort who had a firm grip on his arm," and stopped suddenly upon noticing the presence of his mother and social worker. "With his head hung to the side and his words slurring,

time litigants operate at a severe disadvantage."); Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000) (noting potential problems specialist MHCT judges may encounter). While generalist judges may also experience similar tendencies to "short-cut" the judicial process, specialist judges, seeing "repeaters" more often, should possess greater cognizance of the potential for judicial abuse.

183. See Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000). See also Richard L. Marcus, *Of Babies and Bathwater: The Prospects for Procedural Progress*, 59 BROOK. L. REV. 761, 774 (1993) (arguing for accurate, efficient litigation procedures).

184. See Dreyfuss, *supra* note 180, at 12-13.

185. See *id.* at 14.

186. See *id.* at 15.

187. See *id.* at 11.

188. See Baker, *supra* note 170, at 3.

he held his shackled wrists out toward them and said, 'look what they've done to me. I'm in handcuffs. It's not right.'"¹⁸⁹ Debra Baker observed that generalist judges in state trial courts might easily view Tracey's conduct and agitation as constituting both a threat to public safety and contempt of court, warranting additional imprisonment in the county lockup.¹⁹⁰

However, to a specialist MHCT judge, experienced in handling cases concerning nonviolent mentally ill clients charged with committing minor misdemeanor offenses, Tracey Harris' conduct is more comprehensible.¹⁹¹ Judge Lerner-Wren's patient questioning revealed that Harris' loitering was "not the result of a criminal mind but instead of his mental condition,"¹⁹² posing no danger to public safety. Thus, continued treatment for Harris was justly ordered rather than imprisonment.

Florida's Howard Finkelstein, a chief assistant public defender, commented, "Mentally ill people who commit misdemeanors shouldn't be in jail. It's not humane, it's not right, it's not cost-effective."¹⁹³ Judge Lerner-Wren observed that her MHCT operates

189. *Id.* at 1. A Brazilian cardiologist shot himself and his 5 year old son because he was unable to find employment as a doctor after immigrating to the United States. See Larry Altman, *RB Murder, Suicide Shake Up Neighbors—Father Shoots Son, Himself to Death; 2nd Boy Wounded*, DAILY BREEZE, August 8, 2000, at A1; Jessica Garrison, *Man Kills Son, Self in Redondo Beach*, L.A. TIMES, Aug. 8, 2000, at B3. Perhaps community or MHCT diversionary treatment programs might have prevented this or similar tragedies.

190. See Baker, *supra* note 170, at 1. See also PERLIN, *supra* note 11, at 663-70 and accompanying footnotes. Perlin observes that trial court judges may use certain connotative terms (e.g., "psycho-babble" or "headshrinkers") that reveal their subconscious prejudices against mentally ill offenders, heuristic reductionist thought patterns, or inability to assess the needs of such defendants objectively. *Id.* Perlin notes that some generalist judges may display impatience towards mentally disordered defendants, incorrectly attributing their plight to "weak character or poor resolve." *Id.* Such judges may believe mentally ill defendants fabricate their symptoms, and these judges may view expert testimony relating to predictions of dangerousness as more accurate than the psychiatric literature warrants. *Id.* Moreover, generalist judges may inadvertently allow uncritical acceptance of psychiatric expert testimony, distortion of statutory and case law standards, and deprivation of a defendant's civil liberty because these judges lack an understanding of the intricacies of mental health science and law. *Id.* A judge's subconsciously distorted thinking may adversely affect the court's decisions regarding a client's involuntary civil commitment, refusal to take medications, accuracy of psychiatric diagnosis, or defenses of insanity or incompetence to stand trial. *Id.*

191. *Mental Health Courts Worth a Look*, DESERT NEWS (Salt Lake City), Aug. 31, 1999, 1 (observing that MHCTs may hear misdemeanor cases on an expedited basis, diverting mentally ill offenders into needed outpatient or inpatient treatment programs).

192. Baker, *supra* note 170, at 3.

193. Douglas C. Lyons, *Court Will Handle Cases for Mentally Ill; Hundreds Might Get Treatment Sooner*, SUN-SENTINEL (Ft. Lauderdale), May 23, 1997, at 1B; See also Personal Communication with James Preis (Mar. 16, 2000) (stating that a preferable long-term societal solution would be to decriminalize the mentally ill with diversion of clients directly into treatment programs, perhaps obviating the need for MHCTs).

under the rubric of the therapeutic jurisprudential concept that "the court could do more than just be a mere adjudicator of charges, but could actually take an active role in the treatment of people coming before it."¹⁹⁴

The mental health court (MHCT) judge must be uniquely qualified for this position of responsibility. The model MHCT judge should possess the following attributes: (1) appropriate judicial temperament, (2) compassion and sensitivity to the client's¹⁹⁵ therapeutic needs, (3) tolerance for remission, (4) knowledge of the DSM-IV categories of mental illnesses and their treatment, (5) an ability to objectively assess the value of expert medical testimony¹⁹⁶ and scientific literature, (6) complete understanding of medication effects, (7) a willingness to effect therapeutic change in law enforcement procedures, (8) excellent interpersonal skills, (9) the willingness to represent the goals of therapeutic jurisprudence to the public, (10) a philosophical commitment to treatment and rehabilitative objectives, (11) the perception to recognize preconceptions or biases in him or herself and others, and (12) the capability to efficiently supervise court-mandated treatment plans.¹⁹⁷

For example, prior to serving on Broward County's MHCT, Judge Lerner-Wren's background in mental health and disabilities law included working with indigent clients.¹⁹⁸ She also exhibited extraordinary "energy and zeal for the job,"¹⁹⁹ even hearing additional

194. *Good Morning America I*, *supra* note 5 (noting that "attorneys, case managers, and clinicians try to come up with a treatment instead of a jail sentence" for those who are "willing to accept help").

195. Mental health court inmates, like drug court prisoners, are often referred to as "clients" rather than "prisoners" or "inmates" to emphasize implementation of the therapeutic, rather than punitive, objectives of the justice system.

196. PERLIN, *supra* note 9, at ix (noting Myron Orfield's observation that "89% of judges, public defenders, and prosecutors questioned (including 77% of judges) believed that police officers fabricate evidence in case reports at least 'some of the time' and that a staggering 92% (including 91% of judges) believe that police officers lie in court to avoid suppression of evidence at least 'some of the time.'"). See also Myron W. Orfield, *Deterrence, Perjury, and the Heater Factor: An Exclusionary Rule in the Chicago Criminal Courts*, 63 U. COLO. L. REV. 75, 100-07 (1992).

197. Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000) (noting that MHCT judges should have focused training in issues concerning mentally disabled defendants, experience as an adjudicator of cases pertaining to mental health issues, and personal attributes necessary to competently perform their duties).

198. Baker, *supra* note 170, at 5. The term "clients" is used with the traditional denotation, compared to the term "mentally disordered clients," which refers to "offenders" or "defendants."

199. Ardy Friedberg, *Judge a 'Perfect Fit' for Specialty Court*, SUN-SENTINEL (Ft. Lauderdale), June 17, 1997, at 4B (noting that Judge Lerner-Wren is well-suited for the Broward County MHCT).

MHCT cases on her lunch hour in the MHCT court (apart from her regularly scheduled court docket).²⁰⁰

Task forces may screen for judges with practical experience in adjudicating cases involving indigent mentally ill or disabled clients²⁰¹ to ensure that the objectives of the MHCT in obtaining accurate patient diagnosis and treatment and providing rehabilitative services are met. Moreover, the MHCT judge should be willing and able to take an active role in the management and monitoring of the mentally ill offender's case.

MHCT judges should exhibit sufficient fortitude to resist public pressure or a desire for political expediency in incarcerating the mentally ill. Lotus McClure, former director of the jail and prison committee of a local chapter of the National Alliance for the Mentally Ill (NAMI), says,

People want the mentally ill locked up. Judges think they're doing a public service by locking them up, but they really don't belong in jail. They belong in a psychiatric hospital.²⁰²

Since greater than one-fifth of jails lack even rudimentary mental health services, patients exhibit further deterioration with regularity, leading some inmates to commit suicide.²⁰³ Law enforcement, correctional facilities, hospitals, prosecutors, public defenders, and family members may refer such clients to the MHCT.²⁰⁴

Judges and governmental task forces who wish to establish a MHCT in their state should consider the following suggestions: (1) begin with less complex misdemeanor cases and gradually transition to more complex felony cases; (2) establish organized procedures for law enforcement and jail staff to recognize potential candidates for the MHCT;²⁰⁵ (3) devise probationary and conditional release plans and

200. *Addressing the Issue of Mentally Ill Inmates with a Specialized Court*, CORRECTIONS PROFESSIONAL, Aug. 8, 1997, at 2 [hereinafter, *Specialized Court for Mentally Ill*].

201. Lyons, *supra* note 193, at 1B.

202. Marino, *supra* note 4, at 1. See Baker, *supra* note 170, at 2. NAMI supports the MHCT specialty court's mandate to divert mentally ill offenders from jails and prisons into clinical treatment programs with rehabilitation objectives. *Id.* According to a joint report of NAMI and the Public Citizen's Health Research Group, approximately one-third of jails surveyed housed seriously mentally ill individuals who had no criminal charges filed against them, and most other jails held seriously mentally ill persons on minor charges, such as "disorderly conduct, trespassing, and drunkenness." *Id.*

203. See Baker, *supra* note 170, at 2.

204. See *infra* Appendix A of this Article for the text of the proposed Mental Health Court Diversion Bill.

205. See generally POLICE EXECUTIVE RESEARCH FORUM, THE POLICE RESPONSE TO PEOPLE WITH MENTAL ILLNESSES—INCLUDING INFORMATION ON THE AMERICAN DISABILITIES ACT REQUIREMENTS AND COMMUNITY POLICING APPROACHES—TRAINERS GUIDE AND MODEL POLICY 15-16 (1997). This comprehensive training guide was compiled to

criteria for the release of offenders from institutional commitment; and (4) implement an organized system for follow-up to ensure that mentally ill offenders are regularly reassessed and monitored.²⁰⁶

The Mental Health Department of Los Angeles Superior Court is divided into Departments 95, 95A, 95B, the Office of the Counselor in Mental Health, and the Clerk's Office. All courts operate on a daily basis. Supervising Judge Shabo presides over Department 95, and two bench officers preside over Departments 95A and 95B. Judge Shabo hears a wide range of misdemeanor and felony cases involving such issues as a mentally disordered client's confinement in mental hospitals; a client's capacity to refuse treatment (e.g., medication and ECT)²⁰⁷; the extension of commitment for the dangerously insane upon a prior finding of not guilty by reason of insanity (NGI); the commitment of sexually violent predators (SVPs); commitments for incompetency; commitments for narcotics addiction; and commitments for vagrancy or disturbing the peace.²⁰⁸ In addition, the court's caseload also includes proceedings for commitment of persons who are mentally retarded.

provide law enforcement officials with a training curriculum designed to improve their responses to citizens with mental disabilities under Title II of the Americans with Disabilities Act. Under this approach, a person who is deemed a significant danger to himself or others and is taken into custody by police for the purpose of an involuntary emergency mental health evaluation or placement in a mental health facility is not arrested unless criminally charged. *Id.*

206. See *Specialized Court for Mentally Ill*, *supra* note 200, at 2.

207. Joanna Moncrieff, *Psychiatric Imperialism: The Medicalisation of Modern Living* (visited on Oct. 15, 2000) <<http://www.critpsynet.freeuk.com/sound.htm>>. Moncrieff notes that "A consequence of the move toward community care is that public and political anxiety has replaced the concern for patient rights with concern for protection of the community[,] and psychiatric treatment has become the panacea for this complex social problem." *Id.* She philosophically espouses rejection of societal paternalism, giving mentally disordered offenders "genuine choices" to take or not to take their medications. *Id.*

208. Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000). See also Shabo Staff Interview, (July 6, 2000) (providing information regarding the operations of the Los Angeles MHCT and current caseloads). From January through May 2000, the Los Angeles MHCT reported a current inventory of approximately 7900 cases involving mentally disordered defendants, about 2900 new filings, 4200 hearings or actions, and 2800 transfers or closed cases. *Id.* Judge Shabo hears cases involving the following issues: mental competency under PC 1368, 1370.1 and 1372; mental retardation under WIC 6500; defendants not guilty by reason of insanity [hereinafter NGI]; developmental disability; 180 day post-certification under WIC 5300; mentally disordered sexual offenders [hereinafter MSDO]; MSDO extension, monitoring, or revocation under WIC 6316 or 6316.2; NGI extension, monitoring, or revocation under PC 1026, 1026.2 or 1026.5(b); sexually violent predators under WIC 6250; youth authority extensions under WIC 1800; electroconvulsive treatment under WIC 5327.7; weapons confiscation, return, or restriction lifted under WIC 8102 or 8103; commitment to a mental hospital as a condition of parole under PC 2970; medication capacity appeal under WIC 5334; commitment for narcotics addiction under WIC 3050 or 3051; writs of habeas corpus under WIC 5275; initial conservatorships under WIC 5350; conservatorship reappointments under WIC 5361; certification hearings for 14 and 30 day holds under WIC 5256.1; and facility based medication capacity hearings under WIC 5332.

The work of the court includes establishing and monitoring patients on conditional release; committing persons with developmental disabilities to state hospitals; committing persons found incompetent to stand trial in criminal proceedings; and dealing with California Youth Authority wards who are "physically or mentally defective or dangerous."²⁰⁹ The court also holds conservatorship hearings to appoint a private party conservator or public guardian, granting this individual decision-making responsibilities regarding the treatment and residence of eligible clients.²¹⁰

Department 95A hears mainly LPS conservatorship cases²¹¹ and temporary conservatorship hearings.²¹² It also hears cases regarding the capacity of temporary conservatees who refuse psychiatric medications. Department 95B, founded in January, 1998, hears cases concerning involuntary psychiatric hospitalization under the LPS law, *Riese* appeal hearings for defendants potentially lacking capacity to refuse medication, petitions by the District Attorney on 180 day postcertification to hold patients posing a risk of danger to others, and determination of whether confiscated weapons should be returned to defendants committed under the LPS law. Department 95B is also responsible for hearing all cases involving juveniles held involuntarily in mental hospitals.

The Office of the Counselor in Mental Health assists the bench officer in supporting courtroom operations. The Office performs this

209. Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000) (noting that some of the responsibilities of the MHCT are mandated by California statute and that two bench officers share the work of the MHCT); see also Shabo Staff Interview, Los Angeles, Cal. (July 6, 2000); Nicholas Regush, *Problems with Forced Psychiatric Drug Treatment* (visited on Mar. 3, 2000 <http://abcnews.go.com/sections/living/SecondOpinion/secondopinion_74.html>. Nicholas Regush comments that many Californians oppose new legislation permitting court-ordered psychiatric drug treatments. *Id.* While NAMI purportedly supports paternalistic, imposed treatment of the mentally ill offenders, Regush notes that no scientific studies show that such draconian measures significantly decrease violence and increase public safety. He states that irrational public fear may be the driving force behind this proposed legislation. *Id.*

210. See generally WARREN, *supra* note 170, at 7-8.

211. See generally STEPHEN H. BEHNKE ET AL., *THE ESSENTIALS OF CALIFORNIA MENTAL HEALTH LAW—A STRAIGHTFORWARD GUIDE FOR CLINICIANS OF ALL DISCIPLINES* 73-80 (1998). Under the Lanterman-Petris-Short Act (LPS Act) in the California Welfare and Institutions Code (beginning with section 5000), a court may order involuntary hospitalization of a person with mental disorder for specified limited periods of time provided that, as a result of that mental disorder, the person is a danger to himself, a danger to others, or is gravely disabled. *Id.*

212. See *id.* at 82-83. In *Riese* hearings, the court determines whether the psychiatric patient may choose to refuse psychiatric medications under the LPS Act. *Id.* The court's decision may depend upon whether there is an emergency situation or whether the patient is deemed incompetent. *Id.* In either situation, involuntary treatment with medication may be administered in accordance with statute. *Id.* See also *Riese v. St. Mary's Hospital*, 271 Cal. Rptr. 199 (Cal. Ct. App. 1987).

important court function by (1) supervising the Clerk's Office; (2) scheduling hearings on the court's calendar; (3) managing case files and updating the case management database; (4) coordinating site-based probable cause hearings, medications, capacity hearings and transmitting Writs of Habeas Corpus for patients held at Certification Review hearings; (5) conducting precommitment hearings for cases in which parents or legal guardians seek psychiatric treatment for minors; (6) writing reports to the court for mentally disordered individuals who are involuntarily held or in the age of minority and request release from psychiatric inpatient detention; and (7) serving the community by providing educational training, personal contact, and written information regarding existing mental health laws and resources, both legal and medical.²¹³ The Office also administers the filing of certifications and petitions for medication capacity, yielding over 1500 Certification Review and Medication Capacity hearings per month in over 55 psychiatric treatment sites throughout Los Angeles County.

Jury trials are generally held at different Los Angeles Superior Court locations as well as in the Mental Health Department itself. Offices of the Public Defender, District Attorney, County Counsel, and Public Guardian are situated within the MHCT's facility. At times, prosecutors from other County sites may appear before the court. Ancillary MHCT personnel include a court manager, psychiatric expert witnesses, mental health counselors, social workers, court clerks, bailiffs/sheriffs, court reporters, law externs, and administrative and secretarial staff.²¹⁴

D. The Mental Health Court's Promotion of a Cooperative, Nonadversarial Justice System

In contrast to most generalist state trial courts, which rely upon the time-honored adversarial system to ensure justice, the MHCT judge facilitates largely nonadversarial court proceedings with an approach whose objectives for the qualifying defendant include treatment, rehabilitation, and ultimate release. The judge elicits the participation of the prosecution, defense, correctional facilities, law enforcement, and treatment providers.²¹⁵

213. Shabo Staff Interview in Los Angeles, Cal. (July 6, 2000).

214. See WARREN, *supra* note 170, at 8-9. See also Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000) (noting that the organizational structure of the L.A. MHCT has not changed significantly in the past two decades despite an increasing caseload reflected by both the number and complexity of cases).

215. See generally JAMEY H. WEITZMAN, DRUG COURTS: A MANUAL FOR PLANNING AND IMPLEMENTATION (Robin J. Kimbrough ed., 1995) (supporting a fair balance of treatment and punishment in newly implemented drug courts). See also Interview with Judge Harold E.

In Los Angeles County, Judge Shabo encourages a cooperative, rather than adversarial, environment among various legal and medical personnel, consistent with therapeutic jurisprudence and preventative law principles.²¹⁶ For example, Judge Shabo may patiently encourage withdrawn, medicated, or uncommunicative clients to speak of their therapy needs or discomforting side effects. Judge Shabo regularly mandates physician progress reports in order to ensure that patient treatment is appropriate.

Surprisingly, clients who are unfamiliar with the cooperative modus operandi of MHCTs and who have been “brainwashed” by the court room antics of television or motion picture dramas (for example, “The Practice” or “A Few Good Men”) may be dissatisfied with what they perceive as a “lackluster” court room performance by a lawyer. While some private attorneys may “put on a dog-and-pony-show” for the uninformed defendant who mistakenly equates a “Perry Mason-style” adversarial approach with legal brilliance, an astute judge may find ways to indicate to both client and counsel that the judge finds established cooperative approaches more productive.²¹⁷

E. Initial Court Hearings and Judicial Monitoring of Client Rehabilitation for Release Back to the Community

In a courthouse filled with sad stories, [those of the mentally ill] are among the saddest of all. Some are so mentally disordered

Shabo in Los Angeles, Cal. (Feb. 12, 2000). *But see* Winick, *supra* note 44, at 41-43 (noting that abuses of the nonadversarial system may result in abbreviated commitment hearings lasting only four to nine minutes, rendering these hearings “perfunctory rituals” that compromise procedural due process protections for clients). Winick comments that “judges appear to ‘rubber stamp’ the recommendations of clinical expert witnesses,” with a disturbing correlation frequently of over ninety-five percent between expert witness conclusions and judicial decisions. *Id.*

216. Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000). The Author, serving as a law extern, observed court room procedures and interviewed district attorneys, defense attorneys and support staff.

217. In the Los Angeles MHCT, an occasional privately retained attorney may attempt to justify his fee by using tactics designed more to impress the client than to obtain justice (for example, an aggressive attack of medical expert testimony). Such theatrics are less likely to yield satisfactory results than a logical legal argument supported by case law and statutory authority. A judge may find means of communicating preferred modes of court procedure to defendants and their lawyers. Mentally ill clients may express dissatisfaction with cooperative MHCT procedures, even if such procedures are beneficial to the client’s treatment and preservation of legal rights. The client’s attorney and fellow patients may wish to educate defendants regarding MHCT operations. *See* WARREN, *supra* note 170, at 10 (describing a private attorney who made “a[n] [unnecessarily] lengthy, elaborate, and dramatic case for the release of a patient which had been decided in advance by the judge, DA, and PD.”). *But see* Interview with Professor Jan Costello, Loyola Law School, in Los Angeles, Cal. (Mar. 23, 2000) (defendants are ethically and constitutionally entitled to their “day in court” and to a dramatic defense presentation by their advocate if this is their preference).

that they cannot even make it into the courthouse. Waiting on benches outside [the] courtroom for their few minutes before the judge are some others: a white-haired old woman with a vacant stare living out her days in a nursing home, the angry man in the polyester plaid sport coat gripped by paranoid delusions, or the gifted artist forced to live in a locked facility because he is schizophrenic.²¹⁸

At a mentally ill defendant's initial competency hearing, the judge must evaluate the defendant's mental state to determine whether the defendant is competent and can understand the charges against him or her.²¹⁹ Some mentally ill defendants, such as the homeless and poverty-stricken, may be "disenfranchised" from society, exhibiting resistance to participation in the criminal justice and mental health systems.²²⁰ The client's defense attorney may be queried regarding the defendant's competence to stand trial.²²¹ The judge then determines whether the client should be provided psychiatric diagnosis, treatment, or other medically indicated services as an integral part of the client's treatment plan.²²²

218. Anne Krueger, *Troubled Streets; For Mental Health Judge, Sad Stories*, SAN DIEGO UNION-TRIBUNE, Feb. 23, 1992, at B1. See also Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000) (commenting that in Los Angeles County, the "doubt" is determined in the referring court, while diagnosis and evaluation are performed in the MHCT).

219. See Baker, *supra* note 170, at 3; Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000). In Los Angeles, the generalist trial judge often determines competency. *Id.* However, Judge Shabo recommends assigning this responsibility to the MHCT judge, who may be more experienced in assessing competency. *Id.* If the client is deemed incompetent, the MHCT may monitor this patient further. *Id.*

220. Joel A. Dvorskin & Henry J. Steadman, *Using Intensive Case Management to Reduce Violence by Mentally Ill Persons in the Community*, 45 HOSP. & COMMUNITY PSYCHIATRY 679, 679 (1994) (commenting that many alienated mentally ill defendants come from lower socioeconomic classes and sometimes view "the mental health system and social service systems as their enemy.").

221. See generally Jan C. Costello, *Why Would I Need a Lawyer?* *Legal Counsel and Advocacy for People with Mental Disabilities*, in LAW, MENTAL HEALTH, AND MENTAL DISORDER 15-39 (Bruce D. Sales & Daniel W. Shuman eds., 1996) (noting that every state provides defendants charged with involuntary civil commitment a right to counsel). See also BARBARA A. WEINER & ROBERT M. WETTSTEIN, LEGAL ISSUES IN MENTAL HEALTH CARE 26 (1993) (noting that in less populated areas the court may appoint a private attorney for a mentally ill defendant).

222. CAL. PENAL CODE § 1001.20-35 (1999). Although § 1001.20-35 address a court's diversion of mentally retarded individuals into treatment provided by regional centers, the procedure described is analogous to the proposed diversion of mentally disordered offenders into treatment. If the defendant consents to the diversion process, he waives the right to a speedy trial and the prosecutor, probation department, and regional center are ordered to prepare reports regarding the defendant's case. *Id.* A qualified defendant meeting diversion criteria is then eligible for enrollment in a proposed diversion treatment plan, and the court may order this individual into the program. *Id.* Satisfactory completion of this program may lead to a dismissal of criminal charges. *Id.* In Los Angeles County, a nonstatutory diversion program for mentally ill defendants operates in some courts.

The judge hears expert testimony by psychiatrists and psychologists to diagnose the defendant's mental condition and status (e.g., gravely disabled or dangerous). In cases of grave disability, the judge determines whether the defendant is capable of obtaining basic necessities (e.g., food, clothing, shelter) or utilizing them if provided by others.²²³ In cases of dangerousness, the court assesses the degree to which the defendant is likely to be violent toward himself or others.²²⁴ The judge also monitors the conditions of the defendant's confinement and the degree to which the treating facility respects the defendant's rights.²²⁵ Furthermore, the court is responsible for conducting legally required, site-based administrative hearings to determine the reasons for involuntary confinement and the capacity of the client to refuse treatment.²²⁶

In protecting a client's constitutional rights, all of the court's site-based determinations are subject to judicial review. Mental health counselors employed by the Los Angeles County MHCT contact clients, informing them of their constitutional rights (for example, to a habeas corpus hearing).²²⁷ Mental health counselors also safeguard patients' rights within the hospitals.

Caseworkers assigned to Florida's Broward County sheriff's office screen mentally ill offenders in jails to determine if they are potential MHCT candidates, monitoring their diagnosis and treatment once defendants have had their day in court.²²⁸ Caseworkers in Los Angeles County screen nonviolent alleged misdemeanants and felons to determine whether they are mentally ill and willing to accept treatment, with deferral of trial.²²⁹ In addition, mental health person-

223. Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000).

224. *Id.* See also WARREN, *supra* note 170, at 11-12.

225. The Los Angeles County MHCT judge monitors the way correctional facilities and law enforcement officers treat mentally ill offenders to ensure that offenders are treated humanely and are given such basic necessities as adequate food and access to telephones, medical assistance, or relief from unnecessary restraint. In one instance, jail authorities were ordered to provide a copy of the DSM-IV manual to an inmate to allow him to prepare for court proceedings. In another case, photocopy privileges were ordered to permit an incarcerated man to prepare his defense. In a third situation, jail officials were ordered to give inmates larger numbers of copies of *La Opinion*, a local Spanish newspaper, to permit wider distribution of news. See CAL. WELF. & INST. CODE § 5225.

226. Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000).

227. WARREN, *supra* note 170, at 12.

228. *Specialized Court for Mentally Ill*, *supra* note 200, at 2.

229. Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000); see also Steadman, *supra* note 3, at 1630 (noting that mentally ill offenders arrested "for nonviolent crimes may be diverted from jail to community-based mental health programs"). The National Coalition for the Mentally Ill in the Criminal Justice System also supports diversion of "mentally ill misdemeanants . . . into appropriate mental health treatment services." *Id.* But see Winick, *supra* note 45, at 99. The right to refuse medications provides a mentally disordered defendant

nel staff the county jail to screen new inmates and provide treatment for those identified as mentally ill.

Soon after arrest, a MHCT may participate in screening clients who meet the acceptance criteria for nonviolent (or misdemeanor) offenders, or, alternatively, who are deemed dangerous to themselves or others.²³⁰ Because of the MHCT judge's experience in monitoring such mentally ill clients and the uniquely cooperative communication between treatment and court entities, clients may find they cannot readily manipulate the MHCT system by using deceptive strategies that may otherwise work in traditional trial court settings.²³¹

At an initial hearing, the MHCT judge explains the defendant's rights regarding treatment programs.²³² Judges may elect to release the mentally ill defendant on the condition that the defendant enrolls in a mental health program or complies with probationary requirements.²³³ Judges may condition a client's acceptance of the treatment option upon his or her waiver of the right to a speedy trial.²³⁴

On a typical day at the L.A. MHCT, Judge Shabo may hear forty or more cases, with perhaps four to five defense attorneys repre-

constitutional due process rights because it provides for a hearing, either judicial or administrative, to determine the defendant's capacity to refuse treatment. *Id.* See also *Washington v. Harper*, 494 U.S. 210, 245-46 (1990) (Stevens, J., dissenting) (noting that medication may be improperly used for control purposes rather than for treatment); *Rennie v. Klein*, 476 F. Supp. 1294, 1299 (D.N.J. 1979) (noting evidence at trial revealed that psychiatric medications were routinely prescribed to control patients rather than to treat them).

230. See generally JOHN M. MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* 41-50 (1981); VERNON L. QUINSEY ET AL., *AMERICAN PSYCH. ASS'N, VIOLENT OFFENDERS: APPRAISING AND MANAGING RISK* 20 (1998). But see CURT R. BARTOL, *CRIMINAL BEHAVIOR, A PSYCHOSOCIAL APPROACH* 165 (1995) ("[T]he psychological research has demonstrated 'clear and convincing evidence of the inability of psychiatrists or anyone else to predict dangerousness accurately.'"); Steadman, *supra* note 3, at 1634 (noting that programs designed exclusively to "keep[] mentally disordered persons out of jail to prevent jail overcrowding and disruption" fall short of therapeutic objectives when the programs fail to track follow-up services received by released clients).

231. SEE PETER FINN & ANDREA K. NEWLYN, U.S. DEP'T OF JUSTICE, *DADE COUNTY DIVERTS DRUG DEFENDANTS TO COURT RUN REHABILITATION PROGRAM* 4 (1993) (noting that clients in drug courts find it difficult to manipulate judges or the court system because of the specialized nature of the court and enhanced communication). In the Los Angeles MHCT, clients are seen consistently by the same judge, who coordinates treatment with clinical staff, hospitals, attorneys, and penal institutions; such coordination minimizes the potential for a client to manipulate the justice system and tends to make the mental health system's components accountable to the court. *Id.*

232. See *Drug Court Implementation Initiative* 23 (May 23, 1995) (application for federal assistance, filed to support financing of the Boston Drug Diversion Court).

233. Dvorskin & Steadman, *supra* note 220, at 682. Judges have indicated their frustration with conditional release mechanisms because, in many jurisdictions, "there is no one to accept responsibility for organizing such [mental health treatment] programming." *Id.*

234. See COOPER & TROTTER, *supra* note 152, at 24 (1994) (noting drug offenders' waiver of right to speedy trial and election of treatment is similar to waiver available to mentally ill offenders).

senting clients and two to three district attorneys prosecuting cases on behalf of the People.²³⁵ Most mentally ill offenders in the L.A. MHCT are transported under sheriff supervision into temporary holding cells on site prior to their courtroom appearance.²³⁶ Each day, a panel of psychiatrists is available at the facility to evaluate persons in and out of custody and to report their findings back to the court.

In representing mentally ill clients, defense attorneys may encounter special problems associated with their ethical obligations.²³⁷ Professor Jan Costello states,

Lawyers are likely to share the general public's unease with mental disabilities. A client who cannot readily perform the analytical and decision-making functions that are presumed to be part of the lawyer-client relationship can frustrate the lawyer.²³⁸

Mentally ill clients appearing before a Los Angeles MHCT judge are often, but not always, lower class individuals who may be poor, indigent, unemployed, and deficient in supportive family relationships.²³⁹ At times, these clients may appear either uncooperative, failing to recognize the need for legal representation, or disoriented and incapable of communicating rationally with their lawyer.²⁴⁰ Nevertheless, public defenders assigned to such clients must ensure that the client's needs are met while guarding against overly paternalistic tendencies to "care" for the client.²⁴¹ Professor Costello cautions

235. See WARREN, *supra* note 170, at 10.

236. Occasionally, L.A. MHCT prisoners "act out" in their court holding cells. One inmate flooded the toilets, causing temporary disruption and chaos. Another prisoner spat at guards and resisted them, requiring Judge Shabo to conduct necessary proceedings at the cell site.

237. See generally WEINER & WETTSTEIN, *supra* note 221, at 30-31.

238. Costello, *supra* note 221, at 30-31. "Clients with mental disabilities can be unpredictable in court; their testimony on the stand or behavior at a hearing can be completely unrelated to what they said or did in an interview with the lawyer earlier the same day. All this may be especially unsettling to a lawyer, since one of the attractions of the legal profession is its aura of rationality and control." *Id.*

239. WARREN, *supra* note 170, at 12-13. (speculating that mentally ill individuals who are middle class or upper class have more financial resources to rescue themselves from state hospital systems). Warren further observes that poverty may enhance the probability of mental illness. *Id.*

240. WEINER & WETTSTEIN, *supra* note 221, at 30. See also Jan C. Costello, *Representing Children in Mental Disability Proceedings*, 1 J. CENTER FOR CHILDREN & THE CTS. 101, 107 (1999) ("A client's mental disabilities may be confusing and even frightening to a lawyer/advocate. . . . A client who has a hard time concentrating on the lawyer's questions because she is hearing voices or is deeply depressed may be frightening.").

241. See Costello, *supra* note 240, at 109 ("A client with a mental disability may still possess the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being. . . . What the lawyer really needs to know is how to understand and

that "the lawyer who simply takes on the role of guardian without being appointed by a court violates the client's legal right to make decisions unless and until he or she is declared incompetent by an appropriate authority."²⁴² Thus, she encourages defense attorneys to avoid the "dangers of paternalism" and to give their clients the benefit of complete representation, consistent with counsel's ethical obligations.²⁴³

When clients periodically express dissatisfaction with their defense attorney's representation, the judge may find it advisable to inform the client that the client has delegated decision-making responsibility over many procedural matters to the attorney. However, if dissatisfied, the client may seek to obtain another defense attorney, if available, or to opt for representation *in pro per*.²⁴⁴ When frustrated clients elect to represent themselves, they may discover court proceedings to be too complex to be comprehensible, inadvertently making detrimental decisions. Thus, the MHCT judge should provide the defendant with information regarding the potential risks of self-representation, preserving the client's future option to obtain assistance of counsel.²⁴⁵

communicate as effectively as possible with the client given the client's disability."); Steven J. Schwartz et al., *Protecting the Rights and Enhancing the Dignity of People with Mental Disabilities: Standards for Effective Legal Advocacy*, 14 RUTGERS L. REV. 541, 570-71 (1983) ("Consideration for the clients mitigates in favor of representing their subjective wishes. . . . If advocates do not listen to their clients, respect their views, and assist them to achieve some measure of self-determination, it is not clear who will."); Winick, *supra* note 44, at 42 ("Lawyers in commitment hearings who take the paternalistic or best interests approach serve their clients inadequately" because they may "play largely a clerical role, treating their function as just being 'to look through the paperwork to make sure it is in order,' and thus give the false impression that the client has had the benefit of legal representation. These lawyers 'roll over' in the hearing, deferring to the expert and even stipulating to the hospital's allegations and waiving the client's right to testify."). Defendants at the Los Angeles MHCT are provided phone access to their public defenders, although the defenders' heavy caseloads prohibit the monopolization of their limited time. See Roberts et al., *supra* note 130, at 11. Defense attorneys must balance their clients' need for intensive treatment against the potentially adverse consequences of a waiver of trial or the possibility of court-mandated treatment of an indefinite duration. *Id.* In contrast to a drug addict's situation, for mentally ill offenders, civil commitment for an indefinite duration poses the special danger of a potentially long-term commitment, perhaps without constitutional safeguards. *Id.* The judge safeguards this process by requiring periodic progress reports that review the status of a client's treatment, mindful of the possibility that medically unnecessary medication may also impair the client's cognitive capacities. *Id.*

242. Costello, *supra* note 197, at 110.

243. Costello, *supra* note 240, at 22-25, 30-31.

244. Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000). Defense attorneys may be either court-appointed or retained by clients. Options for defendants may differ depending on the nature of the counsel provided.

245. In one L.A. MHCT hearing, Judge Shabo encountered an African-American defendant who claimed that a young defense attorney was discriminatory against blacks. *Id.* This client wanted to represent himself or have another defense attorney assigned. *Id.* Judge Shabo sug-

MHCT prosecutors seeking to protect public safety must determine, upon initial psychiatric evaluation, whether a particular client warrants treatment or punishment for criminal offenses.²⁴⁶ In select cases, prosecutors may argue that mentally ill offenders could attempt to escape imprisonment if inappropriately assigned to treatment programs.²⁴⁷ Professor Perlin notes a commonly perpetuated public misconception is "that insanity [is] too easily feigned, that psychiatrists [are] easily deceived by such simulation, and that the use of the defense has thus been 'an easy way to escape punishment.'"²⁴⁸ However, this public misconception is not supported by reported scientific studies, and undetected malingering is an infrequent occurrence.²⁴⁹ However, prosecutors may inform the court that they retain the discretion to resume prosecution of alleged offenders if the offenders fail their treatment programs.²⁵⁰

Psychiatric experts are routinely utilized by both defense and prosecution attorneys to determine the clinical diagnostic and prognostic profiles of incarcerated defendants. In the L.A. MHCT, psychiatric experts may be permanently assigned to large state hospitals and regularly testify in court.²⁵¹ Additionally, private psychiatrists also have been appointed by the MHCT judge and reimbursed through court funding.²⁵²

Although MHCT judges may order diagnosed mentally ill clients into necessary treatment, state hospitals or other treatment

gested that before the client made a decision, he might benefit by discussing the lawyer's qualifications and favorable outcomes with fellow inmates. *Id.* The defendant postponed his decision to dismiss counsel. *Id.* In another case, the defendant inadequately represented himself *in pro per*, and Judge Shabo suggested that legal counsel might better aid the client in reaching his objectives. *Id.*

246. See Roberts et al., *supra* note 130, at 16 (indicating some cases may warrant "full prosecution and firm punishment").

247. See *id.* at 15-16 (noting that criminals may attempt to enter drug treatment to escape their sentences and that sane offenders, likewise, may claim mental illness to avoid incarceration).

248. PERLIN, *supra* note 9, at 230-33. (noting that the public fear of feigned insanity is generally unfounded, because "[t]here is virtually no evidence that feigned insanity has ever been a remotely significant problem of criminal procedure . . ." and that prolonged feigning of mental illness requires "a continuity of exertion beyond the power of the sane person.").

249. See David Schretlen & Hal Arkowitz, *A Psychological Test Battery to Detect Prison Inmates Who Fake Insanity or Mental Retardation*, 8 BEHAV. SCI. & L. 75 (1990) (citing studies revealing that medical experts correctly classify 92-95% of all persons as either faking or not faking.). See also Dewey Cornell & Gary Hawk, *Clinical Presentation of Malingers Diagnosed by Experienced Forensic Psychologists*, 13 LAW & HUM. BEHAV. 375, 381-83 (1989).

250. *But see* Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000). (noting if clients are incompetent to stand trial, this prosecution option may not apply).

251. WARREN, *supra* note 170, at 11.

252. *Id.* See also Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000). In 1984, the psychiatric fee was \$150 per half day, but this amount has increased with inflation to \$250-500 plus allocated travel expenses in the year 2000. *Id.*

facilities could conceivably refuse admission because of overcrowding or the defendant's inability to pay for services rendered.²⁵³ Dr. E. Fuller Torrey comments, "[t]he most sobering side of jail diversion . . . is the [often incorrect] assumption that there are public psychiatric services to which the mentally ill individuals can be diverted."²⁵⁴ Yet, Ed Cooper, President of Novastar Opportunities for the Mentally Ill, observes that the court possesses legal authority to "allow[] you to force [provision of] community treatment in a state where there is no community treatment law."²⁵⁵ Judges in states where the community lacks resources may utilize equitable principles to justify interim treatment until adequate legislative or local action is implemented to provide necessary community treatment facilities. Michael Elwell, mental health services coordinator for the Broward County jail, supports expanding existing treatment facilities to accommodate the needs of the mentally ill, commenting, "If you dedicate resources to individuals, somewhere down the line your costs decrease tremendously. Besides, it's the right thing to do."²⁵⁶

Dr. Henry Steadman's comprehensive study found six factors were regularly associated with successful jail diversion programs: "(1) integrated services, (2) regular meetings of key agency representatives, (3) boundary spanners, (4) strong leadership, (5) early identification, and (6) distinctive case management services."²⁵⁷ To meet an anticipated increased medical need for psychiatric care due to MHCT intervention, Broward County recently proposed construction of a \$3 million forensic mental health treatment center, providing beds for

253. Baker, *supra* note 170, at 4.

254. Torrey, *supra* note 9, at 12 (noting that a mentally ill person must be given medications and aftercare to ensure that he can successfully transition back into the community). See also Steadman, *Diversion of Mentally Ill Persons supra* note 3, at 1630-31 (defining "diversion" as "specific programs that screen defined groups of detainees for the presence of mental disorder; use mental health professionals to evaluate those detainees identified in screening; negotiate with prosecutors, defense attorneys, community-based mental health providers, and the courts to produce a mental health disposition as a condition of bond, in lieu of prosecution, or as a condition of a reduction of charges (whether or not a formal conviction occurs); and link the detainee directly to community-based services."). Dr. Steadman further observes that "very few of the programs . . . visited had specific follow-up procedures for diverted detainees. *Id.* Even in instances in which careful attention was placed on linkage to community-based services, few programs had any mechanism to ensure that the initial linkage was maintained." *Id.*

255. Torrey, *supra* note 9, at 5. Cf. Steadman, *supra* note 3, at 1634 (observing that some simplistic jail diversion programs may have a primary goal of "keeping mentally disordered persons out of jail to prevent jail overcrowding and disruption"). More sophisticated diversion programs aim toward "an intensive level of mental health treatment and supervision directed toward the prevention of reoffense." *Id.*

256. Torrey, *supra* note 9, at 5. (commenting that incarceration is more costly than treatment over the long term, since mentally ill individuals lacking treatment may be caught in the jail system's "revolving door" and may be imprisoned several times a year).

257. Steadman, *supra* note 3 at 1631.

treatment lasting up to four months in duration.²⁵⁸ Concerned communities may follow Broward County's lead with similar budgetary commitments to provide increased levels of care for these clients.

Pending results of their treatment, some jurisdictions may elect to defer prosecution of mentally ill clients, while other jurisdictions may wish to find defendants guilty of crimes but also mentally disordered, placing those defendants on probation.²⁵⁹ Clients are motivated to cooperate in treatment, since under either court option, clients who are treatment compliant will not be incarcerated. Those who are not compliant face resumption of criminal proceedings or the completion of their sentences.²⁶⁰

Over the two year period since its creation, judges in Broward County's MHCT ordered 24% of clients into community programs, provided psychiatric evaluations for 17%, hospitalized 15%, and provided treatment by private psychiatrists for another 7%.²⁶¹ In addition, the Broward County Mental Health Task Force successfully obtained \$145,000 to fund a 25 bed hospital center designed to treat and house mentally ill misdemeanor offenders.²⁶²

F. *Creation of Functional Conditional Release Plans to Prevent Potential Relapses or Recidivism*

After the MHCT has accepted a mentally ill defendant into its diversionary program and that client has successfully completed the treatment program, the defendant should be considered potentially eligible for a conditional release or a probationary program. Judges in newly established MHCTs may consider the approaches of Judge Shabo and Judge Lerner-Wren, creating a workable condition-of-release plan in their own jurisdictions to define the circumstances required for the release of a mentally ill offender back to society.²⁶³

For example, in Judge Shabo's L.A. MHCT, a 65-year-old former child molester was imprisoned for most of his lifetime; his first offense occurred at age 17. Later in life, he suffered from such severe dementia that he became disoriented, lost, and could not find his cell after visiting the latrine. While one psychiatric expert testified the defendant might still experience unnatural lusts for children consistent with his past crimes, another medical expert stated that the demented defendant was incapable of executing an organized plan to molest a

258. Torrey, *supra* note 9, at 6.

259. See COOPER & TROTTER, *supra* note 152, 22-23.

260. See FINN & NEWLYN, *supra* note 231, at 10.

261. *Therapy Instead of Jail*, *supra* note 20, at 18A.

262. *Keep Better Track of Funding*, SUN-SENTINEL (Ft. Lauderdale), July 7, 1999, at 22A.

263. *Specialized Court for Mentally Ill*, *supra* note 200, at 2.

child. Judge Shabo released the defendant to a family member who was made a conservator and charged with the responsibility of ensuring that the client was not alone with children, thus minimizing risk of reoffense.

State courts are generally empowered to monitor the use of conditional release and community outpatient treatment programs for mentally ill offenders.²⁶⁴ Professor John Monahan notes that although "individuals with severe mental illnesses are responsible for no more than 5 percent of violent episodes . . . each year," it is "especially unnerving" when such incidents occur.²⁶⁵ Judges necessarily balance the ability of the mentally ill patient to be treated in the community, the least restrictive setting, against any potential danger such treatment poses to public safety.²⁶⁶ Before granting an offender a conditional release, the judge may hear detailed expert medical testimony regarding predictors of future dangerousness and evidence regarding both the offender's mental illness and the absence of his or her potential for violence.²⁶⁷ Even if the judge allows such a release, an offender's violation of conditions in the court's treatment plan will result in discontinuance of treatment and reincarceration.²⁶⁸

Courts may assign responsibility for a mentally ill offender's monitoring and transition back to society to community treatment centers or other mental health professionals.²⁶⁹ For example, following a court order for treatment, Broward County assigns mental health coordinators who ensure that released defendants are safely relocated back into the community.²⁷⁰ In this endeavor, Dr. Steadman recommends deployment of case managers to assist defendants in obtaining such basic benefits as Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Medicaid, General Relief, or food stamps.²⁷¹ Effective diversion programs also include

264. See, e.g., *Brown v. United States*, 682 A.2d 1131 (D.C. Ct. App. 1996); *Felce v. Fiedler*, 974 F.2d 1484 (7th Cir. 1992); *State v. Eaton*, 919 P.2d 116 (Wash. Ct. App. 1996). See also CAL. PENAL CODE § 1600 et seq. (1998).

265. Elaine Jarvik, *Touchy Topic: Mental Health Violence*, THE DESERT NEWS (Salt Lake City), Jan. 16, 2000, at A01.

266. See, e.g., *People v. Sword*, 34 Cal. Rptr. 2d 810 (Cal. Ct. App. 1994); *United States v. Ecker*, 543 F.2d 178 (D.C. Cir. 1976); *Marsh v. State*, 942 S.W.2d 385 (Mo. Ct. App. 1997).

267. See, e.g., *People v. Sword*, 34 Cal. Rptr. 2d 810 (Cal. Ct. App. 1994); *McKee v. State*, 923 S.W.2d 525 (Mo. Ct. App. 1996); *Grass*, 925 S.W.2d at 71.

268. See, e.g., *Levine v. Torvik*, 986 F.2d 1506 (6th Cir. 1993); *United States v. Woods*, 944 F. Supp. 778 (D. Minn. 1996).

269. See, e.g., *People v. White*, 518 N.E.2d 1262 (Ill. Ct. App. 1988).

270. *Specialized Court for Mentally Ill*, *supra* note 200, at 2.

271. *Dvoskin & Steadman*, *supra* note 220, at 681 (noting that case managers may help clients obtain vocational training and Medicaid to "gain access to a physician or other health care professional").

“community-based mental health, substance abuse, and housing services.”²⁷² In addition, as with drug courts, MHCTs may elect to use the guidance of an employment counselor to facilitate rehabilitative transition.²⁷³ To prevent relapse, judges should maintain close supervision over the conditional release treatment process. Some courts require at least initial periodic court appearances (e.g., biweekly) by clients, attorneys, and treatment personnel or probation officers.²⁷⁴

After successful completion of the conditional release program, courts maintain wide discretion in decisions regarding final release or discharge of the offender from treatment and custody.²⁷⁵

VI. PRESCRIPTION FOR JUDICIAL REFORM: ACTION PLAN FOR THE ESTABLISHMENT OF STATE MENTAL HEALTH COURTS

When creating an action plan for establishing MHCTs, the following factors should be considered: (1) obtaining state and local financial and political support for the creation of MHCTs; (2) federal grant availability under America’s Law Enforcement and Mental Health Project (ALEMH Project), recently enacted by Congress to support the establishment of up to 100 pilot MHCT programs; (3) anticipated economic savings obtained in establishing MHCTs; (4) the potential role of MHCTs in reducing criminal recidivism rates; (5) the role of MHCT judges in the news media as advocates of therapeutic jurisprudence; and (6) current progress reported and successes achieved in creating effective state MHCTs. Appendix A of this Article provides proposed legislation, entitled “Mental Health Court Diversion Bill,” for consideration by state legislators, courts, mental health departments, academicians, and other concerned individuals or governmental entities who support the creation of state mental health specialty courts in their respective jurisdictions.

272. Steadman, *supra* note 3, at 1634.

273. See FINN & NEWLYN, *supra* note 231, at 5.

274. See Roberts et al., *supra* note 130, at 6. See also *Drug Court Implementation Initiative*, *supra* note 232, at 14. Drug courts, like MHCTs, may recommend regular and frequent (e.g., weekly, monthly) court appearances to prevent relapses and reoffenses. *Id.* Such court monitoring may be viewed as a short term financial investment, which may be cost effective in the long term. *Id.*

275. See, e.g., *State v. Perez*, 648 So. 2d 1319 (La. 1995); *People v. Bolden*, 266 Cal. Rptr. 724 (Ct. App. 1990); *Canidate v. Stricklin*, 568 So. 2d 1234 (Ala. Civ. App. 1990); *In re Francis S.*, 618 N.Y.S.2d 660 (A.D. 1994) (noting a broad spectrum of past and present behavior may be considered in assessing an offender’s future probability of recidivism); *In re Watt*, 525 A.2d 421 (Pa. Super. Ct. 1987); *Carlisle v. State*, 512 So. 2d 150 (Ala. Ct. App. 1987) (evaluating whether the offender’s mental illness is in remission or controlled by medication, and whether there is a likelihood that the offender will maintain good behavior upon release).

A. *Obtaining Financial and Political Support for Creation of State Mental Health Courts*

Predictably, the greatest barrier to the establishment of state MHCTs is obtaining adequate political and financial support for such programs. Ultimately, state legislators, policy-makers, and citizens hold the purse strings to authorize and permit creation of these specialty courts. At times, a newsworthy criminal event triggers immediate public awareness of the need for specialized courts.²⁷⁶ Alternatively, visionary political leaders may pioneer experimentation in the state judiciary based upon successes reported by specialty courts in distant jurisdictions. MHCT proponents may be encouraged by recently reported successes in the numerous drug specialty courts, now exceeding 425 in number, that have sprouted and substantially grown from meager beginnings.²⁷⁷

For example, Florida's Broward County MHCT was authorized and established by Chief Judge Dale Ross in 1997²⁷⁸ after two years of intensive investigation by the district attorney's office, public defender's office, sheriff's department, and the Henderson Mental Health Center.²⁷⁹ Susan McCampbell, Director of the Broward County Department of Corrections and Rehabilitation, said that in 1994, county officials recognized that cases involving mentally ill offenders were causing backlogs in the civil courts and that jails and forensic treatment centers were overcrowded.²⁸⁰

Henry Steadman, President of Policy Research Inc., noted that while "a lawsuit or a court order" often compels governments to establish new judicial programs such as MHCTs, it is vastly preferable to bring agencies together to discuss common objectives and needs.²⁸¹ Florida's Judge Mark Speiser created a task force of county officials who met monthly to discuss the possibility of creating a state MHCT

276. Josh Meyer, *Sheriff's Dept. to Take Over Court Patrols*, L.A. TIMES, Sept. 6, 1995, at B1 (1999) (noting that the L.A. County Board of Supervisors instituted increased security at courthouses in response to a widely publicized shooting at a downtown courthouse).

277. Goldkamp, *supra* note 128, at 425. See also John S. Goldkamp, *The Origin of the Treatment Drug Court in Miami*, in THE EARLY DRUG COURTS: CASE STUDIES IN JUDICIAL INNOVATION 19, 22 (W. Clinton Terry, III, Ed., 1999) (discussing the creation of the first drug courts and the advantages of such specialty courts over traditional generalist courts).

278. *Therapy Instead of Jail*, *supra* note 20, at 18A; Henry Fitzgerald, Jr., *Year-Old Mental Health Court Celebrates Its Success*, SUN-SENTINEL (Ft. Lauderdale), July 1, 1998, at 3B.

279. See Rocio Diaz, *Court for Mentally Ill in Session*, LAS VEGAS REVIEW-JOURNAL, Aug. 31, 1997, at 17A.

280. *Specialized Court for Mentally Ill*, *supra* note 200, at 2.

281. See *id.* at 2.

based on the successful drug specialty court experiences of other states.²⁸²

Under Florida's proposed task force plan, the MHCT judge identifies nonviolent offenders as candidates for psychiatric evaluations, community mental health services, and possible commitment to state mental health hospitals. Furthermore, the MHCT judge provides the continuity that generalist trial courts lack, ensuring that mental health care providers respond quickly in providing adequate treatment to mentally disordered defendants.²⁸³

In creating the now successful Broward County Florida MHCT, Henry Steadman acknowledged that the most difficult hurdle to overcome was ensuring that sufficient mental health service resources were available to accommodate the large influx of mental health clients entering the court system.²⁸⁴ California observers add that such programs should be furnished with adequate facilities and should provide financial incentives adequate to obtain highly qualified MHCT bench officers, attorneys, and support staff.²⁸⁵ The National Resource Center on Homeless and Mental Illness recently published an excellent resource pamphlet listing major national organizations involved in supporting mental health and related programs.²⁸⁶

In Florida's MHCT, a task force recommended that its new judge begin by hearing misdemeanor offense cases first, before transi-

282. *See id.* at 1.

283. *See id.* at 1-2.

284. *See id.* at 2.

285. *Wrong Answer*, *supra* note 7, at 6. *See also Court Is in a Real Pickle*, L.A. WEEKLY, at 12, Sept. 10, 1999. The Los Angeles MHCT—the oldest in the nation—was constructed in an “aging, decrepit” former mustard-and-pickle factory known as “The Pickle Factory.” *Id.* Judge Shabo notes that “[air conditioning] has been a problem for the nine years I’ve been there. . . . This is all part of the county directing resources away from mental health.” *Id.* Computers at the MHCT are frequently immobilized by crashes that freeze productivity, and software is antiquated. *Id.* Yet, Supervisor Yaroslavsky announced that day that \$450,000 in air conditioning and lighting improvements were completed at the Beverly Hills Municipal Court site. *Id.* *See also Costello*, *supra* note 221, at 36. Professor Costello notes that defense attorneys and nonlawyer advocates for mentally disordered defendants should be comprehensively trained in legal and medical procedures. *Id.* New advocates require training in MHCT procedures and policies, federal and state laws pertaining to the diversion and treatment of mentally disabled clients, techniques for facilitating mentally ill client interviews, correctional and hospital institutional procedures, ethical considerations in the assessment and implementation of client objectives in representation, expert witness examination and cross-examination techniques, interpretation of medical records, the DSM-IV categorization of psychiatric disorders, and frequently prescribed psychiatric medications and their side effects. *Id.*

286. *See generally* NATIONAL RESOURCE CTR. ON HOMELESS AND MENTAL ILLNESS, NATIONAL ORGANIZATIONS CONCERNED WITH MENTAL HEALTH, HOUSING, AND HOMELESSNESS (2000). To obtain this publication, contact the Center at (800) 444-7415 or at nrc@prainc.com.

tioning to more difficult felony cases.²⁸⁷ Judge Lerner-Wren's MHCT started slowly, with about a dozen cases per week.²⁸⁸ This figure has increased, and over 1200 cases have been heard since the court's inception.²⁸⁹ Broward County's MHCT obtained both a \$1.5 million state grant and \$250,000 locally for both the MHCT and the Cottages in the Pines hospital site.²⁹⁰

Other states have followed the examples set by the Los Angeles and Broward County MHCTs. Arkansas' Pulaski County Circuit-Chancery MHCT Judge Mary McGowan says that states such as Arkansas "are really putting their money and resources where their mouth is," as "a major commitment" to state mental health objectives.²⁹¹ Florida's Palm Beach and Fort Pierce judges and mental health workers also debate whether a MHCT should be provided for mentally ill repeat misdemeanants.²⁹²

Circuit Judge Ronald Alvarez publicly comments, "It's hard for me to envision that there is not public or private money for this. We need to keep the mentally ill out of the revolving door of the criminal courts."²⁹³ Dr. Henry Steadman states, "the mentally disturbed jail inmate must be viewed as a community issue."²⁹⁴ Consistent with this philosophy, Florida's Osceola County has already taken the leap of faith by beginning a new MHCT.²⁹⁵ Similarly, Chicago is contemplating a MHCT to "steer—or even mandate mentally ill detainees into treatment."²⁹⁶ Denver's legislative committee is also considering a MHCT to deal with mentally ill offenders guilty of minor offenses,²⁹⁷

287. See *Specialized Court for Mentally Ill*, *supra* note 200, at 2. In contrast, Judge Shabo's Los Angeles County MHCT routinely hears both felony and misdemeanor cases involving mentally disordered defendants.

288. Diaz, *supra* note 279, at 2.

289. *Good Morning America I*, *supra* note 5.

290. Henry Fitzgerald, Jr., *Court a Safety Net for Mentally Ill; Program Wins Award for Providing Counseling Instead of Jail Terms*, SUN-SENTINEL (Ft. Lauderdale), Dec. 28, 1998, at 3B.

291. Susan Roth, *Expert Endorses State Plan to Track Mental Patients*, ARKANSAS DEMOCRAT-GAZETTE, April 22, 1994, at 1A (quoting Pulaski County Circuit-Chancery Judge Mary McGowan as stating that states such as Arkansas "are really putting their money and resources where their mouth is," with plans that are "not an end to [themselves].").

292. See Douthat, *supra* note 175, at 2B; see also Sarah Eisenhauer, *Base Is Laid for Special Court System to Serve Mentally Ill Clients*, FORT PIERCE NEWS, May 14, 1999, at A5.

293. See Douthat, *supra* note 175, at 2B.

294. Steadman, *supra* note 3, at 1634 ("Diversion programs for detainees with mental illnesses will not work without coordination of appropriate services."). MHCTs may provide efficient coordination of services within diversion programs. *Id.*

295. See Debbie Salamone Wickham, *First a Whisper, Then the Storm; System Fails to Stop Violence by Mentally Ill*, ORLANDO SENTINEL, Nov. 1, 1999, at A1.

296. Jerry Dincin, *Getting Medication to the Mentally Ill*, CHICAGO TRIBUNE, June 21, 1999, at 10.

297. *Real Help for Inmates*, DENVER POST, Nov. 14, 1999, at G04.

and Albuquerque hopes to obtain state funding for a pilot MHCT program.²⁹⁸ NAMI notes that a MHCT has just been created in Austin, Texas, and another less publicized MHCT was recently built in Arkansas.²⁹⁹ Ohio's Butler County was promised \$370,000 in operating funds for a MHCT, and additional financial support is anticipated.³⁰⁰ Even the Canadians have joined the bandwagon and acknowledged the utility of MHCTs; upon its inception in May 1998, Toronto's MHCT was lauded in the news as a pioneer for social change.³⁰¹

Among the newest state MHCTs is Washington's King County MHCT, recently started at an initial cost of about \$900,000 a year,³⁰² under the supervision of Judge James Cayce.³⁰³ The stabbing death of a retired Seattle firefighter by a misdemeanor offender who was a paranoid schizophrenic stimulated the creation of the task force that proposed the creation of a MHCT explicitly patterned after the Broward County MHCT. Since more than 200,000 misdemeanor cases are heard by 26 King County District Court judges annually, the new MHCT, with its own judge, prosecutor, and public defender, is slated to hear up to 50 new cases per month.³⁰⁴

For states on limited budgets that cannot immediately create a fully operative MHCT, periodic rotation of mentally ill client cases among traditional trial court judges may pose a more realistic option. For example, in California's San Diego County court, "the job of hearing the mental health cases is rotated yearly among the judges because the caseload is so heavy, and so sad."³⁰⁵ In San Diego, Superior Court Judge Laura Hammes hears cases involving mentally ill

298. Kate Nash, *City Council Split Over Big-I Reconstruction Money*, ALBUQUERQUE TRIBUNE, Jan. 18, 2000, at A4.

299. Roth, *supra* note 291, at 2.

300. See Randy McNutt, *Court for Mentally Ill Offenders Advocated; Judicial Officials at Seminar Told Treatment is Lacking*, CINCINNATI ENQUIRER, Nov. 10, 1999, at B2.

301. See *Criminal System Begins to Recognize Health Issues: Focus on Treatment vs. Punishment*, J. ADDICTION & MENTAL HEALTH, Feb. 1999, at 11.

302. See Barker, *supra* note 8, at B1.

303. Chief Justice Richard P. Guy, *Justice Denied in Washington's Clogged Courts: Supreme Court Justice Sees Resources Lagging Far Behind*, NEWS TRIBUNE, Jan. 23, 2000, at B8. See also Telephone Interview with Judge James Cayce in Seattle, Wash. (Feb. 8, 2000). Judge Cayce notes that the King County MHCT was created informally by the jurisdiction without legislation or judicial order. *Id.*

304. Guy, *supra* note 303, at B8. See also Penny Stuart, *Mental Health Courts Connect People to Services: Treatment vs. Punishment*, 2 J. ADDICTION & MENTAL HEALTH 13 (1999) (noting 308 people have been assessed since the Toronto Court 102 MHCT was launched as a pilot project in May 1998).

305. Krueger, *supra* note 218, at B-1.

clients on Tuesdays and Thursdays, noting, "We do have the law, we just don't have the resources."³⁰⁶

Limited funding negatively impacts the ability of courts to hear and monitor mentally ill offenders' diagnosis and treatment. In one unfortunate incident, Judge Hammes sharply criticized that funding shortages were responsible for the unauthorized medical release of a schizophrenic man she ordered to be temporarily held in the San Diego County Psychiatric Hospital prior to his transfer to a California mental institution.³⁰⁷ Alaska, where about 30 percent of the 3,000 inmates suffer from mental illness, has created "a sort of makeshift mental health court," where two District Court judges hear cases involving mentally ill misdemeanor offenders as part of the new Coordinated Resources Project.³⁰⁸

B. Recent Enactment of "America's Law Enforcement and Mental Health Project" Based Upon Previously Proposed Federal Legislation and Discussion of Proposed State Legislation

On November 13, 2000, "America's Law Enforcement and Mental Health Project" (ALEMH Project) was enacted to provide grants for establishment of mental health courts.³⁰⁹ This progressive Congressional legislation was based upon companion bills, S. 1865 and H.R. 2594, written by Senator Mike DeWine, Senator Pete Domenici, and House Representative Ted Strickland. As its predecessors (H.R. 2594 and S. 1865) proposed, the ALEMH Project provides for \$10 million annually to be granted to "states, state courts, local courts, units of local government, and Indian tribal governments" for up to 100 diversionary programs.

Title I of the Omnibus Crime Control and Safe Streets Act of 1968 was amended to include "Part V—Mental Health Courts" after part U of 42 U.S.C. 3796hh. Paragraph 19 of 42 U.S.C. 3793(a) was amended to provide \$10 million annually for each year from 2001 through 2004. The Attorney General, with assistance of the Secretary of Health and Human Services, was given the authority to administer

306. *Id.*

307. *See id.*

308. *See generally* Lisa Demer, *Mentally Ill Fill Cells; New Program Will Treat, Not Jail, Minor Offenders*, ANCHORAGE DAILY NEWS, July 5, 1998, at 1A. *See also* Elaine M. Andrews & Stephanie Rhoades, *Anchorage District Court Initiates Two New Programs: People with Disabilities Offered Alternatives in Judicial Proceedings*, 23 ALASKA BAR RAG 1 (1999) (noting Anchorage District Court's Coordinated Resources Project establishes a specialty court for mentally ill misdemeanor offenders).

309. *See* America's Law Enforcement and Mental Health Project, 106 P.L. 515; 114 Stat. 2399; 2000 Enacted S. 1865; 106 Enacted S. 1865 (President Clinton signing S. 1865 into law on November 13, 2000).

the ALEMH Project, including issuance of regulations and guidelines for evaluation of state and local diversion programs. Since President Clinton signed this new legislation while this Article was being prepared for publication, the following discussion will provide background information regarding the development of this new law.

Federal legislators, and a few state representatives, have recently promoted bills in support of the creation of mental health courts. In Congress, House Democrat Ted Strickland recently sought passage of federal legislation to provide \$10 million over the next five years to partially fund twenty-five pilot MHCTs throughout the United States.³¹⁰ In Representative Strickland's legislative proposal, America's Law Enforcement and Mental Health Project (H.R. 2594),³¹¹ each MHCT would be provided approximately \$300,000 per year, and the remaining estimated costs of about \$75,000–\$100,000 per year would be paid by local communities. He cited a 1999 U.S. Department of Justice study revealing that over 250,000 jail and prison inmates are mentally ill and potentially in need of state MHCTs that would place them in community treatment programs.³¹²

Congressman Strickland, a former psychologist and ordained minister who previously worked in the Lucasville prison, commented that many mentally ill jail inmates are incarcerated for relatively insignificant minor offenses (trespassing, for example), yet deteriorate in jails, subsequently escalating to worse offenses because of a lack of treatment for their mental disorders.³¹³ Under many state statutes, police, acting as "street corner psychiatrists," may arrest mentally ill street people as substitute "intake procedures" because arrest is deemed less burdensome than the procedures necessary for emergency psychiatric intervention.³¹⁴ Congressman Strickland notes "Jails are becoming America's new mental asylums. Our court systems, prisons and jails are being clogged with mentally ill individuals who should be taking part in mental-health treatment."³¹⁵ Moreover, Strickland says,

310. See *House Republicans Angling to Fill Committee's Vacancy*, COLUMBUS DISPATCH, July 25, 1999, at 7A; Scott Montgomery, *Rep Proposes Experimental 'Mental Health' Courts*, DAYTON DAILY NEWS, July 23, 1999, at 1B.

311. See H.R. 2594, 106th Cong. § 1 (1999). See also *More Humane: Mental Illness; Try Treatment, Not Jail*, CINCINNATI ENQUIRER, Jan. 19, 2000, at A13. [hereinafter *More Humane Treatment*].

312. *House Republicans Angling to Fill Committee's Vacancy*, *supra* note 310, at 2.

313. *Id.* See also *More Humane Treatment*, *supra* note 311, at A13.

314. MENTAL HEALTH AND LAW: RESEARCH, POLICY AND SERVICES 286, 288 (Bruce D. Sales & Saleem A. Shah eds., 1996) (noting that arrest is an efficient way for police to "get[] mentally ill persons off the streets"). See generally L.A. Teplin & N.S. Pruett, *Police as Streetcorner Psychiatrists: Managing the Mentally Ill*, 15 INT. J. LAW AND PSYCHIATRY 139 (1995).

315. *House Republicans Angling to Fill Committee's Vacancy*, *supra* note 310, at 2.

I have seen individuals who are living out the rest of their lives behind bars because they committed crimes that probably would not have been committed had they received mental health treatment. I have seen the effect of prison on the mentally ill and the effect of the mentally ill on prison.³¹⁶

He adds, "I am excited about the concept of having mental-health courts, where appropriately we can divert people into treatment rather than incarceration."³¹⁷

Under Representative Strickland's Mental Health Project plan, eligible offenders with mental illness, retardation, or coexisting mental illness and substance abuse problems may be diverted into MHCT proceedings if these clients are charged with non-violent misdemeanor crimes.³¹⁸ In addition, judicial and law enforcement personnel are provided with training programs "to identify and address the unique needs of a mentally ill or mentally retarded offender."³¹⁹ Strickland's H.R. 2594 first proposed that state government officials would request federal funds to finance a MHCT by submitting an application to the United States Attorney General.³²⁰

Attorney General Janet Reno gave Representative Strickland "positive feedback" regarding his bill, which President Clinton later signed into law.³²¹ Like Strickland, California Assemblyman Bruce Bronzan has estimated that it would cost approximately \$2 billion annually to hospitalize and treat the nation's homeless mentally ill.³²² He supports commitment of public funds for such programs.

Contemplating Representative Strickland's bill, Senator Mike DeWine (R-OH), a former prosecutor, and Senator Pete Domenici (R-NM) have introduced companion Congressional legislation (S. 1865) providing for "125 pilot mental health court programs during the next five years."³²³ This project "is designed to identify at an early

316. *More Humane Treatment*, *supra* note 311, at A13.

317. Jonathan Riskind, *Clinton Urges Mental-Health Parity*, COLUMBUS DISPATCH, June 8, 1999, at 1A.

318. See H.R. 2594, 106th Cong. § 1 (1999).

319. *Id.* (matching contribution of 25% from the state; federal contributions may not exceed 75% of costs).

320. See *House Republicans Angling to Fill Committee's Vacancy*, *supra* note 304, at 2; H.R. 2594, 106th Cong. § 1 (1999) (noting that unless the Attorney General waives a matching contribution of 25% from the state, the federal contribution to the state MHCT may not exceed 75% of costs.).

321. See *House Republicans Angling to Fill Committee's Vacancy*, *supra* note 310, at 2.

322. See *Wrong Answer*, *supra* note 7, at 2.

323. DeWine, *supra* note 12, at 1; see also *More Humane Treatment*, *supra* note 287, at AX; America's Mental Health Companion Senate Bill, *supra* note 19, at 1; America's Law Enforcement and Mental Health Project, 106 P.L. 515, 114 Stat. 2399. The ALEMH Project provides for "not more than 100 programs" for mental health courts over the period from 2001 through

stage those non-violent mentally ill offenders within our justice system, and to use the power of the court to assist them in obtaining appropriate treatment from trained experts."³²⁴ Senator DeWine states:

Each mental health court program would include: Specialized training of law enforcement and mental health court judicial personnel to address the special needs and challenges of nonviolent mentally ill offenders; Centralized case management of all nonviolent cases involving qualified mentally ill or retarded offenders; Voluntary assignment of qualified offenders to outpatient or inpatient mental health treatments; Life skills training, job placement, and education for mentally ill participants; and Continuing judicial monitoring of offenders participating in a treatment plan.³²⁵

Under this MHCT project, "[e]ach court would have its own judge, prosecutor, defender, social worker and probation officer working with local mental health specialists on treatment plans, including medication, counseling, housing, even job training."³²⁶ Senator DeWine states that "Mental health courts offer an alternative. These courts are a very good and viable means of addressing this problem, providing the mentally ill with the proper treatment and help they need."³²⁷

Recently, Senators Domenici, Kennedy, and Wellstone presented the Mental Health Early Intervention, Treatment, and Prevention Act of 2000 (S. 2639), which would amend the Public Health Service Act to provide treatment programs for the mentally ill.³²⁸ This bill provides for up to 125 Mental Health Court grant programs to provide full evaluation of potentially mentally disordered defendants by qualified mental health professionals, specialized training of court personnel and law enforcement to address needs of mentally disordered defendants, judicial supervision of the delivery of mental health treatment, and centralized case management. The Bazelon Center for Mental Health Law notes that the Domenici bill limits the length of

2004. In addition, the Attorney General is authorized to grant federal funding for only up to 75% of the total costs of the program, unless this requirement for matching state or local contributions is waived by the Attorney General.

324. DeWine, *supra* note 14, at 1.

325. *Id.*

326. *More Humane Treatment*, *supra* note 287, at A13.

327. DeWine, *supra* note 14, at 1.

328. S. 2639, 107th Cong. (2000). Senators Domenici, Kennedy, and Wellstone sponsored a bill to amend the Public Health Service Act to provide programs for the treatment of mentally disordered persons, including the creation of a federally-funded mental health court grant program.

court supervision to the maximum length of the sentence for the pending charge.³²⁹ Mr. Chris Koyanagi, Bazelon Director, expressed support for S. 2639 because it allows state MHCTs to assist “those who fall through the cracks” as well as seriously mentally ill offenders charged with more serious crimes.³³⁰

The position taken by Representative Strickland, Senator DeWine, and Senator Dominici finds support with the NAMI position, which also firmly endorses the establishment of MHCTs and the transfer of nonviolent offenders from prisons and jails into treatment centers.³³¹ Likewise, the American Jail Association, the American Correctional Association, the American Sheriff’s Association, and the National Mental Health Association endorse the creation of state MHCTs.³³² With the recent passage of the ALEMH Project legislation, organizations interested in MHCT diversionary programs are encouraged to support the establishment of MHCTs nationwide.

Like congressional MHCT proponents, NAMI argues for a preventative law approach that uses allocated funds in community law enforcement programs to establish crisis intervention teams designed to reduce criminal recidivism among mentally ill clients.³³³ NAMI recognizes that police should be educated to appreciate that such crisis teams, in linking offenders to treatment, function to “help make the community safer.”³³⁴ NAMI also supports access to mental health treatment through either private health insurance or government-funded medical programs.

NAMI is critical of the shortage of police training regarding mental illness, noting that police in 84% of the country’s jails have less than three hours training in this area.³³⁵ NAMI proposes that federal laws be amended to allow states to use prison funds obtained under the Violent Offender and Truth-in-Sentencing grants to improve diagnosis and treatment of the incarcerated mentally ill.³³⁶

329. Judge David L. Bazelon Center for Mental Health Law, *Comprehensive Mental Health Bill Introduced: Fast-Track Legislation Would Expand Services, Study Outpatient Commitment* (visited Nov. 27, 2000) <<http://www.bazelon.org/600mhbill.html>>.

330. Chris Koyanagi, *Letter to the Sponsors of New Mental Health Legislation* (visited Nov. 27, 2000) <<http://www.bazelon.org/newmhlegisltr.html>>.

331. See *Mentally Ill Need More Than Cells: Jails and Prisons are Ill-Equipped to Help Disturbed Inmates*, DAYTON DAILY NEWS, July 18, 1999, at 12B.

332. See DeWine, *supra* note 14, at 2.

333. *Id.*

334. Dvoskin & Steadman, *supra* note 220, at 682 (observing that the goal of diversion treatment programs is not to “help . . . people with mental illness avoid responsibility for crime,” but instead to create safe communities).

335. See *NAMI Calls for Congressional Hearings Following Justice Department Report*, PR NEWSWIRE, July 12, 1999.

336. See *id.*

Similarly, at the state level, California Senator Wesley Chesbro (D-Arcata) has promoted Senate Bill 1769; this bill would create mental health courts to which mentally ill offenders would be diverted, "where judges, with the help of therapists and other experts, would order various types of treatment, instead of sending the individuals to prison."³³⁷ Senator Chesbro's companion bill, Senate Bill 1770, "would require people to receive detailed treatment plans when they are released from state hospitals," rather than being released without care.³³⁸ Unfortunately, California Governor Grey Davis recently vetoed both S.B. 1769 and S.B. 1770.³³⁹

Two California bills, A.B. 1762 and A.B. 1718, would improve police interface with the mentally ill, responding to reports that, since 1994, there were 25 shooting deaths of mentally ill people by the Los Angeles police.³⁴⁰ A.B. 1718 was approved by the Governor to provide for a continuing education training program for law enforcement officers, instructing them in the proper handling of persons with mental illness and developmental disabilities. In spite of his recent vetoes of some mental health programs, this year California Governor Gray Davis began a \$10 million program "aimed at bringing homeless mentally ill people off the streets and into treatment."³⁴¹ California legislators called this pilot program "an unmitigated success" that "needs to go well beyond \$10 million."³⁴² Within four months of its

337. Dan Morain, *Care for the Mentally Ill Emerges as Key Issue; Politics: Legislative Leaders Seek to Increase Funding and Overhaul System*, L.A. TIMES, Mar. 2, 2000, at A3. Senator Chesbro's California Senate Bill 1769 provides for appropriations from the General Fund by the Board of Corrections, State Department of Mental Health, and State Department of Alcohol and Drug Programs to award grants for the establishment of mental health courts.

338. *Id.*

339. See *Governor Grey Davis Veto Message on S.B. 1769* (visited Oct. 15, 2000) <http://www.leginfo.ca.gov/pub/99-00/bill/sen/sb_1751-1800/sb_1769_vt_20000929.html> (vetoed on Sept. 29, 2000). Governor Davis' veto letter stated that the 2000-01 Budget Act already included \$1.8 billion for mental health, a \$155 million increase in funding. However, this Act fails to specifically fund programs that establish MHCTs and divert mentally ill persons from the criminal justice system into treatment. *Id.*; *Governor Grey Davis Veto Message on S.B. 1770* (visited Oct. 15, 2000) <http://www.leginfo.ca.gov/pub/99-00/bill/sen/sb_1751-1800/sb_1770_vt_20000928.html> (vetoed on Sept. 28, 2000) (stating that counties, as well as programs such as the Integrated Services to Homeless Adults and the Mentally Ill Offender Crime Reduction Grant programs, should provide mental health services to residents of communities).

340. Morain, *supra* note 337, at A3. See Cal. Penal Code § 13515.25 (2001) (entitled "Continuing education as to disabled and mentally ill persons"); 200 Cal. A.B. 1718; 2000 Cal. A.L.S. 200; Stats 2000 ch. 200 (approved by the Governor on July 24, 2000 and providing for a continuing education training course to be developed in conjunction with various organizations, agencies, and consumer and family advocacy groups with expertise in mental illness and developmental disabilities).

341. *Id.*

342. *Id.*

inception, the program has reportedly already helped to remove 1,000 people from Northern and Southern California streets.

In New Jersey, Assemblyman LeRoy J. Jones, Jr. recently introduced A.B. 2355 to establish the Mental Health Court Pilot Program³⁴³ to divert nonviolent mentally ill and mentally retarded offenders from incarceration into treatment. Under this bill, mentally disordered or retarded defendants charged with nonviolent petty offenses would be transferred to the Mental Health Court Pilot Program for diversion into treatment in a "short-term care facility" as a voluntarily admitted patient until release.

Thus, recent passage of the ALEMH Project legislation with the concomitant Congressional endorsement of the establishment of demonstration MHCTs provides states and local governments with the impetus, political support, and financial resources necessary to begin effecting necessary societal transformations in the humane treatment of the mentally ill. It is predicted that states, local governments, and communities will now immerse themselves in the immediate task at hand, creating both supportive programs for the formation of new MHCTs and ancillary programs, preserving the Congressional intent to divert the mentally ill from the criminal justice system into treatment.

C. *Computing Projected Economic Savings of Mental Health Courts*

State and local governments should consider the potential economic savings that result from establishing MHCTs. However, since information regarding anticipated cost savings for recently created state MHCTs is limited, estimated cost savings for MHCTs may be analogized, at present, from similar state family and drug court programs.

As a baseline, it has been estimated that in Broward County, it costs approximately \$65 to \$100 per day to house mentally ill offenders in jail.³⁴⁴ One preliminary report indicates the costs of incarceration may be dramatically reduced by treatment, yet, state agencies understandably hesitate to pay high initial start-up costs of up to \$350 per day to treat mental illness without demonstrably justified downstream cost savings.³⁴⁵

However, cost savings for drug court-mandated drug treatment programs are projected to be substantial, estimated at approximately

343. A. 2355 209th Leg. (N.J. 2000) Assemblyman Jones introduced a "Mental Health Court Pilot Program" bill on May 8, 2000. *Id.*

344. Baker, *supra* note 170, at 4.

345. *Id.*

\$5,000 per jailed inmate.³⁴⁶ The average cost for treating drug addicts in jails ranges between about \$900–\$1,600 per participant. If the client was originally a state or federal prisoner, annual cost savings can approach \$20,000 per client, since successful treatment reduces the need for prolonged incarceration or reimprisonment for repeat offenses.³⁴⁷ Significant cost savings—including reductions in the costs incurred in traditional courts for prosecution and trials—justify the existence of various specialty courts.³⁴⁸ For example, in King County's drug court, the cost savings to taxpayers are estimated to be \$522,000 in the first three years due to successful rehabilitation of drug court clients.³⁴⁹

Family court critics condemn the high costs and redundancy of specialized courts.³⁵⁰ These critics argue that generalist trial court judges can learn to be as competent as their specialist judge counterparts.³⁵¹ However, recent studies show that family courts result in substantial long-term cost savings due to increased judicial efficiency, economy, competency, and quality of adjudication, accompanied by smooth coordination among judicial, criminal justice, and treatment personnel.³⁵² Clearly, follow-up investigation is necessary to substantiate these initially encouraging findings of significant economic savings for these various state specialty courts.

D. Proposed Further Investigation of the Role of Mental Health Courts (MHCTs) in Reducing Criminal Recidivism Rate

Preliminary reports indicate that MHCTs have been effective in reducing rates of criminal recidivism among mentally ill offenders.³⁵³

346. See DRUG COURT RESOURCE CENTER, U.S. DEP'T OF JUSTICE, PRELIMINARY ASSESSMENT OF THE DRUG COURT PROGRAM EXPERIENCE 1 (1995) [hereinafter PRELIMINARY ASSESSMENT].

347. See Elaine R. Jones, *The Failure of the "Get Tough" Crime Policy*, 20 U. DAYTON L. REV. 803, 804 (1995).

348. See PRELIMINARY ASSESSMENT, *supra* note 346, at 1.

349. See Elaine Porterfield, *King Court to Specialize in Mentally Ill Offenders; Purpose Is to Improve Both Justice and Treatment, Instead of Simply Sending People Back to the Streets*, NEWS TRIBUNE (Tacoma, WA), May 16, 1998, at A1 (noting that savings of \$322,00 over three years in drug courts may indicate potential savings in specialty courts (e.g., MHCTs)).

350. See E. HUNTER HURST & JEFFREY A. KUHN, A FAMILY DEPARTMENT FOR THE DISTRICT COURTS OF KANSAS: RECOMMENDATIONS FOR IMPLEMENTATION 7 (1993).

351. See E. Hunter Hurst, *Judicial Rotation in Juvenile and Family Courts: A View from the Judiciary*, 42 JUV. & FAM. CT. J. 13, 15-20 (1991) (comparing the merits and disadvantages of judicial rotation to family courts with dedicated judges); see also H. TED RUBIN & VICTOR EUGENE FLANGO, COURT COORDINATION OF FAMILY CASES 36 (1992).

352. See HURST & KUHN, *supra* note 350, at 7.

353. *All Things Considered, Broward County, Florida's Mental Health Court Helps Clear Out Some of the Jail Population by Dealing with the Mentally Ill Who've Committed Non-Violent Misdemeanors* (National Public Radio, Mar. 12, 1999). Radio host Robert Siegel states that Broward

According to Judge Lerner-Wren, more than 675 clients have entered the Florida MHCT, and no defendant has committed an additional violent crime to date.³⁵⁴ This initial finding is consistent with a 1998 MacArthur Foundation study showing that “[m]entally ill people who take their medications are no more dangerous than the population in general.”³⁵⁵

Dr. Barbaree, a renown Canadian forensic psychiatric expert, explains, “There are strong indications of reductions in recidivism among those who receive treatment.”³⁵⁶ Similarly, Dr. Janice Marques of the California State Department of Mental Health has obtained encouraging preliminary results in controlled longitudinal studies utilizing sophisticated statistical analyses that indicate the effectiveness of psychological treatment of sex offenders.³⁵⁷

Likewise, the renown Dr. Karl Hanson has published meta-analyses suggesting that risk assessment for mentally ill offenders may have immense value in providing valid scientific predictors of criminal recidivism that are dynamic, rather than static.³⁵⁸ Further research is necessary to determine the long-term effectiveness of mental health treatment in diminishing criminal, violent, and sexual recidivism among mentally disordered defendants.³⁵⁹ In this regard, John Monahan cautions that “knowledge of the appropriate base rate [of a targeted criminal behavior] is the most important piece of information necessary to make an accurate prediction [of risk assessment for offenders].”³⁶⁰

Similarly, drug specialty courts have had a measurable impact in the “war against drugs.” One report states, “Recidivism has been significantly reduced for offenders participating in a drug court program.”³⁶¹ For example, in Florida’s Broward County drug court, 90%

County’s MHCT has “cleared the Broward jails of an entire class of inmate, the mentally ill who commit non-violent misdemeanors. It’s a modest program but so far, recidivism is low.” *Id.*

354. See Barker, *supra* note 8, at B1.

355. Jarvik, *supra* note 265, at A01.

356. *Criminal System Begins to Recognize Health Issues: Focus on Treatment vs. Punishment*, J. ADDICTION & MENTAL HEALTH, Feb. 1999, at 11.

357. See generally Janice K. Marques et al., *Effects of Cognitive-Behavioral Treatment on Sex Offender Recidivism, Preliminary Results of a Longitudinal Study*, 21 CRIM. JUST. & BEHAV. 28 (1994). It should be noted that long-term longitudinal studies take several years to complete in this treatment context.

358. See generally James Bonta et al., *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis*, 123 PSYCHOL. BULL. 123 (1998).

359. See generally Marnie E. Rice, *Violent Offender Research and Implications for the Criminal Justice System*, 52 AM. PSYCHOLOGIST 414 (1997).

360. See generally JOHN MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* 34 (1981).

361. See GAO and American University’s Drug Court Resource Center *Release Drug Court Reports*, NADCP NEWS, June 1995, at 2.

of participants remained arrest-free.³⁶² Likewise, Oregon's drug court reported lowered re-arrest statistics as a result of successful treatment.³⁶³

In the same manner, 18 months after the court's inception, the Miami drug court, with a heavy caseload of eighty defendants per day,³⁶⁴ has reported significantly lower rearrest rates and longer periods between rearrests than traditional nondrug courts.³⁶⁵ Subsequent follow-up reports on long-term results are needed to determine whether the Miami drug court has been successful in breaking the vicious cycle generated between drug dependency and crime. Similarly, controlled scientific investigations are needed to assess the effectiveness of court-ordered treatment intervention in curtailing reoffenses by mentally ill offenders.

In a preventative law approach, MHCT advocates note that "[b]etter training and sensitivity on the part of law enforcement officers" might result in fewer arrests of mentally ill clients for petty crimes as well as the channeling of mentally ill clients toward community mental health programs.³⁶⁶ Critics maintain that "[p]olice have a misunderstanding of the mentally retarded [and mentally ill]. They are very excitable. Police see them as a threat, but they are not."³⁶⁷ For example, in one recent, tragic story, the Los Angeles Police Commission found that a "5-foot-1, 102-pound[,] mentally ill woman 'brandishing a screwdriver' did not pose a deadly threat to two bicycle patrol officers" who shot and killed her.³⁶⁸

362. See Brown, *supra* note 128, at 93 (citing Ronnie Green, *Drug Court Audit Praises 'Favorable Results,' But Pans Judge*, HERALD, Feb. 18, 1996, at 3).

363. See Mark Curriden, *Drug Courts Gain Popularity*, A.B.A.J., May 1994 at 16, 18. Mark Curriden cited rearrest rates after six months as 6% for those completing the treatment program and 24% for those not completing the treatment program. *Id.* At completion of the program, 15% of graduates reoffended versus 54% of program drop-outs. *Id.*

364. See FINN & NEWLYN, *supra* note 231, at 3.

365. See *id.* at 2. See also John S. Goldkamp, *Miami's Treatment Drug Court for Felony Defendants: Some Implications of Assessment Findings*, 73 PRISON J. 110, 126-27 (1994).

366. Baker, *supra* note 170, at 4. See also Torrey, *supra* note 9, at 12 (stating that "effective pre-booking jail diversion programs" are important aspects of law enforcement programs where officers "spend[] increasing amounts of their time responding to psychiatric crises and must decide whether to take the person to a mental health center or to jail.").

367. Baker, *supra* note 170, at 5.

368. Scott Glover & Matt Lait, *Police Slayings of Woman Violated Policy, Panel Says*, L.A. TIMES, Feb. 16, 2000, at 1 (noting that the Police Commission "found the fatal police shooting of a frail homeless woman . . . violated department policy."). See also *Investigators Say Abuse of Involuntary Commitment Law Led to Shooting Deaths of Disabled Men* (May 19, 2000) <<http://www.pai-ca.org/prVaughnNoble.htm>>. Catherine Blakemore, Executive Director of Protection & Advocacy, Inc., notes that a lack of adequate police training and the absence of mental health/law enforcement interagency cooperation resulted in police officers killing two nondangerous mentally disabled men who refused involuntary hospitalization. *Id.*

Law enforcement reformers may be encouraged by Seattle's progressive King County program, which permits police to take mentally ill offenders who have committed nonviolent crimes directly to the Community Psychiatric Clinic's treatment facility for immediate medical attention instead of arresting them.³⁶⁹ Similarly, in Los Angeles County, a special team consisting of a trained law enforcement officer and mental health professional investigates potentially mentally disordered persons to determine whether the person "should be hospitalized, can returned to a safe environment with responsible relatives or friends, or needs to be booked in jail."³⁷⁰ Judge Shabo notes that these teams have significantly reduced arrests and bookings in jails.³⁷¹ Over a period of six years, approximately 1600 violent confrontations and 3,500 arrests have been prevented. Judge Shabo comments,

State and local governments should be encouraged to replicate these relatively inexpensive programs where feasible in order to divert out of the criminal justice system at the earliest stage those who need not be there and to ensure appropriate disposition of law enforcement contacts in favor of community based mental health treatment.³⁷²

Further scientific investigation is necessary to follow the long-term impact of newly-instituted law enforcement programs upon reduction of crime by the mentally ill.

E. MHCT Judges in the News Media as Advocates of Treatment of Mental Illness as a Disease

MHCT judges are highly visible advocates in the news media and they possess unique opportunities to represent the need for community support, treatment, and rehabilitation programs for mentally ill clients in a manner consistent with the concern for public safety.³⁷³ For example, Judge Lerner-Wren of Florida's MHCT regularly states to news reporters, "Individuals who are ill should be in hospitals, not

369. *Id.*

370. Shabo, *supra* note 11, at 4 (noting that a special team checks for treatment compliance a few days after the incident to ensure the well being of potentially mentally disordered individuals who are not imprisoned, but are either hospitalized or returned to safe environments).

371. *Id.*

372. *Id.* at 7.

373. See Roberts et al., *supra* note 130, at 19 (observing the virtual impossibility of identifying the potential for criminal recidivism while offenders are in treatment). This recurring concern is also important in situations where prosecutors argue, based upon past crimes, that a mentally ill client will reoffend, while defense and medical experts argue that dynamic factors more appropriately predict future criminal recidivism and should be used out of constitutional fairness concerns to defendants. *Id.*

jails.”³⁷⁴ She recently noted that the Henderson Mental Health Center outpatient program, called Positive Alternatives to Medication, “is designed to give the mentally ill some quality of life,” and is an alternative to more costly mental facility treatment that may cost up to \$350 per day.³⁷⁵

New MHCT judges may correctly perceive that mentally ill patients are “a hard population to sell” since “[t]here’s a tremendous stigma related to the mentally ill. They’re a population that’s easy to ignore.”³⁷⁶ Yet, Good Morning America recently featured a television broadcast highlighting this issue, stating, “nearly a quarter of a million Americans with mental illness . . . end up in prison instead of getting the kind of treatment they need.”³⁷⁷

On this television program, Florida’s Judge Lerner-Wren noted “the [mental health] court could do more than just be an adjudicator of charges, but could actually take an active role in the treatment of people coming before it.”³⁷⁸ Similarly, California’s Judge Shabo serves on the National Working Group on Adult Offenders with Mental Health Needs, advises the Council of State Governments, and appears before the California Legislature; he is a visible spokesperson speaking publicly on a variety of mental health issues.³⁷⁹ Thus, it is clear that progressive MHCT judges have the opportunity to publicize and correct societal misconceptions concerning mentally ill offenders and to promote the acceptance of diversionary treatment programs.

Washington’s King County MHCT has a unique Internet website that publishes a MHCT fact sheet, task force recommendations, press coverage, downloadable sample court forms, mental health resource links, and photographs.³⁸⁰ Such computerized systems should

374. Diaz, *supra* note 229, at 17A.

375. *Id.*

376. Marino, *supra* note 4, at 2.

377. *Good Morning America I*, *supra* note 5. See also *Good Morning America* (ABC television broadcast, Jan. 26, 2000). [hereinafter *Good Morning America II*].

378. *Good Morning America II*, *supra* note 377.

379. Shabo, *supra* note 11, at 3. Judge Shabo has discussed various issues, including the plight of the mentally ill who, while in prisons and jails, suffer the loss of their SSI benefits after 30 days of incarceration. This is the result of an unfortunate “gap in the law” that cripples the ability of released patients to receive treatment and contributes to the “revolving door” cycle of homelessness, incarceration, rehospitalization, and release. *Id.* See also Interview with Judge Harold E. Shabo in Los Angeles, Cal. (Feb. 12, 2000). Judge Shabo notes the Working Group’s research reveals that CFR § 416.211 and § 202 of the Social Security Act permit state officials to immediately discontinue a mentally disordered defendant’s benefits (Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), or Medicaid) upon incarceration. *Id.* When a mentally disordered inmate is released from incarceration, he often cannot obtain medical treatment for his psychiatric illness unless a reapplication for benefits has been processed by correctional facility personnel well in advance of his release date. *Id.*

380. King County District Court, *Mental Health Court Home Page* (last modified Nov. 26,

be developed in other jurisdictions to permit mutual communication and sharing of "best court practices" consistent with the principles of total quality management (TQM) commonly utilized in business.

Judges can best serve the interests of justice by focusing public attention on a newsworthy rehabilitated offender's successes as well as his or her needs for housing, vocational training, education, and employment placement.³⁸¹ Richard Guy, Chief Justice of the Washington State Supreme Court, states,

As our society enters the new millennium, we all face new challenges and changing priorities. . . . Together, we can insure that our courts provide equal justice for all. I urge you to write to your state representatives or senators with your opinions on the future of our judiciary.³⁸²

F. Current Progress in Creating State Mental Health Courts of the New Millennium

At the dawn of the twenty-first century, progressive states have the opportunity to investigate the successes of mental health courts in jurisdictions such as California, Florida, Alaska, Toronto, and Washington to determine whether establishing such novel specialty courts will meet the changing mental health needs of their communities.³⁸³ For example, Utah's Division of Mental Health is exploring the creation of a MHCT as a "common sense approach to dealing with the

2000) <<http://www.metrokc.gov/kcdc/mhhome.htm>>. The fact sheet notes that the King County MHCT hopes to obtain "faster case processing time, improved access to public mental health treatment services, improved well-being, and reduced recidivism" for mentally disordered defendants charged with misdemeanor crimes. *Id.* The Author thanks Judge Jim Cayce, Presiding Judge of the King County MHCT, for sharing valuable information concerning his court's operations.

381. See *Drug Court Implementation Initiative*, *supra* note 232, at 14; Roberts et al., *supra* note 130, at 7.

382. Guy, *supra* note 303, at B8.

383. See Dennis Rombo, *State Studies Mental Health Courts*, DESERT NEWS (Salt Lake City), Aug. 26, 1999, at B5 (noting that mental health workers, court personnel, and law enforcement officials will travel to Seattle to study the Washington MHCT). Alaska and Florida have also begun MHCTs. *Id.*; Wickham, *supra* note 295, at A1 (noting that Osceola County is beginning a new MHCT). Many other states are considering establishing MHCTs as well. See *A Man Accused of Slashing a TTC Streetcar Driver Has Been Found Fit to Stand Trial*, TORONTO STAR, Mar. 11, 1999; Nash, *supra* note 298, at A4 (noting that Albuquerque city officials hope to obtain state funding for a pilot program to establish a MHCT); *Real Help for Inmates*, DENVER POST, Nov. 14, 1999, at G4 (stating that legislative committee is contemplating creating a Colorado MHCT to deal with mentally ill offenders guilty of minor offenses); Randy McNutt, *Court for Mentally Ill Offenders Advocated*; *Judicial Officials at Seminar Told Treatment Is Lacking*, CINCINNATI ENQUIRER, Nov. 10, 1999, at B2 (noting Butler County has been promised \$370,000 in operating funds for a MHCT, with additional financial support expected).

growing number of mentally ill inhabiting county jails and prisons."³⁸⁴ A multiagency team was recently scheduled to visit Washington's MHCT to study the methods by which incarcerated clients are channeled into outpatient or inpatient treatment programs under judicial supervision.³⁸⁵

After two fatal shootings in Salt Lake City by mentally ill offenders, Utah Governor Mike Leavitt requested that the state Mental Health Board study the potential for rehabilitating mentally disordered patients through the creation of a state MHCT.³⁸⁶ His proposed 2001 budget provided funding for a Program for Assertive Community Treatment (PACT), giving "comprehensive care from a team of physicians, nurses and social workers on a round-the-clock basis."³⁸⁷ Six states have extensive PACT programs, and nineteen others have pilot programs.³⁸⁸

Dr. Fuller Torrey, President of the Treatment Advocacy Center in Virginia commented on these Utah shootings that "it may be . . . that the threat of violence will finally get public mental health agencies the law and funding they need."³⁸⁹ This would put an end to the perceived apathetic "collective shrug" encountered in response to the "pathos of the homeless [and imprisoned] mentally ill."³⁹⁰

In affirmative response, the Division of Mental Health has procured 75 beds in the Utah State Hospital's new forensics unit, allowing the unit to conduct psychiatric diagnostic evaluations of defendants awaiting trial and house criminal defendants found by the courts to be either mentally incompetent or mentally ill.³⁹¹ Moreover, the Utah State Prison will open a 140-bed unit at its Olympus Forensic Mental Health Facility, staffing it with psychiatric technicians and corrections

384. *Mental Health Courts Worth a Look*, DESERT NEWS (Salt Lake City), Aug. 31, 1999, at 1.

385. *Id.* at 1.

Such a court could have diverted the Triad Center and LDS Family History Library shooters into treatment on their first offenses. Both shooters had previously committed misdemeanor offenses, and each suffered from mental illness. All of that is Monday-morning quarterbacking, of course. But it has become increasingly apparent that Utah must do more to address the growing number of mentally ill people behind bars. More than 600 people with mental illnesses are in the state prison system, where they now receive arguably little treatment.

Id.

386. Romboy, *supra* note 383, at 1.

387. Jarvik, *supra* note 265, at A1.

388. *Id.*

389. *Id.* (noting that a second Utah incident in April 1999 involved a Russian immigrant who shot and killed library patrons before being killed by police).

390. *Id.*

391. Romboy, *supra* note 383, at 1.

officers.³⁹² Even with these plans, John Pace of Utah's Disability Law Center adds, "We need more resources for (caseworkers)[sic] to go out in the community to see clients. We need more housing for the mentally ill."³⁹³

Finally, Utah has already instituted a pilot preventative Crisis Intervention Team program in conjunction with law enforcement to help police officers identify mentally ill citizens who may be channeled into mental health treatment services prior to any escalation into problematic criminal behavior.³⁹⁴ Mental health staff members are training law enforcement and correctional facility personnel to recognize and handle individuals with mental illnesses, enabling those individuals to receive necessary treatment.³⁹⁵ For example, police now may recognize that misdemeanor clients who have been imprisoned for more than two days and have not attempted to be released may need psychiatric help. Susan McCampbell, Director of Florida's Broward County Department of Corrections and Rehabilitation, states that this acquiescent, counter-intuitive behavior could be a significant early indicator of mental illness in the detection of MHCT candidates who may be referred to defense attorneys or social workers for follow-up and monitoring.³⁹⁶

Similarly, Richard Davenport of Des Moines, Iowa comments that law enforcement departments should have officers trained to defuse innocuous situations involving the mentally ill to prevent potentially fatal shootings.³⁹⁷ Likewise, Linda Priebe of the Bazelon Center for Mental Health Law notes that a federal jury's \$5.4 million dollar award to a mentally ill defendant—"the largest damage award to a person with a mental illness for lack of mental health treatment in a jail"—deters "reckless indifference" by the correctional system toward mentally disabled defendants, such as denying medical care to a mentally disabled defendant and unconstitutionally punishing him through solitary confinement.³⁹⁸ She continues:

392. *Id.* at 2.

393. Jarvik, *supra* note 265, at A1.

394. Rombay, *supra* note 383, at 1.

395. *Id.* at 2.

396. *Specialized Court for Mentally Ill*, *supra* note 200, at 2.

397. Lynn Hicks, *Police Consider Crisis Teams to Help Mentally Ill*, DES MOINES REGISTER, Oct. 20, 1999, at 1.

398. Judge David L. Bazelon Center for Mental Health Law, *Federal Jury Awards \$5.4 Million in Damages for Solitary Confinement of Prisoner with Schizophrenia* 1-3 (visited Mar. 6, 2000) <<http://www.bazelon.org/lawsonpg.html>>. The jury awarded a schizophrenic patient, unjustly held in solitary confinement for more than 65 days, \$400,000 in compensatory damages for pain and suffering and \$5 million in punitive damages. *Id.* Linda Priebe, Bazelon Center senior attorney, observes, "it's an extraordinary award in any context, because our legal system generally values the lives of people with mental disabilities as worth less than others; and as having

This case sets an important precedent. . . . It sends a strong message to both jail and mental health administrators that the public is concerned about the increasingly widespread incarceration of people with mental illnesses in jails and prisons and their inadequate treatment there.³⁹⁹

Overcrowding at the nation's jails is prevalent and results from tough anticrime legislation such as Washington's "three strikes" law.⁴⁰⁰ Notwithstanding diminishing crime rates in cities, some law enforcement officers place the mentally ill in jails as "mercy bookings," designed to guarantee food and shelter to needy individuals.⁴⁰¹ Most jails and correctional facilities lack treatment facilities for mentally ill inmates, and only 51% of incarcerated clients interviewed by the Justice Department report receiving any treatment at all.⁴⁰²

A few forward-looking correctional facilities, such as Ohio's Cuyahoga County jail, possess an organized system for diagnosing and treating mentally ill clients.⁴⁰³ There, psychiatrists, nurses, and fellows from the University Hospitals Fellowship in Forensic Psychology program diagnose the mental disorders and diseases of inmates. At these Ohio jails, assigned mental health caseworkers monitor treatment and facilitate communication between mentally disordered patients and the courts, guiding clients either to state hospitals for therapy or transitioning rehabilitated patients back into the community.

Echoing the Utah experience, Ohio commentators support both "additional training for law enforcement officers and establishing a 'mental health court,' as other cities have done."⁴⁰⁴ It is encouraging that Governor Gray Davis may consider signing California bill AB34, which proposes to fund a \$10 million pilot program to "expand exist-

even less value if the person has been accused of a crime." *Id.*

399. *Id.* at 3.

400. Kery Murakami & Nancy Bartley, *Wallenstein Brought Creativity to Jail Job—Sims Lauds Director for Finding Innovative Solutions to Crowding*, SEATTLE TIMES, Aug. 18, 1999, at 1 (a county task force report predicting that the county will require a third jail by 2004).

401. *First, Finish the Study*, DENVER POST, Sept. 24, 1999, at B6.

402. Marino, *supra* note 4, at 2.

Mentally ill offenders committed to jails and prisons often are abused and sometimes killed by correctional authorities, ignorant of the signs and symptoms of mental illness. . . . The inappropriate use of force and infliction of punishment upon inmates who are incapable of obeying orders and understanding the reason for punishment must stop. Appropriate training and rigorous compliance with procedures designed specifically to deal with mentally ill offenders are indispensable in this regard. Correctional officers who violate such procedures should be promptly and predictably sanctioned in order to deter mistreatment of mentally ill offenders.

See Shabo, *supra* note 11, at 11-12.

403. *Id.* at 2-3.

404. *Id.* at 3.

ing services [to the homeless] through intensive outreach in order to determine the impact those services have on keeping people with mental illness out of jail."⁴⁰⁵ More programs are urgently needed to investigate the beneficial effects of treatment on reducing rates of criminal recidivism and incarceration. Judge Harold Shabo notes, "Effective mental health treatment requires that the system address all components of an individual's needs, from medications to employment to housing to education."⁴⁰⁶

G. Proposed Model Legislation: The Mental Health Court Diversion Act

The proposed Mental Health Court Diversion Act (hereinafter MHCT Diversion Bill), which appears in Appendix A of this Article, was drafted for use by state governments, legislators, judges, administrators, academicians, hospitals, law enforcement, mental health professionals, correctional facilities, and others who wish to investigate and promote legislative support for the establishment of state mental health specialty courts for the just treatment of mentally ill offenders. This model legislation incorporates statutory language consistent with the objectives of therapeutic jurisprudence and preventative law in the diversion of qualified mentally disordered defendants from correctional facility settings into treatment. The MHCT Diversion Bill is designed to provide long-term cost savings by breaking the predictable but costly "revolving door" pattern of a mentally disordered offender's homelessness, reoffense, incarceration, and release.

The Bill provides for the creation of state-funded pilot MHCTs as focal points to centralize the case management of qualifying mentally disordered defendants; its goal is to diagnose, treat, hospitalize, and rehabilitate mentally disordered defendants, potentially returning them to the community as productive members of society through court probation and conditional release programs. The Bill also includes a procedural "safety net" to ensure that constitutional due

405. *California Poised to Expand Services, Outreach to Homeless*, 11 ALCOHOLISM & DRUG ABUSE WEEKLY, Sept. 27, 1999, at 5.

406. Shabo, *supra* note 11, at 3, 8, 11. Judge Shabo comments, "[t]he court should play the central role of enforcing interagency cooperation and accountability just as the court evaluates the individual's compliance with treatment." *Id.* He adds,

It is unrealistic to expect that a person attempting to fend for himself/herself without housing, a dependable income source, and without the other necessary attributes of personal stability and security is going to participate in mental health treatment or be treatment compliant [T]he release of patients and inmates without income support plays a major role in the problems of homelessness, rehospitalization and incarceration of persons with persistent and serious mental illness.

Id.

process rights of mentally disordered defendants are retained throughout judicially-monitored treatment plans and court proceedings. Annual funding of one million dollars per year is given as a realistic amount that would permit the initial establishment of approximately 2-3 pilot state MHCTs. Larger states might appropriate greater amounts for the creation of additional experimental MHCTs, whereas smaller states might commit lesser sums for such courts. State and local courts and governments may obtain federal funding for up to 75% of their MHCT programs through the recently enacted ALEMH Project.

The MHCT Diversion Bill creates an independent Evaluation Committee whose purpose is to assess the impact of MHCTs in enhancing judicial efficiency and economy, decreasing high correctional facility costs, promoting efficacy of treatment, and reducing rates of criminal recidivism. States may determine their own levels of financial commitment and the duration of pilot MHCT programs. As a guideline, recently proposed federal bills have suggested that to cover costs of operation, each newly established MHCT should be provided with approximately \$400,000 per year for five years.⁴⁰⁷ The projected annual costs for the year 2000 for the King County MHCT program were estimated to be approximately \$650,000.⁴⁰⁸ MHCT advocates are encouraged to tailor this proposed MHCT Diversion Bill to meet their state's specific jurisdictional, financial, logistical, and other related needs for judicial and/or legislative reform. In addition, Congressional MHCT proponents may wish to utilize concepts presented in this Bill to synergistically strengthen proposed federal programs for creation of state MHCTs.

H. Creation of MHCTs by Judicial Administrative Order

Florida's Broward County MHCT was created on May 22, 1997 by Dale Ross, Chief Judge, in accordance with Rule 2.050 of the Florida Rules of Judicial Administration. The Administrative Order for "Creation of a Mental Health Court Subdivision within the County Criminal Division" is provided in Appendix B of this Article. This Order establishes that a "part time Mental Health Subdivision shall be operational within the County Criminal Division," with Judge Ginger

407. See note 310 and accompanying text (noting Representative Strickland's bill provides \$300,000 per year in federal funding with up to \$100,000 in matching state funding). See also H.R. 2594, 106th Cong. § 1 (1999).

408. Personal Communication from Kari Burrell, Program Manager, Mental Health Court, Office of the Presiding Judge, King County District Court (August 1, 2000) (noting that the total projected annual costs for the MHCT were \$634,947, including costs for the district court, court monitoring and treatment, prosecution, and defense).

Lerner-Wren presiding as magistrate. It is particularly noteworthy that the court's role is explicitly specified as monitoring the functions of the "Department of Children and Family Services, Henderson Clinic, Nova Southeastern Outpatient Care Clinic, private mental health providers, County Court Probation, and Pretrial Services of the Broward Sheriff's Office."

The courts' supervision of mentally disordered defendants' treatment plans is critical to the success of any diversion program. State Chief Justices or Court Committees may wish to consider drafting a judicial order to establish similar pilot MHCT programs in their jurisdictions.

VII. CONCLUSION: JURISPRUDENTIAL FOUNDATIONS OF MENTAL HEALTH SPECIALTY COURTS REVISITED

Judge Jack Weinstein, an ardent advocate of therapeutic jurisprudence and preventative law, maintains that specialized courts must be placed "in a social context, as part of a web of institutions" that allows citizens to live together peaceably. Legal institutions should not exist in a vacuum, but in "a larger ecology in which various dispute institutions interact." He continues,

As these interconnections become common knowledge, those who would design or justify legal institutions must accept responsibility not only for the small world of adjudication, but for the larger world of disputing and bargaining in which it is set.⁴⁰⁹

Thus, progressive MHCT reformers are advised to maintain a unified, cohesive vision to maximize justice for mentally ill defendants and to consider complex interactions with existing legal systems, families, and society. Advocates of such an ecological approach⁴¹⁰ encourage courts "to look beyond the individual litigants involved in any . . . matter, to holistically examine the larger social environments in which participants live, and to fashion legal remedies that strengthen . . . supportive relationships."⁴¹¹

Proponents of therapeutic jurisprudence support MHCT judges and other concerned advocates in participating proactively in the adjudication process as "healers" in a court "that restores people to

409. Jack B. Weinstein, *Some Benefits and Risks of Privatization of Justice Through ADR*, 11 OHIO ST. J. ON DISP. RESOL. 241, 248 (1996).

410. See generally URIE BRONFENBRENNER, *THE ECOLOGY OF HUMAN DEVELOPMENT* (1979).

411. See Barbara A. Babb, *An Interdisciplinary Approach to Family Law Jurisprudence: Application of an Ecological and Therapeutic Perspective*, 72 IND. L.J. 775, 803 (1997).

their integrity and overcomes undesirable conditions,"⁴¹² rather than merely accepting the traditional, generally passive approach to decision-making.⁴¹³ Proactive MHCT judges therefore should be expected to exhibit a greater degree of patience, respect, and empathy in their implementation of the judicial process.⁴¹⁴ Optimally, a MHCT judge's integrated therapeutic jurisprudence and preventative law approach toward the resolution of cases involving mentally ill clients should mobilize a cadre of attorney advocates, clinicians, therapists, social workers, treatment and correctional facility administrators, law enforcement personnel, employment counselors, mediators, probation officers, and other committed professionals.⁴¹⁵

Professor David Finkelman notes that application of therapeutic jurisprudence to mental health law and other fields "promises to reinvigorate the area and, if successful, . . . to produce . . . better treatment for those who find themselves involved in the mental health system."⁴¹⁶ He encourages those "thoughtful individuals who occupy the front line of forensic mental health services" to "gather observations to feed the debate [concerning therapeutic jurisprudence], to challenge it, and to test its heuristic value in a world dominated by complex political and practical demands."⁴¹⁷ The promotion and creation of state

412. Susan Snow & Steve Friedland, *The Judge as Healer: A Humanistic Perspective*, 69 DENV. U.L. REV. 713, 713 (1992).

413. *Id.* at 714.

414. *Cf. id.* at 716. Snow and Friedland observe that the traditionally neutral role of the trial court adjudicator may be frustrating for judges.

The growing size and complexities of many court systems . . . aggravates the perception that one is on an assembly line, since a given judge may only handle a small aspect of the case before it moves on through the system. This is less than satisfying for judges . . . because they may never see or know the final outcome. Removed from the results of their own labors, as well as the people involved in the cases they have dealt with, it is understandable that judges come to feel disconnected from the individuals who appear in their courtroom.

Id.

415. See Lynne M. Kenney & Diane Virgil, *A Lawyer's Guide to Therapeutic Interventions in Domestic Relations Court*, 28 ARIZ. ST. L.J. 629, 635-38, 641 (1996). See also Deborah Dorfman, *Through a Therapeutic Jurisprudential Filter: Fear and Pretextuality in Mental Disability Law*, 10 N.Y.L. SCH. J. HUM. RTS. 805, 819 (1993) (emphasizing that treatment providers, such as psychiatrists and social workers, who utilize therapeutic jurisprudence approaches must introspectively investigate their own underlying reasons for selecting treatment choices to "assess . . . why [they] are making this choice" to ensure that the client's expressed interests and desires are reflected).

416. David Finkelman & Thomas Grisso, *Therapeutic Jurisprudence: From Idea to Application*, 20 N.E.J. ON CRIM. & CIV. CON. 243, 248 (1994). See also Joel Haycock, *Speaking Truth to Power: Rights, Therapeutic Jurisprudence, and Massachusetts Mental Health Law*, 20 N. ENG. J. ON CIV. & CRIM. CONFINEMENT 301, 317 (1993) (commenting that "the success of therapeutic jurisprudence will depend in part on the degree to which it empowers the objects of therapeutic and judicial attention.").

417. Finkelman & Grisso, *supra* note 416, at 252.

mental health specialty courts is consistent with the objectives of therapeutic jurisprudence and preventative law because it facilitates the treatment and rehabilitation of mentally ill offenders for their return to society as constructive members of their respective communities.

APPENDIX A: MENTAL HEALTH COURT DIVERSION ACT⁴¹⁸

LeRoy L. Kondo and Judge Harold E. Shabo

A BILL:

To provide grants for the establishment of mental health courts for the purpose of diverting mentally disabled offenders from the criminal justice system into treatment programs with objectives of rehabilitation, reducing criminal prosecution, and reducing costs of incarceration while maintaining public safety.

SHORT TITLE:

This Bill may be cited as the "Mental Health Court Diversion Act."

BACKGROUND:

The National Alliance for the Mentally Ill (NAMI) estimates that 25–40% of the mentally ill population in America has experienced contact with the criminal justice system. The American Jail Association states that between 600,000 and 700,000 mentally ill offenders are booked in jails each year. The Department of Justice Bureau of Justice Statistics (July, 1999) reported that over a quarter million prison and jail inmates are mentally ill, comprising 16% of the correctional facility population nationwide. The National Law Center on Homelessness and Poverty and the National Coalition for the Homeless estimate that at least two million Americans experience homelessness annually, with about 40–50% of them suffering from mental disorders. Crowded jails and prisons have been utilized ineffectively as surrogate mental hospitals, housing mentally ill offenders and homeless individuals who are often convicted of nuisance crimes such as loitering or panhandling. Law enforcement officers have periodically placed the homeless mentally ill in correctional facilities without accompanying charges because local government is purportedly overwhelmed by the unmet needs of the poor and mentally ill. According to a joint report of NAMI and the Public Citizen's Health Research

418. Correspondence regarding proposed legislation may be directed to the Authors c/o The Seattle University Law Review or to LeRoy Kondo via e-mail at LLkondo@aol.com. The Authors wish to express appreciation to the following individuals for their comments and suggestions regarding this proposed legislation: Ronald Honberg, Legal Affairs Director, National Alliance for the Mentally Ill (NAMI); Michael Thompson, Director of Criminal Justice Programs, The Council of State Governments, Eastern Regional Conference, New York, N.Y.; Steven Ingley, Director, American Jail Association; James Preis, Director, Mental Health Advocacy, Los Angeles, Cal.; Melinda Bird, Paul Gerowitz, and Pamela Lew, Protection & Advocacy, Inc., Los Angeles and Sacramento, Cal; and Professors Sande Buhai, Jan Costello, and Scott Wood, Loyola Law School, Los Angeles, Cal.

Group, approximately one-third of jails surveyed housed seriously mentally ill individuals who had no criminal charges filed against them, and most other jails held such persons on minor misdemeanor charges consisting of disorderly conduct, trespassing, and drunkenness.

Since greater than one-fifth of jails lack even rudimentary mental health services, it is predictable that many mentally ill patients experience further deterioration of their mental condition, leading some inmates to commit suicide. Senator Michael DeWine notes, "Law enforcement agencies and correctional facilities simply do not have the means, or the expertise, to properly treat mentally ill inmates."

Furthermore, costs of housing mentally disordered offenders in prisons and jails are exorbitantly high. Almost half of states report per capita correctional facility costs for incarcerating prisoners to be between \$20,000 and \$30,000 per year. These per capita expenditures can rapidly approach astronomical figures: In 1996, annual state and federal prison expenditures were \$22 billion and \$2.5 billion respectively. These expenditures include costs of operations; employee wages, salaries and benefits; food service; medical care; transportation; land and building purchases; utilities; and building construction, renovation, and repair.

Due to the prohibitively high costs associated with the imprisonment of the mentally ill offender population, states have examined whether mental health courts might be utilized to reduce such costs. In support of states and local governments, Congress has recently enacted "America's Law Enforcement and Mental Health Project," providing for \$10 million annually to states, state courts, local courts, and governments for up to 100 diversionary mental health court programs. Mental health courts have previously been established in Los Angeles County, California; Broward County, Florida; and King County, Washington. Notably, the Florida and Washington courts have recently reported the successful diversion of nonviolent mentally disordered offenders from jails and prisons into judicially monitored mental health treatment programs. These court-supervised treatment programs have connected offenders to treatment and reduced rates of criminal recidivism.

OBJECTIVES:

This Bill provides that grants be awarded to counties on a competitive basis for five years for programs that establish mental health courts for the purpose of the diversion of mentally disabled offenders from the criminal justice system into treatment programs. The mental health court shall provide a unified point of contact whereby the court

may order diagnosis, treatment, and ancillary services for a mentally disabled offender who meets the statutory criteria that follow: (1) the presence of a diagnosed mental disorder that was a substantial contributory factor in the commission of the alleged offense, arrest or conviction, or during the person's confinement, (2) the defendant is not currently charged with an offense involving the infliction or attempt to inflict substantial physical harm to another, (3) a physician provides a written statement that the defendant would benefit from treatment, (4) the defendant is willing to enroll in a treatment plan on a voluntary basis, and (5) the defendant expressly agrees to waive the right to a speedy trial. Defendants who voluntarily participate in outpatient or inpatient mental health treatment and successfully complete their treatment programs shall be granted either dismissal of charges or a reduced sentence. Diversion of mentally disabled defendants into treatment serves the interests of justice by ensuring the defendants' treatment rather than imprisonment, reducing the high costs of prosecution and incarceration, and enhancing public safety.

Primary objectives of the mental health courts shall include:

1. Appointment of experienced judges and judicial bench officers who possess training in the specialized issues surrounding mental disabilities, including treatment and rehabilitation.

2. Facilitation of coordination among law enforcement, criminal justice, and mental health resources through a unified court system.

3. Development of law enforcement and correctional facility programs utilizing assigned mental health professionals for the timely identification and diagnosis of putative mentally disordered individuals who may qualify for diversionary programs into treatment through diversion.

4. Specification of the court staff's level of expertise in determining a defendant's amenability to treatment.

5. Specification of the statutory criteria for acceptance of qualified mentally disabled individuals.

6. Increased judicial efficiency and economy through centralization of case management within the unified mental health court. This court shall monitor and coordinate all decision-making regarding the implementation of a mentally disordered defendant's mental health treatment program, and social and legal services including, but not limited to, the following activities: provision of psychiatric evaluation and medication treatment; tracking of medication conflicts and side effects; provision of defense counsel; monitoring of correctional facility seclusion and restraint; participation in individual and group therapy; provision of medical, nursing, and dental care; access to life skills and

other services including education, vocational training, housing, and job placement; and assessment of the defendant's treatment program violations or compliance.

DEFINITIONS:

In this Act, a "mentally disordered defendant" or "mentally disordered offender"⁴¹⁹ is a presumptively qualified individual who:

1(A). has been currently diagnosed by a licensed board-certified psychiatrist or psychologist⁴²⁰ as having a mental illness,⁴²¹ or co-existing mental illness and substance abuse disorders,⁴²² and has either been accused or convicted of the commission of a criminal offense in which the mental disorder plays a substantial part; or

1(B). has currently exhibited signs of mental illness or co-existing mental illness and substance abuse during the commission of the alleged offense, arrest, confinement, or judicial proceedings; and

2. is deemed to be eligible for diversion consideration by a judicial officer in the mental health court or by a judicial officer in another court with jurisdiction over the defendant.

In this Act, "diversion" is defined as the voluntary⁴²³ transfer of a qualified mentally disordered defendant from the criminal justice system into a treatment program with the objectives of treatment, rehabilitation, crime reduction, and penal cost reduction. In this Act, the "treatment program"⁴²⁴ is a program, regularly monitored by the mental health court, in which a mentally disordered defendant in a

419. Some advocates prefer some variation of the phrase, "persons with mental disability," which has fewer undesirable connotations than terms such as "mentally ill or disabled" or "offender." While Protection & Advocacy, Inc., the U.S. Department of Justice, and others have promoted changes in terminology, wide acceptance of such phrases has not yet occurred.

420. The requirement for use of DSM-IV criteria as the basis of professional diagnosis of mental disorders promotes the uniformity of diagnostic criteria. Judges, however, should be aware that these criteria may have limitations.

421. States may wish to address mental retardation in this statute or in other statutes.

422. Defendants who are diagnosed with co-existing mental illnesses and substance abuse disorders raise special considerations for the court that should be considered in any implementation of an appropriate treatment program.

423. Once the court determines that a mentally disordered defendant qualifies for diversion, the defendant shall retain the voluntary choice of diversion into a treatment program or, alternatively, continued prosecution or sentencing for the charged crime. This requirement of "voluntariness" retains constitutional safeguards absent in some court-mandated treatment programs.

424. Jurisdictions may wish to provide for statutory provisions that permit the judge to approve interdisciplinary individualized treatment programs for persons suffering from mental retardation, mental disorders, or co-existing mental illness and substance abuse disorders.

nonpenal environment is provided with individualized services including, but not limited to, psychiatric treatment; medical, nursing, and dental care; vocational training and job placement; and housing.

CRITERIA:

The mental health court shall meet the following criteria:

1. Applications for a grant award under this part shall:

(1) set forth a detailed strategy and implementation plan for the mental health court(s);

(2) certify that all affected agencies and departments have been consulted for the purpose of facilitating coordination among these agencies and departments when the mental health court is established to provide mentally disordered defendants diverted into the court's program with necessary treatment;

(3) ensure that all defendants who appear before the court, including, but not limited to, first time offenders without a history of mental illness, shall receive a mental health evaluation by a licensed psychiatrist or other qualified mental health professional;

(4) certify that judges and/or bench officers shall periodically monitor and evaluate treatment program objectives for and achieved results of mentally disordered defendants in periodic reviews;

(5) demonstrate the ability to obtain independent funding from federal, state, local, and private funding sources and the predicted financial ability to independently sustain the mental health court program in the future in the absence of continued support from this pilot state program;

(6) set forth the objectives and evaluation methodology to be used to objectively assess the effectiveness of the mental health court in achieving its stated goals;

(7) include an outcome assessment by the Evaluation Committee of the diversion program that measures the success of treatment, the rate of recidivism by participants, the cost of incarceration compared to the cost of treatment, and the annual cost savings resulting from the mental health court diversion program;

(8) ensure that the mental health court's computerized information systems will be developed or modified to facilitate compliance with the mandated treatment and to provide a database enabling the Evaluation Committee to measure outcome parameters; and

(9) maintain qualified confidentiality for purposes of treatment by ordering court records and treatment records to be sealed and retained at the mental health court. For outcome study purposes, participants shall be assigned a number or code to ensure that names of defendants are never revealed.

2. The State Diversion Program Committee (hereinafter SDPC) shall consist of the Chief Justice of the Supreme Court; the Senior Justice of the state's highest intermediate court; the President Pro Tem of the Senate, or his or her designee; the Speaker of the Assembly, if applicable, or his or her designee; and the Governor. For the purpose of awarding grants, the SDPC shall establish criteria for evaluating county plans for the creation of mental health courts. Upon completing evaluation of county plans, the SDPC shall then award grants to counties for the establishment of mental health courts. The SDPC shall consider the following factors in assessing an award of a grant to a county or local government entity: (1) the number of mentally disordered defendants to be served in a particular county or locality, (2) the county or locality's demonstrated ability to provide adequate treatment to defendants accepted into the court's program, (3) the county or locality's demonstrated capacity to administer the program, (4) the county or locality's demonstrated computerization and ability to monitor the evaluation methodologies to determine effectiveness of the program, (5) demonstrated commitment of local agencies, departments, and the court to meet therapeutic jurisprudential objectives, and (6) the county or locality's demonstrated financial commitment by provision of matching county or local funds for support of the court.

3. The mental health court shall be provided staff including, but not limited to, a presiding judge, a law enforcement officer, a staff attorney, a clerk, a court reporter, and administrative staff members. Prosecutors and public defenders shall be assigned to the court. The court staff shall also include the following personnel in a "Treatment Program Group"⁴²⁵: a licensed psychiatrist, a clinical or psychiatric social worker, a psychologist, a substance abuse counselor, a probation officer, and a caseworker. The Treatment Program Group shall be responsible for writing individualized treatment programs for each qualifying defendant. The court shall designate one Treatment Program Group to assume duties of the "Service Coordinator." The Service Coordinator⁴²⁶ shall be responsible for coordinating treatment and other services, reporting regularly to the court, and ensuring that public or private service providers also report regularly to the court.

4. Judges assigned to the mental health court shall, as a condition of assignment, complete a course of study that includes psychi-

425. Mental health personnel may be state, county, or local mental health professionals.

426. The Service Coordinator's role is critical in facilitating coordination between the criminal justice system and service providers to ensure that the individualized treatment programs are written and provided to defendants in a timely manner.

atric diagnoses, modalities of treatment, and communication skills in relation to persons suffering from severe mental disorders. Mental health court judges may appoint subordinate bench officers who shall participate in the same training. The mental health court judges also shall designate the title, duties, and compensation of court administrative personnel consistent with budgetary requirements. The county or local treasurer shall pay salaries, compensation and expenses for all mental health court employees and activities from money appropriated for the operation of the mental health court.

5. The court shall promote diversion of qualified mentally disordered offenders from the criminal justice system into adequately staffed and equipped hospitals or other community treatment facilities. Referrals of potentially eligible mentally disordered defendants to the mental health court shall be made by sources including, but not limited to, the following agencies, departments, or entities: law enforcement, correctional facilities, the district attorney, the public defender, probation officers, or other courts. The mental health court shall encourage law enforcement to conduct training programs to ensure that officers are trained in the appropriate handling of persons who may exhibit symptoms of mental disorders. Family members or their attorneys may refer mentally disordered defendants that have been accused or convicted of a crime to the mental health court to address issues including conservatorship or guardianship. Eligible defendants must voluntarily consent to the referral prior to the transfer of their case to the mental health court.

6. Nothing contained in this Act shall prohibit the mental health court from considering any mentally disordered offender whose case is pending in another court as potentially eligible for participation in the mental health court's diversion program at any time prior to sentencing. Any judge from another court may request evaluation of a potentially transferable defendant in a criminal case by the mental health court to determine if the defendant qualifies for diversion into treatment as a mentally disordered defendant. The mental health court shall evaluate these potentially transferable defendants through investigation and hearings to determine eligibility for the court's treatment program. The mental health court shall make the final determination of eligibility of a defendant for diversion. A defendant who meets the statutory requirements for diversion and voluntarily chooses to participate in the court's treatment program shall be entitled to such diversion. If the qualified transferred defendant accepts diversion into the court's treatment program, the case shall continue to be heard in the mental health court until the defendant is either rejected or com-

pletes the treatment program. If a defendant either does not qualify for diversion or refuses to participate in diversion, the defendant shall be returned to the referring court for continuation of criminal prosecution, speedy trial, and acquittal or sentencing.

7. The court will not try any person while that person is mentally incompetent. If the judge possesses evidence supporting a doubt regarding the mental competence of the defendant, the judge shall state that doubt on the record and inquire of counsel for the defendant whether, in the opinion of counsel, the defendant is mentally competent. At the request of the defendant, or counsel for the defendant, or upon the court's own motion, the court shall recess the criminal proceedings for a reasonable time necessary to permit counsel to confer with the defendant and to form an opinion regarding the defendant's mental competence. If counsel states to the court that he or she believes the defendant is or may be mentally incompetent, the court shall order that the defendant's mental competence is to be determined in a court hearing. The court may also order a hearing on the issue of mental competence on its own motion. The court shall appoint an attorney for defendants who lack representation. If counsel informs the court that it is the counsel's belief that the defendant is or may be mentally incompetent, the court shall assign one or more licensed psychiatrists or psychologists to evaluate the mental competence of the defendant, and the court shall order a hearing, as a civil proceeding, to be scheduled to determine the defendant's mental competence. When an order for a hearing into the present mental competence of the defendant has been issued, criminal prosecution shall be suspended until the hearing is concluded and the defendant is found competent. The question of mental competence may be determined either by a trial by the court without a jury, or with a jury upon demand by either prosecution or defense. The judge may declare a defendant mentally incompetent if, as a result of mental disorder or developmental disability, the defendant is unable to understand the nature or purpose of the criminal proceeding against him or to assist defense counsel in a rational manner. In a jury trial, the jury shall return a verdict either that the defendant is or is not mentally competent to stand trial. A defendant found to be mentally incompetent cannot be tried or sentenced to punishment for a charge or offense. If the court or jury finds that the defendant is mentally incompetent, unless the court determines that the defendant has recovered fully, the court shall order that the community treatment program director or licensed forensic psychiatrist evaluate the defendant and submit to the court a written recommendation within two weeks of the court hearing or jury trial

regarding the placement of the defendant in outpatient, inpatient, hospital, or alternative treatment facilities consistent with the standard set forth in section 10.⁴²⁷

8. When the judge has substantial evidence to support a belief that a person is incompetent to stand trial, the court must declare that a doubt exists. Under this circumstance, the court must assign experts and set trial to determine competence in a civil proceeding. Counsel for the defense or the prosecutor may file a petition to the state court of appeals for judicial review.

9. The mental health court judge shall make the final determination of a defendant's eligibility for diversion at a scheduled hearing. The judge shall also determine whether a mentally disordered defendant may be dually diagnosed as possessing a mental illness and a substance abuse addiction, qualifying the defendant for admission into a drug treatment plan that addresses both. The judge shall determine whether a defendant qualifies for diversion by consideration of the following: (1) medical testimony regarding the defendant's current mental and physical condition, including previous medical history, treatment for prior illnesses, and substance abuse; and the judge may consider if applicable; (2) employment and military service records;⁴²⁸ (3) educational background; (4) motivation to comply with treatment objectives; (5) voluntary consent to the treatment program; and (6) waiver of the right to a speedy trial.⁴²⁹ At this hearing, the court shall order that the defendant be treated for mental disorder in the least restrictive, most appropriate treatment environment. The judge shall place the defendant in a public or private outpatient facility, inpatient facility, or state hospital, depending on the severity of the mental incapacity or state of mind. Either the defendant, his attorney, or the district attorney may petition for a hearing or an appeal to challenge the order of commitment to a treatment facility. The court shall provide copies of documents to the treatment facility including the commitment order with specification of charges, the maximum term of commitment, the psychiatric and medical examination or evaluation reports, the criminal history and arrest records from law enforcement, and the community program director's placement recommendation report. The court shall schedule periodic hearings to evaluate the

427. Under California's Lanterman-Petris-Short (LPS) Act, a defendant with a mental disorder who is found to be gravely disabled or, alternatively, dangerous to himself or others can be detained for 72 hours or up to 14 days for treatment.

428. Lack of employment should not disqualify an otherwise eligible defendant for diversion.

429. If sentencing is to be deferred, the defendant shall voluntarily waive his or her right to speedy sentencing.

progress of the defendant in the treatment plan. The medical director of the facility shall provide a written progress report concerning the defendant to the court, district attorney, and prosecutor two weeks prior to the date of the scheduled hearing.

10. The judge shall appoint the Service Coordinator and Treatment Program Group to conduct an investigation, to be started after the defendant's initial hearing and before the final hearing, for determination of eligibility for the court's treatment diversion program.⁴³⁰ The results of the investigation and written recommendations shall be sent to the judge, defendant, assigned public defender or counsel, and district attorney for review at least one week prior to the next scheduled hearing. After review of the investigation by the district attorney, public defender, and defendant, a written plea agreement containing a recommended treatment plan may be negotiated.

11. The hearing to determine eligibility for participation in the court's diversion program shall be set no more than three weeks from the date of the initial hearing, unless extended by the court. Participation by qualified mentally disordered defendants in the mental health court diversion program is entirely voluntary.⁴³¹ However, to obtain diversion, the defendant shall agree to enroll in the treatment program ordered by the court and to cooperate in examination by the court's designated licensed psychiatrists, psychologists, social workers, and/or other treatment staff members. If the judge determines that the defendant is not qualified for participation in the diversion program, the judge shall state on the record the reasons for that decision. The mental health court shall adopt court rules consistent with the objectives of this Act.

12. Qualified mentally disordered defendants shall possess the right to be represented by counsel in any court hearings and proceedings at all stages of criminal prosecution pertaining to the mental health court's diversion program. The Public Defender's Office shall select counsel for defendants, or alternatively, in the absence of an available public defender, the judge may appoint independent counsel to represent mentally disordered defendants, paid from county funds. However, the defendant retains the right to knowingly waive the right to counsel at any time during court proceedings.

The judge shall state on the record that if the qualified defendant fulfills the obligations of the agreement to complete treatment (herein-

430. The Service Coordinator and Treatment Program Group should work closely with community resources to ensure that the defendant's treatment program is provided in the least restrictive environment available.

431. Civil liberties groups such as Protection & Advocacy, Inc., support expanding voluntary choices for mentally disabled defendants in the courts and criminal justice system.

after, "treatment agreement"), then criminal charges may be dismissed and the prosecution set aside; or, if the defendant has been sentenced after a guilty plea or trial, then successful completion of the court-mandated treatment program may result in either immediate release of the defendant or probation with ultimate release to the community.

13. Once a qualified defendant is initially transferred to the mental health court and the defendant agrees to participate in the court's treatment program, the defendant shall voluntarily and unambiguously waive the right to a speedy trial and the right to a preliminary hearing, if applicable, to be considered a candidate for the court's diversion program. The defendant shall sign an agreement with the court that he or she will comply with the terms and conditions of the court's treatment plan. However, the court must terminate diversion and reinstate the defendant's right to a speedy trial upon written or oral motion. The court may order defendants who fail to adhere to reasonable conditions of the treatment program to return to correctional facility custody for reincarceration.

14. Clear statements shall be included in the court's treatment program that should the defendant (1) fail to comply with the terms of the agreement, or (2) be arrested and charged with a new offense, or (3) be convicted of any felony offense, the court may, after notice and a hearing, terminate the defendant's participation in the diversion program. For defendants terminated from diversion, the court may order that criminal proceedings be resumed.

15. The court may request the assistance of the state and local Departments of Mental Health, hospitals, law enforcement, community treatment facilities, public and private service providers, and correctional facilities to advance the court's objectives in obtaining treatment for qualified mentally disordered defendants. All treatment service providers shall be certified annually by the Department of Mental Health by evaluations of performance in accordance with written standards promulgated and published by the Department. The court shall periodically review these standards to ensure that quality treatment programs are available to mentally disordered defendants.

16. The court is granted the authority to use all reasonable means necessary to fulfill the objectives of this Act. Once a qualified defendant has entered treatment, the court shall require the treatment program director to submit periodic progress reports to the court. Hearings regarding the defendant's progress should be scheduled to occur at least quarterly,⁴³² and the court may require the defendant to

432. Different policy decisions may govern the frequency of hearings for individuals charged or convicted of either misdemeanor or felony crimes.

appear. At progress hearings, the judge shall review the defendant's needs, progress, treatment plan, and medical care. At that time, the judge shall consider motions for modification of the treatment program. The hearing may also be scheduled on the court's own motion or if the defendant, defense attorney, district attorney, or treatment provider believe that modification of the treatment program would be beneficial to the psychiatric, medical, or other needs of the defendant, or to the security needs of the community.

17. For nonviolent offenses, the judge shall consider relapses and restarts in the treatment program as predicted integral components of the treatment, recovery, and rehabilitation process of mentally disordered defendants. When relapse occurs, the judge may monitor the defendant's compliance with the treatment program either by providing incentives to the defendant or by ordering progressively increasing sanctions for noncompliance rather than by removing the defendant from the mental health diversion program.

18. If the judge has a reasonable belief that removal from the diversion program is required, notice of the termination hearing shall be given to the defendant, the defense attorney, and the district attorney. If the judge finds that the defendant is currently unable to comply with the terms and conditions of the treatment plan and his or her agreement, the defendant shall be terminated from the diversion program and returned to the criminal justice system for resumption of criminal proceedings, which may include either a trial, an imposition of sentence for the original offense, or return to custody if a sentence was previously imposed.

19. Upon successful completion of the treatment program by a defendant, the judge shall consider dismissal of the defendant's charges and release, or, alternatively, a grant of probation to the defendant.⁴³³

20. The judge may consider the following factors in determining whether to grant probation to or impose a sentence upon a mentally disordered defendant in the interests of justice and for the mutual benefit of the community and the defendant: (a) the nature and circumstances of the crime charged, (b) the length of time the defendant has been in treatment, (c) the current mental and physical condition of the defendant, (d) whether it is probable that the defendant will benefit from continued treatment and comply with reasonable terms of probation, (e) whether the proposed probation and treatment program

433. Statutory provisions may further define the conditions under which the judge would order dismissal, or alternatively, conditional release or probation, with a consideration of public policies balancing the individual's liberty interests with the safety interests of the community.

would meet the therapeutic needs of the defendant, (f) whether the defendant would be able to complete probation successfully, and (g) any other relevant circumstances.⁴³⁴

21. If the judge determines that a defendant is eligible for enrollment in the mental health court's probation program, the court shall accept the defendant's guilty plea if required, suspend or defer the imposition of a sentence, and place the defendant in the court's probation program subject to the defendant's agreement with its terms and conditions. If the judge determines that the defendant is not qualified for inclusion in the probation program, the judge shall state the reasons for that determination on the record.

22. The judge shall assign the eligible probationer to a licensed community treatment program. If sufficient community treatment services are not available, the judge shall order the probationer to be temporarily housed in the least restrictive environment available for treatment and the judge shall order that the defendant's treatment be paid for using public funds until such time as community treatment facilities become available. The judge shall also order treatment providers to assist the probationer in obtaining federal and state governmental financial benefits, including, but not limited to, Social Security Disability Insurance, MediCare, General Relief, or other assistance prior to the starting date of the probationer's program if necessary.

23. Upon a probationer's successful completion of the mental health court probation program, the judge may either vacate the judgment of conviction and dismiss the criminal proceedings against the probationer, or, alternatively, discharge the defendant from probation into a conditional release program. The judge may order dismissal or discharge if the criminal offense was for a misdemeanor or first felony offense. However, if the offender has one or more prior felony convictions, the judge may provide a disposition order as specified in the written plea agreement. Dismissal and discharge under this provision shall have the same effect as acquittal, except that the conviction is admissible as evidence and may be considered in sentencing if the defendant has a subsequent conviction. After dismissal or discharge, the defendant's records shall not be used by any employer or potential employer for the purposes of denying the defendant employment or withholding employee benefits from the defendant.

434. Some jurisdictions may wish to add the following phrase: "The mentally disordered defendant will not be required to enter a guilty plea to a criminal offense in order to be eligible for this probation program, unless the judge is compelled to impose this guilty plea requirement upon a defendant in the interests of justice."

24. The mental health court shall develop criteria for the eligibility of mentally disordered offenders for its conditional release programs. Such programs shall include an aftercare plan developed in conjunction with the mentally disordered defendant, medical personnel, the county mental health department, and community mental health service providers. This aftercare plan shall provide for continued community treatment, provision of governmental benefits (SSI, SSDI, Medicare, General Relief, food stamps), housing placement, life skills training, educational and vocational training, employment counseling and placement, provision of health care, substance abuse treatment where co-existing disorders exist, a relapse prevention program, and other services consistent with facilitating each defendant's rehabilitation objectives.

25. The mental health court shall develop and oversee a program for training court staff, district attorneys, public defenders, correctional facility staff members, medical staff, and law enforcement personnel consistent with the objectives of the court in facilitating the appropriate adjudication and/or treatment of mentally disordered persons. The mental health court shall direct and supervise all aspects of the development of a training manual for the purpose of promoting and educating staff in court procedures, rules, and protocols consistent with underlying therapeutic jurisprudence and preventative law principles.⁴³⁵ The judge shall delegate writing and revision of sections or chapters of this training manual to appropriate agencies and departments. Each agency or department shall be responsible for providing funds for writing and revision of its delegated portions of this training manual.

26. One designated mental health court judge in the state shall supervise the promulgation of the rules, procedures, and forms necessary to promote uniformity throughout the state. All mental health court judges may issue summonses, warrants, citations, subpoenas, and other writs to a bailiff, sheriff, marshal, police officer, or other law enforcement officer to ensure that court objectives stated herein are met by correctional facilities, hospitals, community treatment facilities, law enforcement, or other departments, agencies, or entities.

27. An independent Evaluation Committee shall be created for the purpose of assessing the impact of the mental health courts on judicial efficiency and economy in processing cases involving mentally disordered defendants, correctional facility costs, promoting the efficacy of timely diagnosis and treatment, and reducing rates of criminal

435. Therapeutic jurisprudence and preventative law concepts are presented in Part II of this Article.

recidivism. Members of the Evaluation Committee shall include the mental health court judge, a member of the State Legislature, a public defender, a district attorney, a State Mental Health Department representative, a representative of the local mental health department, a law enforcement or correctional facility official, a mental health law scholar, a board certified psychiatrist, a licensed clinical psychologist, a consumer of mental health services, a Protection & Advocacy attorney,⁴³⁶ and a family member of an individual with mental disability. The mental health court judge shall preside over the Evaluation Committee meetings and each member shall receive one vote.

a. Selection of the Evaluation Committee shall be by the Legislature in a procedure whereby the Majority and Minority Leaders of the Senate and Assembly respectively shall each select at least two (2) Committee members and the Governor shall select remaining Committee members. The order of selection shall be as follows: (1) the Senate Majority Leader, (2) the Senate Minority Leader, (3) the Assembly Majority Leader, (4) the Assembly Minority Leader, (5) the Governor. No more than half of the Committee members may be of the same political party.

b. No later than 18 months after the date of enactment of this section, the Evaluation Committee shall issue a preliminary report to the Legislature evaluating the effectiveness of the newly created mental health courts in diverting mentally disordered defendants into treatment facilities, making recommendations for mental health court reform and the establishment of similar mental health specialty courts in other jurisdictions, voicing suggestions for the early identification of potentially qualified defendants in correctional institution settings who may be eligible for diversion, projecting cost savings to be achieved by establishment of this court, noting additional resources needed, and proposing legislation. After the initial report, the Committee shall issue annual reports to the Legislature in June of each subsequent calendar year. The Evaluation Committee shall present its findings and recommendations to the Legislature within three (3) months of the issuance date of the initial report and each subsequent annual report.

FUNDING:

The sum of _____ dollars (\$ _____) per year for ___ years is hereby appropriated from the State General Fund for the purpose establishing pilot mental health courts.

436. Protection & Advocacy, Inc., present in every state, is mandated by federal law to protect the rights of physically and mentally disabled persons.

APPENDIX B: ADMINISTRATIVE ORDER CREATING THE
BROWARD COUNTY MENTAL HEALTH COURT SUBDIVISION⁴³⁷

IN THE CIRCUIT COURT
OF THE SEVENTEENTH JUDICIAL CIRCUIT, IN AND FOR
BROWARD COUNTY, FLORIDA
ADMINISTRATIVE ORDER
NO. VI-97-I-1
IN RE:
CREATION OF A MENTAL HEALTH
COURT SUBDIVISION WITHIN THE
COUNTY CRIMINAL DIVISION

_____ }
In accordance with the authority vested in the Chief Judge by
Rule 2.050, Florida Rules of Judicial Administration . . .

WHEREAS, this Circuit has recognized that the creation of
“specialized courts” within other divisions of the Court has enhanced
the expediency, effectiveness and quality of Judicial Administration;

WHEREAS, it is essential that a new strategy be implemented to
isolate and focus upon individuals arrested for misdemeanor offenses
who are mentally ill or mentally retarded in view of the unique nature
of mental illness or mental retardation, and the need for appropriate
treatment in an environment conducive to wellness and not punish-
ment, as well as the continuing necessity to insure the protection of the
public, and

WHEREAS, there is a recognized need to treat defendants qual-
ified to participate in the Court before a specialized trained Judge who
possesses a unique understanding and ability to expeditiously and effi-
ciently move people from an overcrowded jail system into the mental
health system, without compromising the safety of the public, and,

WHEREAS, the rapidly increasing number of misdemeanor
cases involving mentally ill or mentally retarded defendants has con-
tributed to congesting and overburdening of the court dockets in the
county court criminal division, as well as a jail overcrowding, and,

WHEREAS, a centralized Mental Health program would in-
crease the efficiency of the criminal court system in this circuit, and

WHEREAS, a continuing shrinkage of mental health care
resources necessitates that such resources be centralized into a system,

437. This Administrative Order was graciously sent from Judge Ginger Lerner-Wren,
Broward County Courthouse, to the Author on May 19, 2000.

before specialized personnel, thereby making them more accessible, and

WHEREAS, it is necessary that this circuit utilize available community resources and support, to establish an individualized judicial process that will, where appropriate, tailor treatment rather than punishment for the mentally ill and mentally retarded misdemeanant,

IT IS NOW THEREFORE;

ORDERED that:

Effective June 16, 1997, a part time Mental Health Subdivision shall be operational within the County Court Criminal Division to hear cases involving defendants arrested for misdemeanors who are suffering from mental illness or are mentally retarded, with the exception of those charged with Domestic Violence and Driving Under the Influence. Defendant[s] . . . charged with Battery, a violent misdemeanor, may be admitted with the victim's consent. Defendant[s] . . . charged with violent misdemeanor offenses which occur at mental health treatment facilities shall be assigned to the Mental Health Specialty Judge.

The Clerk of the Court shall assign or transfer all nonviolent misdemeanor cases, including traffic criminal[,] who preliminarily qualify for admission to the program. The defendants will be preliminarily qualified at any point in the proceedings, if they previously or currently have been diagnosed by a mental health expert as suffering from mental illness or mental retardation during arrest or confinement or before any court. Motions for transfer into the program may be made sua sponte by any court or by the Defense or the State accompanied by documentation or testimony in support thereof and will be heard by the Specialty Judge, who shall make the final determination of a defendant's eligibility. Any motion to transfer a defendant into the program, unless specifically objected to by defense counsel, shall be deemed a waiver of the defendant's right to a speedy trial and formal discovery, other than the providing of documentation relating to defendant's mental health status and all available statements and police reports. If the assigned Judge determines that a defendant is mentally ill or mentally retarded, she or he is eligible for the program. If a defendant is not mentally ill or mentally retarded, she or he is not eligible for the program. If a defendant is determined to be ineligible for the program, the case shall be transferred back to the original division or, if it had not been previously assigned to another division, randomly assigned by the Clerk of the Court to a County Court Criminal Division and the defendant's right to a speedy trial and formal discovery may be reinstated upon a written demand. If a defendant is

eligible for the program, all the defendant's misdemeanor cases, including violations of misdemeanor probation, shall be consolidated and transferred to the assigned mental health Judge. Once a defendant is accepted into the program and it is determined that the case will be set for trial within said Court, the defendant's right to a speedy trial may be reinstated upon written demand.

IT IS FURTHERMORE ORDERED that the Sheriff of Broward County will make all reasonable efforts to secure the attendance of all Defendants whose cases are to be heard before the Court, unless effectuating such will case a danger to the public or the Defendants themselves.

IT IS FURTHERMORE ORDERED that Judge Ginger Lerner-Wren is hereby designated as the Judge assigned to this special unit. In that capacity, Judge Lerner-Wren will be responsible for administering the program and coordinating the role of the judiciary with the functions of the Department of Children and Family Services, Henderson Clinic, Nova Southeaster Outpatient Care Clinic, private mental health providers, County Court Probation, and Pretrial Services of the Broward Sheriff's Office. Judge Lerner-Wren shall be responsible for magistrating all defendants preliminarily determined to be eligible for the program who have not magistrated previously. The holding of said magistrate hearing shall constitute notice to the State and Defense, and the above mental health programs, providers and services to obtain all necessary criminal history and mental health history and input from pertinent victims and witnesses. Judge Lerner-Wren will still maintain her caseload in her regular County Court Division while serving as Judge of the Mental Health Subdivision.

IT IS FURTHERMORE ORDERED that Ginger Lerner-Wren is hereby appointed as an acting Circuit Court Judge in all matters relating to Chapters 393, 394, and 397, of the Florida Statutes. In the absence of Judge Lerner-Wren, the Honorable Mark A. Speiser, Circuit Judge, shall serve as her alternate, to enter orders which are necessary, fit and proper, and/or as required by law.

DONE AND ORDERED in Chambers at Fort Lauderdale, Broward County, Florida on this the 22nd day of May, 1997.

DALE ROSS, CHIEF JUDGE (Cty. Disk #30)