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Ramsey County Mental Health Court: Working with Community Partners to Improve the Lives of Mentally Ill Defendants, Reduce Recidivism, and Enhance Public Safety

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RAMSEY COUNTY MENTAL HEALTH COURT: WORKING WITH COMMUNITY PARTNERS TO IMPROVE THE LIVES OF MENTALLY ILL DEFENDANTS, REDUCE RECIDIVISM, AND ENHANCE PUBLIC SAFETY

Hon. John H. Guthmann[†]

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The author wishes to acknowledge the work of Brandi Stavlo, Ramsey County Mental Health Court Program Coordinator. Ms. Stavlo is the primary author of the Ramsey County Mental Health Court reports and program materials that are cited extensively in this Article.

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I. INTRODUCTION

One individual is charged with making obscene or harassing telephone calls. Another is charged with fourth-degree assault after spitting on a police officer in the course of being transported to the hospital. That individual has multiple detox admissions in the prior year. Still another person is a serial shoplifter charged with numerous prior charges and convictions. Finally, a fourth person is charged with disorderly conduct after going from customer to customer and eating food off of their plates in a restaurant. It is one of five trespass, disorderly conduct, and obstruction of legal process charges that person picked up in a month. What do these folks have in common? Each of them is a repeat criminal offender with a history of mental illness.[1] Every time these individuals have a police contact resulting in an arrest and criminal charges, the public and law enforcement officers are potentially endangered, the mentally ill defendant could be injured, and precious public resources are expended through the police, local jails, and the court system. Moreover, the unaddressed and often inadequately treated mental health conditions leading to arrest are commonly

1. Mental illness is: "A medical condition, disrupting a person's thinking, feeling, mood, ability to relate to others and daily functioning." *What Is a Mental Illness?*, MAKEITOK.ORG, http://makeitok.org/what-is-a-mental-illness/ (last visited Nov. 14, 2014). The condition is characterized by alterations in thinking, mood, and/or behavior associated with distress and/or impaired functioning in social, occupational, or other areas. *Id.* The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* defines a mental disorder as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 20 (5th ed. 2013) [hereinafter DSM-V].

accompanied by frequent and expensive emergency room, detox, and other acute treatment or intervention modalities.

The persons discussed in the previous paragraph have something else in common. Each later entered and successfully graduated from Ramsey County Mental Health Court (RCMHC). RCMHC is part of a nationwide movement toward the use of therapeutic jurisprudence in problem-solving—or specialized—courts to address specific offender populations that do not respond to traditional correctional approaches.[2] This Article will briefly trace the history of problem-solving courts in the United States and in Minnesota before focusing on crime, the mentally ill, and development of mental health courts. This Article concludes with an examination of RCMHC and its mission, goals, operation, and results—a sort of virtual site visit. By studying RCMHC and its outcomes, readers will be well-positioned to understand and appreciate the role that mental health courts play in enhancing public safety, reducing recidivism, and helping mentally ill individuals who commit crimes improve their lives.

II. THE ADVENT OF THERAPEUTIC JURISPRUDENCE THROUGH PROBLEM-SOLVING COURTS

The "problem" needing a solution stems from a variety of changes in our society and their accompanying behavioral and social consequences.[3] Courts do not control their caseload any more than the police control what laws are violated. Due to societal changes, courts in recent years have dealt with the aftermath of "substance abuse, family breakdown, and mental illness."[4] Moreover, as rising caseloads and ineffective outcomes coincided, medical and other treatment providers, law enforcement,

2. *Mental Health Courts*, COUNCIL ST. GOV'TS JUST. CENTER, http://csgjusticecenter.org/mental-health-court-project/ (last visited Nov. 14, 2014); *see also* MINN. STAT. § 245.462, subdiv. 20(a) (2014) (defining "mental illness" as "an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation").

3. David Rottman & Pamela Casey, *Therapeutic Jurisprudence and the Emergence of Problem-Solving Courts*, 240 NAT'L INST. JUST. J. 12, 13 (1999), *available at* https://www.ncjrs.gov/pdffiles1/jr000240.pdf.

4. *Id.*

corrections departments, the judiciary, and the public grew more dissatisfied with business as usual. Courts that do not adapt to changing conditions are ineffective courts.[5]

Problem-solving courts emerged as one solution and are now found in every state. The first problem-solving courts were drug courts.[6] The first drug court was founded in Miami, Florida, in 1989.[7] "Drug courts sprung out of necessity, not fashion or vogue."[8] Drug offense cases were overwhelming the criminal justice system. By 1991, for example, drug offenses accounted for thirty-one percent of all convictions in state courts.[9] Offenders sentenced to state or local prisons for drug crimes frequently violated their probation, reoffended, or both, producing a revolving door from the streets to the courthouse, to jail, and then back to the streets where the cycle begins anew.[10]

The founders of the Miami-Dade County Drug Court developed a new methodology and helped spark a national movement toward the use of specialized jurisprudential approaches to address seemingly intractable offender populations. Their response was to merge drug treatment[11] with the structure of probation and the authority of judges.[12]

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5. *See* BUREAU OF JUSTICE ASSISTANCE, TRIAL COURT PERFORMANCE STANDARDS WITH COMMENTARY 20 (1997), *available at* https://www.ncjrs.gov/pdffiles1/161570.pdf ("The trial court anticipates new conditions and emergent events and adjusts its operations as necessary.").

6. *See History*, NAT'L ASS'N DRUG CT. PROFESSIONALS, www.nadcp.org/learn/what-are-drug-courts/drug-court-history (last visited Nov. 14, 2014).

7. *See id.*

8. PAUL L. CARY ET AL., NAT'L DRUG COURT INST., THE DRUG COURT JUDICIAL BENCHBOOK 1 (Douglas B. Marlowe & William G. Meyer eds., 2011), *available at* http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf.

9. *See* WEST HUDDLESTON & DOUGLAS B. MARLOWE, BUREAU OF JUSTICE ASSISTANCE & NAT'L DRUG COURT INST., PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 5 (2011), *available at* http://www.ndci.org/sites/default/files/nadcp/PCP%20Report%20FINAL.PDF.

10. For further discussion of the revolving door, see Evelyn L. Stratton, *Solutions for the Mentally Ill in the Criminal Justice System: A Symposium Introduction*, 32 CAP. U. L. REV. 901, 901–03 (2004).

11. The United States Supreme Court decision in *Robinson v. California*, 370 U.S. 660 (1962), is often cited as opening the door to viewing addiction as a disease and turning to treatment as an alternative to incarceration. In *Robinson*, Justice Stewart wrote:

> It is unlikely that any State at this moment in history would attempt to

Drug courts are based upon voluntary participation by individuals meeting each court's eligibility requirements. Once admitted, the participating defendant's case is processed in drug court instead of through the traditional track taken by the typical criminal defendant charged with a drug offense.[13] During the year or more of drug court attendance, the participant is provided with chemical dependency treatment, is regularly and randomly tested for drug use, is held accountable by the drug court judge, appears frequently in court to review progress or lack thereof with the judge, and is rewarded for success or sanctioned for not fulfilling obligations.[14] Drug court participation may occur pre- or post-adjudication.

Initial success led to the growth of drug courts. By 2007, there were 2147 drug courts up and running in the United States.[15] Along the way, extensive research was conducted to document the most effective approaches and to validate the concept. Early research led to the development of the Ten Key Components as the core framework of a properly functioning and research-based drug

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> make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.

Id. at 666 (citing State of Louisiana *ex rel.* Francis v. Resweber, 329 U.S. 459 (1962)).

12. *See History, supra* note 6.

13. For purposes of this article, references to the "traditional track," "traditional punishment and probation models," or similar terminology mean the regular criminal-case process in which a convicted defendant is incarcerated, or placed on probation, with no or limited special services to address the defendant's chemical or mental health.

14. *See What Are Drug Courts?*, NAT'L ASS'N DRUG CT. PROFESSIONALS, www.nadcp.org/learn/what-are-drug-courts (last visited Nov. 11, 2014). Drug court programming may also include other components, such as cognitive therapy, community supports, or treatment for a co-occurring mental health disorder.

15. *See* Nat'l Drug Court Inst., *Timeline of Drug Courts and Other Problem-Solving Courts in the United States*, NAT'L ASS'N DRUG CT. PROFESSIONALS, www.nadcp.org/sites/default/files/nadcp/Timeline.pdf (last visited Nov. 11, 2014).

court.[16] They ultimately became the core framework of most problem-solving court programs.[17] The Ten Key Components are:

(1) Drug courts integrate alcohol and other drug treatment services with justice system case processing.

(2) Using a nonadversarial [sic] approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

(3) Eligible participants are identified early and promptly placed in the drug court program.

(4) Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

(5) Abstinence is monitored by frequent alcohol and other drug testing.

(6) A coordinated strategy governs drug court responses to participants' compliance.

(7) Ongoing judicial interaction with each drug court participant is essential.

(8) Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

(9) Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.

(10) Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.[18]

Drug courts and the foundation supplied by the Ten Key Components ushered in a new era of "therapeutic jurisprudence." "Therapeutic jurisprudence proposes the exploration of ways in which, consistent with principles of justice, the knowledge,

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16. 1 NAT'L ASS'N OF DRUG COURT PROF'LS, ADULT DRUG COURT BEST PRACTICE STANDARDS 1 (2013), *available at* http://www.nadcp.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf.

17. *Id.*

18. *See* BUREAU OF JUSTICE ASSISTANCE & NAT'L ASS'N OF DRUG COURT PROF'LS, DEFINING DRUG COURTS: THE KEY COMPONENTS, at iii (2d prtg. 2004), *available at* https://www.ncjrs.gov/pdffiles1/bja/205621.pdf (listing table of contents subheadings only and omitting accompanying text).

theories, and insights of the mental health and related disciplines can help *shape* the development of the law."[19] Therapeutic jurisprudence requires a perspective much broader than the criminal charges that placed a particular defendant in front of the judge. Instead, "therapeutic jurisprudence directs the judge's attention . . . toward the needs and circumstances of the individuals involved in the dispute."[20]

Research demonstrates that drug courts work. For programs following the Ten Key Components, seventy-five percent of graduates have not been arrested two years after leaving the program, drug court graduates reoffend up to forty-five percent less than defendants that are traditionally sentenced, and offenders in a drug court are six times more likely to remain in treatment long enough to gain remission from use.[21] Significantly, for every dollar invested in drug courts, up to twenty-seven dollars are saved in victimization and healthcare utilization costs.[22] By contrast, drug court programs that do not use the Ten Key Components lose as much as half of their potential effectiveness.[23]

III. DRUG COURTS IN MINNESOTA

In 1996, Hennepin County opened Minnesota's first drug court.[24] However, drug courts did not become widespread in the state until the mid-2000s.[25] By July 2007, one-third of Minnesota's counties were covered by the twenty-seven operating drug courts.[26]

19. DAVID B. WEXLER & BRUCE J. WINICK, LAW IN A THERAPEUTIC KEY, at xvii (1996).

20. Rottman & Casey, *supra* note 3, at 12, 14.

21. *Drug Courts Work,* NAT'L ASS'N DRUG CT. PROFESSIONALS, www.nadcp.org/learn/facts-and-figures (last visited Nov. 6, 2014).

22. *Id.*

23. *See* 1 NAT'L ASS'N OF DRUG COURT PROF'LS, *supra* note 16, at 1.

24. MINN. JUDICIAL BRANCH, MINNESOTA STATEWIDE ADULT DRUG COURT EVALUATION 19 (2012).

25. *Id.*

26. *Id.* at 6. Ramsey County's Adult Substance Abuse Court (ASAC) opened in 2002. *See Adult Substance Abuse Court Program,* MINN. JUD. BRANCH, http://www.mncourts.gov/district/2/?page=58 (last visited Nov. 11, 2014). ASAC was selected as a "mentor court" in 2010 by the National Drug Court Institute. *Id.* Judge Joanne Smith, ASAC's founding judge, was named to the Stanley M. Goldstein Drug Court Hall of Fame in 2012 by the National Association of Drug Court Professionals. *Id.* Ramsey County also operates a DWI Court and a Veteran's Court, as well as the Mental Health Court. *See Problem-Solving Courts,* MINN. JUD.

That same year, Minnesota's Judicial Council approved Judicial Council Branch Policy 511.1, a set of standards governing drug courts based upon the Ten Key Components.[27] Policy 511.1 permits local innovation and flexibility, but adherence to the Ten Key Components insures a minimum level of uniformity and effectiveness.[28]

Following through on the evaluation measurement requirements of the Ten Key Components, the Minnesota Judicial Council approved a Statewide Drug Court Evaluation plan in 2007.[29] Utilizing data from all Minnesota drug courts and their participants during the July 2007 to December 2008 timeframe, the "evaluation measure[d] drug court processes, compliance with the standards, outcomes for incarceration time served by participants, and recidivism rates of new charges and convictions."[30] The Drug Court Evaluation plan also identified a comparison group made up of court participants meeting drug court eligibility criteria and the characteristics typical of drug court participants.[31]

IV. BEYOND DRUG COURTS

With the success of drug courts and subsequent validation of their methods through research, the therapeutic jurisprudence approach embodied in the Ten Key Components led to the establishment of other problem-solving courts aimed at addressing different populations. Since the first drug court opened in 1989, local jurisdictions have started veteran treatment courts, community courts, DWI courts, courts aimed at juvenile offenders, and mental health courts.[32] Each court is different, and each operates under its own rules and procedures.

BRANCH, http://www.mncourts.gov/district/2/?page=4996 (last visited Nov. 11, 2014); *see also Veterans Court Track*, RAMSEY COUNTY, http://www.co.ramsey.mn.us /attorney/rc-vets (last visited Nov. 11, 2014).

27. MINN. JUDICIAL BRANCH, *supra* note 24, at 20.

28. *Id.* at 6.

29. *Id.*

30. *Id.*

31. *Id.* For an overview of the history and development of Minnesota drug courts, see *id.* at 6, 20.

32. Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illness: The Role of Mental Health Courts in System Reform*, 7 UDC/DCSL L. REV. 143, 146 (2003).

A. *The Unforeseen Consequences of Efforts to Treat the Mentally Ill More Humanely*

The last half century was a time of significant change regarding the way persons with mental illness were viewed, housed, and treated by society. In the past, those with the most significant mental illnesses lived in institutions and rarely interfaced with society.[33] In the 1960s, deinstitutionalization became the norm.[34] The purpose of the new paradigm was to reduce the stigma of being mentally ill and to integrate mental health services into the community.[35] Unfortunately, despite the best of intentions, not all of the resources formerly devoted to institutionalization were transferred to community-based care of the mentally ill. There were simply inadequate systems in place to deal with mental health care, housing challenges, and employment needs.[36] These shortcomings, coupled with what some viewed as the disruptive behavior of

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33. *See* Matthew Epperson et al., *Mental Health Court: One Approach for Addressing the Problems of Persons with Serious Mental Illnesses in the Criminal Justice System, in* 3 CRIMINAL PSYCHOLOGY 367 (J. Helfgott ed., 2013).

34. The 1963 Community Mental Health Centers Act (CMHCA) has been credited for being a prime catalyst in the movement away from institutionalization. *See* CHRIS KOYANAGI, JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH LAW, LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM 5–7 (2007), *available at* http://www.nami.org/Template.cfm?Section=About_the_Issue&Template=/ContentManagement/ContentDisplay.cfm&ContentID=137545; *Our History*, MENTAL HEALTH AM., http://www.mentalhealthamerica.net/our-history (last visited Apr. 20, 2015). The CMHCA authorized community mental health centers, called for the deinstitutionalization of the mentally ill, and encouraged increased access to community services. *Id.* The changes triggered by the CMHCA are illustrated by institutionalization statistics in the United States:

> In 1955, there were 558,239 severely mentally ill patients in our nation's public psychiatric hospitals. In 1994, there were 71,619 . . . . Our jail population of people with mental illness has swelled to 285,000. According to a U.S. Department of Justice July 1999 Report, sixteen percent of state prison inmates and sixteen percent of those in local jails reported either a mental condition or an overnight stay in a mental hospital. According to that same study, half of mentally ill inmates reported three or more prior sentences.

Stratton, *supra* note 10, at 901.

35. Epperson et al., *supra* note 33, at 367.

36. KOYANAGI, *supra* note 34, at 10.

certain persons with serious mental illness, resulted in increased police contact and arrests.[37]

After two years of study, the Council of State and Local Governments found in 2002 that "[p]eople with mental illness are falling through the cracks of this country's social safety net and are landing in the criminal justice system at an alarming rate."[38] The report observed that people with mental illnesses are "[o]verlooked, turned away, or intimidated by the mental health system" and "end up disconnected from community supports."[39] Thus, people with mental illness often lack access to appropriate mental health treatment, services, and assistance in the community. Without access to these services, there is a greater likelihood of police contact and, once a criminal case is resolved in the traditional court system, recidivism.[40] In jail, inmates with a mental illness are unlikely to receive appropriate treatment.[41] "Not surprisingly, officials in the criminal justice system have encountered people with mental illness with increasing frequency."[42]

To complicate matters, the social challenges faced by persons with mental illness coincided with the explosion of drug use in the United States.[43] It is likely no coincidence that the susceptible population of persons with mental illness engaged in a destructive form of self-medication.[44] The co-occurring disorders of mental illness and drug or alcohol abuse characterize approximately seventy-four percent of state prisoners and seventy-six percent of local jail inmates with mental illness facing criminal charges.[45]

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37. Epperson et al., *supra* note 33, at 368.

38. COUNCIL OF STATE GOV'TS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT, at xii (2002), *available at* https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf.

39. *Id.* at xiii.

40. *Id.* at 6 (citing Lois A. Ventura et al., *Case Management and Recidivism of Mentally Ill Persons Released from Jail*, *in* PSYCHIATRIC SERVICES 49:10, at 1330–37 (1998) (noting that in a study of jail detainees who have mental illnesses, 188 of the 261 detainees returned to jail within thirty-six months of release)).

41. *Id.* at 8.

42. *Id.*

43. *Compare supra* text accompanying note 9, *with supra* text accompanying notes 33–35.

44. COUNCIL OF STATE GOV'TS, *supra* note 38, at xii.

45. *See, e.g.*, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 213600, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), *available at* http://www.bjs.gov/content/pub/pdf/mhppji.pdf; COUNCIL OF STATE GOV'TS,

The criminalization of persons with mental illness produced the exact opposite effect of what was intended when institutionalization of the mentally ill was phased out. With criminal justice system contact came the risk of trauma for the incarcerated person with a mental illness; a new stigmatization; and a criminal record that could impact access to housing, employment, and medical care.[46] The traditional court system was not working for the public and for individuals with mental illness charged with crimes. As Ohio Supreme Court Justice Evelyn Lundberg Stratton stated in 2004, "A revolving door problem has developed in this country. Jails and prisons have become the de facto mental health system of our day."[47]

B. *Mental Health Courts Arrive*

The alarming arrest and incarceration rates that led to the formation of drug courts were also the impetus behind mental health courts. Mentally ill defendants are disproportionately represented in our country's jails and prisons. In 2005, sixty-four percent of jail inmates and fifty-six percent of state prison inmates had either a history or symptoms of a mental illness.[48] Mental illness and the co-occurring disorders of drug or alcohol abuse are directly linked to repeat criminal offenders.[49] High recidivism rates

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supra note 38, at 4, 260.

46. For a brief discussion of the difficulties mentally-ill incarcerated persons face when re-integrating to the community, see THE SENTENCING PROJECT, MENTALLY ILL OFFENDERS IN THE CRIMINAL JUSTICE SYSTEM: AN ANALYSIS AND PRESCRIPTION 9, 11 (2002), *available at* http://www.sentencingproject.org/doc/publications/sl_mentallyilloffenders.pdf; *see also* Olinda Moyd, *Mental Health and Incarceration: What a Bad Combination*, 7 UDC/DCSL L. REV. 201, 211 (2003).

47. Stratton, *supra* note 10, at 902.

48. *See* BUREAU OF JUSTICE STATISTICS, *supra* note 45, at 3.

49. COUNCIL OF STATE GOV'TS, *supra* note 38, at 44, 260. Considering the number of people with mental illness in the United States, it is no surprise that they are disproportionately represented in the court system. Recent data demonstrates that up to three in ten homeless citizens in this country have a serious mental illness and there are more than 38,000 suicides in the United States each year—more than double the homicide rate. NAT'L ALLIANCE ON MENTAL ILLNESS, MENTAL ILLNESS FACTS AND NUMBERS 1 (2013), *available at* http://www.nami.org/factsheets/mentalillness_factsheet.pdf; *see* DIV. OF VIOLENCE PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION, SUICIDE FACTS AT A GLANCE 1 (2012), *available at* http://www.cdc.gov/violenceprevention/pdf/suicide_datasheet-a.pdf (reporting the number of suicides in 2010).

In Minnesota, more than half of the homeless population has a serious

demonstrated that traditional punishment and probation models ineffectively addressed the issues triggering law enforcement and court contact with persons who have an untreated mental illness.[50] Being mentally ill in the criminal justice system is also associated with greater substance use, longer sentences, higher rates of physical violence, and increased homelessness.[51]

The ineffectiveness of traditional models focusing on punishment and not the underlying cause of criminality was as noticeable as the "frequent fliers"[52] coming before the bench. Consequently, mental health courts were partially born out of judicial frustration.[53] As with drug courts, Florida was the incubator

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mental illness or chemical dependency diagnosis with over 500 suicides each year. *Mental Illness in the Twin Cities*, TOUCHSTONE MENTAL HEALTH, http://www.touchstonemh.org/about-us/mental-illness-in-the-twin-cities (last visited Nov. 14, 2014). In Minnesota prisons, about sixty-five percent of women and twenty-five percent of men receive psychological care. MINN. DEP'T OF CORR., FACT SHEET: MENTAL HEALTH SERVICES 1 (2014), *available at* http://www.doc.state.mn.us/pages/files/2113/9878/6664/MentalHealthFactSheet.pdf. It is not known how many more go undiagnosed and untreated. In Ramsey County, it is estimated that over 31,000 people have a serious mental illness. *Frequently Asked Questions About Mental Illness*, RAMSEY COUNTY, http://www.co.ramsey.mn.us/hs/mhc/AdultMentalHealthFAQ.htm (last visited Nov. 14, 2014).

50. *See* CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT, COUNCIL OF STATE GOV'TS JUSTICE CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESS: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT 11 (2008) [hereinafter IMPROVING RESPONSES], *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-essential-elements.pdf.

51. Dale E. McNiel, Renée L. Binder & Jo C. Robinson, *Incarceration Associated With Homelessness, Mental Disorder, and Co-Occurring Substance Abuse*, 56 PSYCHIATRIC SERVICES 840, 844–45 (2005).

52. The term "frequent flier" is often used to describe a person with numerous prior arrests. *See* Joshua A. Engel, *Frequent Fliers at the Court: The Supreme Court Begins to Take the Experience of Criminal Defendants into Account in Miranda Cases*, 7 SETON HALL CIRCUIT REV. 303, 304 (2011) (footnote omitted). They are people who are seen regularly by the police, in local jails, and in the courts. *See id.*

53. A widely quoted expression of the judicial frustration giving rise to problem-solving courts comes from former Minnesota Supreme Court Chief Justice Kathleen Blatz:

> [T]he innovation that we're seeing now [the rise of problem-solving courts] is a result of judges processing cases like a vegetable factory. Instead of cans of peas, you've got cases. You just move 'em, move 'em, move 'em. One of my colleagues on the bench said: "You know, I feel like I work for McJustice: we sure aren't good for you, but we are fast."

Greg Berman, *"What Is a Traditional Judge Anyway?" Problem Solving in the State Courts*, 84 JUDICATURE 78, 80 (2000).

for mental health courts. What is generally regarded as the nation's first modern mental health court began operation in Broward County, Florida, in 1997.[54] Mental health courts offer a departure from business as usual.[55] A successful mental health court requires an array of community partners.[56] Working "as a team and under the judge's guidance, prosecutors, defense attorneys, and mental health service providers connect eligible defendants with community-based mental health treatment and, in lieu of incarceration, assign them to community-based supervision."[57]

There are now more than 349 mental health courts throughout the country, including three in Minnesota.[58] Nevertheless, research-based mental health court practices are in the embryonic stage.[59] Yet, building on the drug court model as a platform,[60] most mental health courts have evolved to include the following common characteristics:

- A specialized court docket, which employs a problem-solving approach to court processing in lieu of more traditional court procedures for certain defendants with mental illnesses.
- Judicially supervised, community-based treatment plans for each defendant participating in the court, which a team of court staff and mental health professionals design and implement.
- Regular status hearings at which treatment plans and other conditions are periodically reviewed for appropriateness, incentives are offered to reward adherence to court conditions, and sanctions are

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54. Gregory L. Acquaviva, Comment, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 983 (2006); Ginger Lerner Wren, *Mental Health Courts: Serving Justice and Promoting Recovery*, 19 ANNALS HEALTH L. 577, 587 (2010).

55. *See* IMPROVING RESPONSES, *supra* note 50, at 11.

56. *Id.* at 8.

57. *Id.* at 11.

58. RAMSEY CNTY. MENTAL HEALTH COURT, POLICY AND PROCEDURES MANUAL 4 (June 4, 2014) [hereinafter RCMHC P&P MANUAL].

59. *See, e.g.*, LAUREN ALMQUIST & ELIZABETH DODD, MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE, at v–vi, 2 (2009), *available at* https://www.bja.gov/Publications/CSG_MHC_Research.pdf; COUNCIL OF STATE GOV'TS JUSTICE CTR., BUREAU OF JUSTICE ASSISTANCE, MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS 13–14 (2008).

60. ALMQUIST & DODD, *supra* note 59, at 1.

imposed on participants who do not adhere to the conditions of participation.

- Criteria defining a participant's completion of (sometimes called graduation from) the program.[61]

Some states have developed written guidelines to ensure consistent mental health court operation.[62] Following a decade of experience, the Bureau of Justice Assistance and the Council of State Governments Justice Centers published a list of ten essential elements of a mental health court in 2008.[63] The elements deserve publication in full:

(1) Planning and Administration: A broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court.

(2) Target Population: Eligibility criteria address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria also take into account the relationship between mental illness and a defendant's offenses, while allowing the individual circumstances of each case to be considered.

(3) Timely Participant Identification and Linkage to Services: Participants are identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible.

(4) Terms of Participation: Terms of participation are clear, promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that

61. IMPROVING RESPONSES, *supra* note 50, at vii.

62. *See, e.g.*, JUDICIAL COUNCIL OF GA., ADMIN. OFFICE OF THE COURTS, STANDARDS FOR GEORGIA ACCOUNTABILITY COURTS: ADULT MENTAL HEALTH COURT STANDARDS 17 (2013), *available at* http://georgiacourts.gov/files/Accountability%20courts/JC%20Standards%20for%20Accountability%20Courts%202nd%20Oct.%202013%20Revision.pdf.

63. *See generally* IMPROVING RESPONSES, *supra* note 50 (describing elements of what a mental health court is and should strive to be).

the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.

(5) Informed Choice: Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant's competency whenever they arise.

(6) Treatment Supports and Services: Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use—and increase the availability of—treatment and services that are evidence-based.

(7) Confidentiality: Health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and their constitutional rights as defendants. Information gathered as part of the participants' court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.

(8) Court Team: A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.

(9) Monitoring Adherence to Court Requirements: Criminal justice and mental health staff collaboratively monitor participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery.

(10) Sustainability: Data are collected and analyzed to demonstrate the impact of the mental health court, its performance is assessed periodically (and procedures are modified accordingly), court processes are institutionalized, and support for the court in the community is cultivated and expanded.[64]

Not all mental health courts are the same. The structure and operation of a mental health court is strongly influenced by funding sources, community needs, and participating justice partners.[65] Accordingly, it is common for mental health court teams to visit other mental health courts to learn and adapt.

V. RAMSEY COUNTY MENTAL HEALTH COURT— A VIRTUAL SITE VISIT

The same considerations and frustrations that formed the catalyst for the creation of the first mental health court in Broward

64. *Id.* at 1–10 (listing headings only and omitting accompanying text).

65. ALMQUIST & DODD, *supra* note 59, at 29 ("No two mental health courts are exactly alike. Each is shaped by the target population, jurisdictional constraints, available treatment services, and other community factors."). Almquist and Dodd discuss in some detail the tensions that may exist when combining two systems that were not originally designed to work together:

> The criminal justice system was not designed to provide mental health treatment; its main purposes are to ensure public safety, promote justice, and punish and prevent criminal behavior. The mental health system, in contrast, focuses primarily on the treatment of illnesses, public health, and harm reduction. Despite these differing mandates, the two systems have been thrust together because of overlapping commitments to the same people. Mental health courts attempt to coordinate these responses under the purview of the courts so that each system can fulfill its duty and produce the best outcomes for people with mental illnesses and their communities.
>
> The court alone does not comprise a comprehensive treatment intervention; instead, mental health courts motivate individuals to connect to community-based treatment services while the court monitors their progress and ensures public safety. Thus, collaboration between criminal justice agencies and mental health treatment providers is critical.
>
> Despite general similarities among mental health courts, each court develops locally, based on the needs and legal regulations of that particular jurisdiction and the treatment services available. As a result, there is no single mental health court model.

Id. at 5–6.

County led to the formation of the RCMHC. Like other mental health courts across the country, RCMHC is based on the national problem-solving court model.[66] As in other jurisdictions, RCMHC was the direct result of a local realization that "persons with mental illness and co-occurring substance abuse disorders were in need of more specialized and individualized jurisprudential approaches."[67]

RCMHC opened in May 2005 and was funded by the Ramsey County District Court in collaboration with Ramsey County Community Human Services, Adult Mental Health.[68] The founders of RCMHC were Ramsey County District Court Judge Gregg Johnson and Clinic Manager of the Ramsey County Mental Health Center, Nancy Houlton.[69] Throughout its years of existence,

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66. RCMHC P&P MANUAL, *supra* note 58, at 4.

67. *Id.*

68. *Second District: Mental Health Court Program*, MINN. JUD. BRANCH, http://www.mncourts.gov/district/2/?page=1576 (last visited Feb. 3, 2015). RCMHC has received funding from a variety of sources. The physical court facilities, judge time, and judicial and administrative staff time is furnished in kind by the Second Judicial District of Minnesota. Three judges volunteer for the assignment. They take turns presiding on a bi-monthly schedule. Since inception, other judges include Judge Paulette Flynn, Judge William Leary, Judge Gail Change Bohr, and Judge Teresa Warner. In 2006, RCMHC was awarded a one-year Problem-Solving Partnership Grant from the Minnesota Office of Justice Program. The grant permitted funding of its core employees: a program administrator and a case manager. Since 2008, RCMHC has received its principal funding from the Minnesota Department of Human Services, Adult Mental Health Division.

Justice partners, such as the Ramsey County Attorney's Office and St. Paul City Attorney's Office, have also assigned their prosecutors to the RCMHC team. In addition, RCMHC has benefited from significant legal community support. For several years, attorney Warren Maas offered pro bono criminal defense services to RCMHC participants. Beginning in 2010, the Briggs & Morgan law firm provided a team of three pro bono criminal defense attorneys. The team of pro bono attorneys has also supervised a student attorney from the Minnesota Justice Foundation.

Along the way, program expansion funding has come from three federal grants. In 2010, RCMHC received a two-year Bureau of Justice Assistance (BJA) Adult Drug Court Discretionary Grant Program Expansion grant. With the BJA grant, RCMHC included select felony offenders for the first time. In 2013, RCMHC was one of eleven BJA expansion grant recipients in the country. The grant funded a doubling of RCMHC's capacity, primarily through the funding of an additional case manager. Finally, a 2014 BJA grant will permit RCMHC to add a full-time probation officer to the team as well as a part-time public defender to represent qualified defendants through the screening and acceptance process.

69. RCMHC P&P MANUAL, *supra* note 58, at 5.

RCMHC has operated under a human services model of program delivery.[70]

A. *Cornerstone Philosophy, Policies, and Procedures*

A review of the history and development of RCMHC demonstrates an alignment with what became the ten essential elements of a mental health court. Created from a community-based collaborative process, RCMHC drafted and adopted a mission statement, program goals and objectives, and participant eligibility requirements.[71] The *Policy and Procedures Manual* contains all of the program elements and forms, while the *Participant Handbook* explains RCMHC and its requirements to program participants.[72]

RCMHC, like all problem-solving courts, is mission driven. Its mission is:

> [T]o increase public safety by reducing recidivism among those whose criminal behaviors are attributable to mental illness. Through court supervision and the coordination of mental health and other social services, the Court supports a psychiatrically stable and crime-free lifestyle *[through more responsible behavior, greater self-sufficiency, and an improved quality of life]* among its participants.[73]

Like other mission-driven organizations, RCMHC closely links its goals and objectives to its mission. The goals of RCMHC are to:

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70. For purposes of this Article, the term "human services model" means the practice of building a mental health court's program-delivery component around human services case managers rather than probation officers. A case manager links participants to available community mental and chemical health services. *See, e.g.*, *id.* at 37–38 (RCMHC case management responsibilities). Lincoln University defines a "human services professional" as a person "who uses the human services practice model to assess and deliver services. This model views people, service and the social environment as integrated entities. This perspective helps individuals, families and communities address and overcome issues and barriers that arise from a variety of social problems and adverse societal conditions." *What Is a Human Service Professional?*, LINCOLN U. COMMONWEALTH PENN., http://www.lincoln.edu/mhs/define.html (last visited Feb. 3, 2015). Deborah Strasser and Allison Husman are RCMHC's current human services case managers.

71. *See generally* RCMHC P&P MANUAL, *supra* note 58.

72. *See id.*

73. *Id.* at 4.

- Reduce recidivism.
- Improve public safety.
- Reduce the costs of prosecution, incarceration, and hospitalization to taxpayers.
- Improve defendants' access to public mental health and substance abuse treatment services and other community resources.
- Enhance collaboration between criminal justice agencies and the mental health system to better serve those with mental illness.
- Improve the quality of life of mentally ill defendants.[74]

To achieve its goals, RCMHC directs eligible defendants "from the criminal justice system to community-based mental health, substance abuse and support services."[75] It provides eligible defendants, whose criminal conduct was substantially the product of mental illness, an opportunity to complete court-supervised treatment.[76] RCMHC uses the problem-solving court methodology of focusing on each defendant's underlying mental health and chemical health needs instead of utilizing the traditional court approach, which looks almost exclusively at the defendant's criminal activity.[77] RCMHC participants are held accountable through regular monitoring by case management and probation, frequent court appearances, a written treatment plan, and a system of sanctions and rewards.[78]

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74. *Id.*
75. *Id.*
76. *Id.*
77. *Id.*
78. *See id.* at 24–28. RCMHC focuses attention on both the mental health of its participants and on the ancillary impacts on lifestyle and quality of life that may be influenced by mental health and may affect criminal behavior. Furthermore, RCMHC does not provide supports and services that disappear upon graduation from the program. Instead, among its goals are developing lasting community services and supports for participants that remain in place post-graduation. According to one commentator, the broader view taken by programs like RCMHC is more akin to a form of "therapeutic rehabilitation" than therapeutic jurisprudence. *See* E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 547–51 (2012). According to the commentator, the former appears justified by existing research, while the latter is not. *Compare id.* at 529–46, *with id.* at 575–76, 579 (discussing two theories—the second and third—that most closely resemble the RCMHC approach).

At every level of operation, RCMHC depends upon multiple stakeholder collaboration. All intake, eligibility, evaluation, treatment alternative, and case management decisions involve team input. As of 2014, the RCMHC team includes a program coordinator,[79] two community human-services case managers,[80] three rotating judges, a probation officer, a Ramsey County Attorney's Office prosecutor, a St. Paul City Attorney's Office prosecutor, a pre-acceptance attorney from the Ramsey County Public Defender's Office, three rotating pro bono defense attorneys, one certified student attorney, one graduate-clinical case management intern, Project Remand,[81] and the Second Judicial District Research Department.[82] RCMHC also works closely with other community partners. They include the Ramsey County Community Mental Health Center, Ramsey County Community Corrections, Adult Probation Department, Ramsey County Correctional Facility, and the Ramsey County Sheriff's Office.[83] Together, the RCMHC team and its partners continue to refine the program and its effective delivery to participants in order to achieve the program goals.

B. RCMHC Referrals and Eligibility

Unlike drug court participants, who are typically identified at the criminal charging stage, potential mental health court participants enter the program through a variety of avenues.[84] In the case of RCMHC, thirty percent of referrals come from criminal defense attorneys, eighteen percent are referred at the time of arraignment, fifteen percent are referred by Project Remand,[85]

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79. For a complete statement of the Program Coordinator's role and duties, see RCMHC P&P MANUAL, *supra* note 58, at 36–37.

80. For a full description of the duties and responsibilities of case management, see *id.* at 37–39.

81. Project Remand is a nonprofit corporation that contracts with Ramsey County to provide bail evaluation and conditional release services. *See id.* at 41–42.

82. *Id.* at 34 (identifying by name the members of the RCMHC team in 2014).

83. *See id.* at 6–7, 33–34.

84. COUNCIL OF STATE GOV'TS, A GUIDE TO MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION 47 (2005), *available at* https://www.bja.gov/Programs/Guide-MHC-Design.pdf.

85. A basic mental health screen is conducted by Project Remand as a part of all bail evaluations. RCMHC P&P MANUAL, *supra* note 58, at 13 (providing the Brief Jail Mental Health Screen and CAGE Questionnaire). Referrals by Project

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twelve percent of referrals are from judicial officers, and ten percent of referrals are from community mental health professionals.[86]

Once referred, potential participants must successfully complete a qualification and screening process before their admission is considered. Eligibility for the program requires that the person being referred is an adult Ramsey County resident[87] who has been charged with a crime that may be related to a significant mental illness.[88] In addition, a person will not be considered for participation in RCMHC unless they are accused of committing a qualifying nonviolent misdemeanor, gross misdemeanor, or felony.[89] Qualifying criteria also include diagnosis with a significant mental illness and legal competence.[90] If the potential participant meets the basic qualifications, further screening must be approved by the prosecutor.[91]

C. *The RCMHC Screening Process*

A RCMHC screen involves much more than a criminal history search. After establishing program qualification and receiving initial prosecutor approval,[92] the assigned case manager conducts a detailed psychosocial assessment of each potential participant. The assessment requires gathering the person's medical history and all

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Remand to RCMHC may be triggered by the results of the screen. *See id.* at 13–14.

86. RAMSEY CNTY. MENTAL HEALTH COURT, SECOND JUDICIAL DIST. OF MINN., 2010 TO 2012 REPORT 8 (2013) [hereinafter RCMHC 2010 TO 2012 REPORT].

87. *Id.* at 5. Nonresidents of Ramsey County are considered on a case-by-case basis. *Id.*

88. *Id.*

89. For a list of the disqualifying offenses, see RCMHC P&P MANUAL, *supra* note 58, at 10. If an offense on the list is marked with an asterisk, the individual may be considered for admission to RCMHC on a case-by-case basis. *Id.*

90. *Id.* at 9.

91. *Id.* at 13.

92. Whether a defendant is initially eligible for referral to a problem-solving court is generally considered within the prosecutor's discretion. *See, e.g.*, Woodward v. Morrissey, 991 P.2d 1042, 1045–46 (Okla. Crim. App. 1999); State v. DiLuzio, 90 P.3d 1141, 1144–45 (Wash. Ct. App. 2004) (citing State v. Taylor, 769 So. 2d 535, 537 (La. 2000)) (holding that permitting the prosecutor to make initial determinations of drug court eligibility is not an unconstitutional delegation of judicial power). *But see* RCMHC P&P MANUAL, *supra* note 58, at 16 (noting that a judge has discretion to make a post-adjudicatory referral to mental health court in the context of a probation violation despite the prosecutor's objection).

relevant medical records.[93] Of course, procuring medical records necessitates obtaining signed medical authorizations from the potential participant.[94] If the medical record is incomplete or the potential participant lacks a prior or recent psychological workup, an evaluation may be conducted by a staff psychiatrist at the Ramsey County Mental Health Center. The process can take up to six weeks. During the screening phase, the potential participants are monitored by Project Remand while on conditional release and they appear at each court session.[95] The conditional release includes regular check-ins; a chemical health assessment, if needed; and regular testing for the use of prescription drugs, non-prescription drugs, and alcohol.[96] The court appearances are useful in two ways. Potential participants get an opportunity to see RCMHC in operation, which permits an informed participation decision. In addition, the team develops a sense of each person's ability to handle the rigor of the program.

Once the criminal history and medical profile are compiled, the team has the information it needs to determine the potential participant's diagnosis, gauge any risks the person may pose to public safety, and assess the person's ability to comply with a treatment plan and court-imposed obligations.[97] Using the profile developed during the psychosocial assessment, the team weighs several additional factors as part of the acceptance decision.[98] A primary consideration is whether the person has the ability to follow through with the conditions of participation and treatment recommendations.[99] The team also reflects on whether the potential participant will benefit from the services that RCMHC can provide or recommend.[100] It is also important that the person will likely be positively influenced by regular court interaction.[101] Finally, the team considers whether RCMHC can provide or

93. RCMHC P&P MANUAL, *supra* note 58, at 52–59.
94. *Id.* at 14.
95. *Id.* at 13.
96. *Id.* at 17.
97. *See generally id.* at 18.
98. *See generally id.*
99. *See generally id.*
100. *See generally id.*
101. *See generally id.*

connect the potential participant to the appropriate community resources for recovery.[102]

While the team reviews the assessment results, the potential participants, with the assistance of counsel, review their options. The prosecutor typically offers the individual a case resolution proposal for both the traditional court track and RCMHC. It is up to the potential participant to choose between taking the case to trial, a plea with probation in the traditional criminal court, or acceptance of the RCMHC offer.[103]

If the psychosocial assessment produces an acceptance recommendation, the team makes a final decision regarding program entry. As part of the acceptance process, the psychosocial assessment information gathered during screening is used to craft an individualized treatment plan for the participant and to match the person to appropriate community-based services.[104]

D. *Program Acceptance*

RCMHC is a voluntary program.[105] After initially qualifying, passing through the screening process, and being approved for

102. *See generally id.*

103. The prosecution offer is usually designed to give the potential participant an incentive to enter RCMHC. The mental health court offer may provide for diversion, less jail time, a shorter period of probation, or other distinctions from the traditional track. However, agreeing to participate in RCMHC does not give the defendant a "get-out-of-jail-free" card. In virtually every case, a defendant who agrees to participate in RCMHC is involved in a more rigorous program with greater supervision, more expectations, and the need to expend more effort than a defendant in the traditional court system. Potential participants are fully informed of the increased expectations at program entry.

104. RCMHC P&P MANUAL, *supra* note 58, at 17–18. "All members of the RCMHC [team] must agree for a case to enter the program." *Id.* at 18. If a potential participant is not accepted, or declines the opportunity to participate, the person returns to the traditional track. *Id.* A potential participant may also be referred for consideration by another Ramsey County problem-solving court.

105. *Id.* at 18.

admission,[106] all participants must commit to a program that is usually more rigorous than traditional criminal courts.[107] Every participant has an individualized treatment plan.[108] A case manager reviews the plan with each potential participant prior to admission into RCMHC, and the participant must agree to comply with all aspects of the treatment plan in open court as a condition of program admission.[109] While in RCMHC, participants must attend

106. RCMHC currently serves a maximum of forty persons at a time. The limit includes both accepted and pending participants, as most referrals receive services, even those not ultimately accepted. From 2005 to 2013, the limit was twenty-five. The limit is primarily dictated by the number of persons who a full-time case manager can serve. According to best practice standards set by the Minnesota Department of Human Services, the average caseload for a full-time direct-service mental health case manager is fifteen to twenty clients. For RCMHC, the case manager's job includes assessment, planning, referral, linkage, monitoring, and coordination. The caseload may vary depending upon whether services can be brokered to the community or the RCMHC case manager is the primary provider. The following chart documents referrals versus the number of persons receiving some level of service for each year of RCMHC's existence. Both accepted and pending participants are included in the second column.

Year	RCMHC Referrals	MMH Services
2005	25	24
2006	19	21
2007	17	16
2008	64	51
2009	56	47
2010	61	50
2011	49	44
2012	50	37
2013	53	41
2014	69	54
avg. 2005–2013	**43.8**	**36.8**
avg. 2009–2013	**53.8**	**43.8**

RCMHC, RCMHC Internal Database (unpublished data) (on file with author at RCMHC).

107. RCMHC P&P MANUAL, *supra* note 58, at 18.

108. *Id.*

109. *Id.* at 17–18.

all scheduled court hearings.[110] They are also expected to meet frequently with their RCMHC case manager.[111] Participants must "[r]emain law abiding[,] [a]bstain from illegal or non-prescribed drugs[,] [s]ubmit to random drug and alcohol testing[,] [c]omplete community work service hours[,] [i]dentify and maintain appropriate housing[,]" comply with all medication prescriptions, and attend all psychiatric appointments.[112] Moreover, participants agree to waive their right to a full-blown probation violation hearing if they violate the terms and conditions of RCMHC.[113] A participant may opt out of RCMHC at any time, but the person may face the specter of a probation violation in traditional court as a result.[114] In addition, an involuntary termination is also possible.[115] A participant could face termination from RCMHC if a new charge is picked up, there is a new conviction, the person absconds or fails to make court appearances or appointments, or the person fails to comply with program requirements.[116]

Most potential participants qualify for representation by the public defender's office.[117] RCMHC is fortunate to have a team of pro bono attorneys from the Briggs & Morgan firm.[118] At the time of acceptance, pro bono counsel substitutes for the public defender.[119]

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110. *See id.*

111. *Id.* at 17.

112. *Id.* at 17–18.

113. *Id.* at 18.

114. A condition of every accepted participant's probation is compliance with the terms and conditions of RCMHC. Thus, a decision to opt out both triggers a probation violation and restores the participant's right to a traditional-track probation violation hearing. *Id.* at 30; *see also id.* app. I, at 62, para. 5 (citing MINN. R. CRIM. P. 27.04) (Waiver of Probation Violation Hearing form). In other words, if a participant violates a RCMHC condition, a consequence cannot be avoided simply by opting out of the program. The participant either receives a consequence for the violation without a hearing as part of the RCMHC process or, following opt out, a probation violation is triggered and heard in the traditional criminal court.

115. RCMHC P&P MANUAL, *supra* note 58, at 29–30.

116. *Id.*

117. RCMHC 2010 TO 2012 REPORT, *supra* note 86, at 21.

118. *Id.*

119. *Id.*

E. *Program Phases*

Participants must complete four phases of the program in addition to the pre-acceptance referral phase.[120] RCMHC admits participants both pre-adjudication[121] and post-adjudication.[122] The program typically lasts twelve months for participants with misdemeanor offenses, twenty-four months for gross misdemeanor offenses, and up to three years for felony offenses.[123] To advance into the next phase, participants must complete an application that documents satisfactory completion of their current phase.[124] The RCMHC team approves the phase move application if the participant is compliant with the goals in the treatment plan, RCMHC court conditions, and the advancement requirements of each phase.[125] The phase application itself is also a factor in the decision to advance a participant. Preparing the phase move application gives participants an opportunity to reflect on the progress they have made and the role RCMHC's involvement has played in their life to date.

It is worth reemphasizing that RCMHC is an individualized program. Not every participant travels the same path to recovery and stability.[126] The challenges associated with a mental illness and co-occurring disorders do not always lead to successful linear progress through the RCMHC program.[127] Thus, some advancement requirements may "vary from participant to participant."[128] In addition, "[p]articipants may be in more than one phase at a time and may re-enter phases" during their involvement in RCMHC.[129] The "length of each phase" may also vary for each individual based upon factors such as the criminal

120. For a description of the four participation phases, see RCMHC P&P MANUAL, *supra* note 58, at 23–29.

121. Pre-adjudication admission permits participation without a guilty plea or conviction, as in the case of diversion. *Id.* at 19.

122. Post-adjudication participants enter the program after a guilty plea, conviction, or sentencing. *Id.* at 19–20.

123. *Id.* at 12.

124. *Id.* at 23–24.

125. *Id.*

126. *Id.* at 23.

127. *See id.*

128. *Id.*

129. *Id.*

charge, level of program engagement, and medical and psychological stability.[130]

The referral phase usually lasts six weeks.[131] As already discussed, the referral phase involves gauging the person's interest in RCMHC; orienting the person to the RCMHC process, which includes regular court attendance; introducing the participant to the RCMHC team; working with a case manager; and assessing the participant.[132] The referral phase ends upon acceptance into RCMHC.[133]

Phase I is the engagement phase.[134] It lasts two to six months, depending upon the length of the sentence to RCMHC and the participant's success.[135] The participant and case manager work together to develop a crisis plan; establish measurable goals from the treatment plan; "and assess the participant's need for mental health and chemical dependency treatment, resources, and/or education."[136] At this early stage, identifying unmet needs is an important consideration. Participants frequently encounter barriers, not directly related to their mental health, that interfere with access to mental health services.[137] Common obstacles are the absence of health insurance, a lack of daycare for children, unstable housing, and inadequate transportation.[138] During the engagement phase, the participant and case manager identify and address any access impediments so mental health services may be utilized more effectively.[139]

Advancement to Phase II is based upon an RCMHC team assessment following review of the phase-move application.[140] The team looks for the participant to follow all RCMHC rules, remain law abiding, and advise the appropriate team member of any "new law enforcement contact[s]."[141] In addition, the participant must cooperate with the case manager and probation officer, attend

130. *Id.*
131. *Id.* at 24.
132. *Id.*
133. *Id.*
134. *Id.*
135. *Id.* at 25.
136. *Id.* at 24.
137. *Id.*
138. *See id.* at 24–25.
139. *See id.* at 25.
140. *See id.*
141. *Id.*

court and all appointments on time, assist with development of the treatment plan and any chemical dependency plan, commence the process of identifying a community work service site, comply with all treatment and chemical dependency plans, establish a payment plan for court fees and any restitution obligation, submit to random drug and alcohol testing if applicable, and work with the case manager to obtain services in the community.[142] During Phase I, participants may work with their case manager to procure "housing, healthcare, [governmental] benefits, psychiatry, mental health care, chemical dependency treatment, therapy, employment, pro-social activities, and/or educational options."[143]

Phase II is the active treatment phase.[144] It lasts three to ten months, depending upon the length of the sentence to RCMHC and the participant's success.[145] While in the active treatment phase, the RCMHC team continues to assist the participant to connect with mental health providers and services in the community.[146] During this phase, it is expected that participants demonstrate an initial ability to manage their mental illness; engage in a level of self-care, such as taking prescribed medications; and function in the day-to-day activities of ordinary life.[147] The participant engages in mental health care and follows recommendations.[148] Case management also works with the participant to set individualized goals and directs the participant into positive activities aimed at increasing stability and improving the quality of life.[149]

Advancement to Phase III requires continued success in connection with the conduct that resulted in movement to Phase II.[150] In addition, the participant must demonstrate that they have developed "a support system for their mental and chemical health needs"; made payments toward court fees and restitution; completed and verified one-third of any court-ordered community work service hours; registered in and started attending any court-

142. *Id.*

143. *Id.* For a summary of supports, treatments, and activities that are often available to RCMHC participants, see *id.* app. W, at 109–16.

144. *Id.*

145. *Id.* at 26.

146. *Id.*

147. *Id.* at 25.

148. *Id.*

149. *Id.*

150. *See id.* at 26.

ordered educational programs; and identified, obtained, and maintained necessary services in the community.[151] The participant must also be "actively involved in a job, education, vocational, and/or positive pro-social activity."[152] Finally, in the case of participants who have a co-occurring disorder, they must have a sobriety plan, identify an Alcoholics Anonymous or Narcotics Anonymous sponsor, abstain from alcohol and non-prescribed drugs as directed, or achieve significant progress toward sobriety.[153]

Phase III is the stabilization stage.[154] It lasts six to eighteen months depending upon the length of the sentence to RCMHC and the participant's continued success in the program.[155] During Phase III, the RCMHC team monitors and assists the participant's efforts in maintaining a healthy and stable lifestyle through responsible decision-making and accessing community resources, reliable housing, and mental health care.[156]

Advancement to Phase IV requires continued success in connection with the conduct that resulted in the participant's movement to Phase III.[157] The RCMHC team also examines the participant's progress with the treatment and sobriety plans, and maintenance of the programs and services that were obtained with the assistance of case management.[158] Finally, the participant must complete at least two-thirds of any court-ordered community work service hours; demonstrate sobriety; continue payment of court-ordered fees, fines, and restitution; and continue participation in a job, education, vocational, or other pro-social activity.[159]

Program completion with graduation is the fourth and final phase.[160] To graduate, the participant must "fulfill[] all RCMHC requirements."[161] The participant must demonstrate mental stability and have "established medical and community supports [with] on-going providers" in place.[162] "All court-ordered conditions must

151. *Id.*
152. *Id.*
153. *Id.*
154. *Id.* at 27.
155. *Id.*
156. *Id.*
157. *See id.* at 27–28.
158. *Id.* at 27.
159. *Id.*
160. *Id.* at 28.
161. *Id.*
162. *Id.*

. . . [be] met" with completion of all community service hours and payment of all fees, fines, and restitution.[163] Of course, this means that the participant has complied with the treatment plan and takes all prescribed medication as directed.[164] If applicable, the participant is sober and in compliance with the sobriety plan.[165]

Before graduation is approved by the team, several components aimed at the participant's future success and stability must be in place.[166] Participants verbally commit to remaining law abiding.[167] They develop a written action plan to prevent recidivism.[168] They also prepare a wellness plan to guide their future treatment and lasting mental health.[169] The wellness plan also identifies appropriate community supports and triggers for unhealthy behaviors.[170] Finally, at graduation, the participant appears in court and receives a certificate of completion; all charges are dismissed on the record for pre-adjudication cases, and probation is discharged in post-adjudication cases.[171]

The RCMHC phases were designed with the knowledge that traditional court and probation systems are limited in what they can do to effect change.[172] Court programs are usually temporary or provided on a one-time basis. RCMHC seeks to connect participants to community resources and supports that may be relied and built upon long after graduation and court involvement.[173] While the coercive power of the judge and the court system may initially motivate and compel cooperation, long-term success depends upon participant independence, sobriety, proactive and continuous involvement in mental health treatment, and law-abiding behavior.[174]

163. *Id.*
164. *Id.*
165. *Id.*
166. *Id.* at 29.
167. *Id.*
168. *Id.*
169. *Id.*
170. *Id.*
171. *See id.*
172. *See id.* at 35.
173. *See id.*
174. *See generally* RCMHC 2010 TO 2012 REPORT, *supra* note 86.

F. Staffing Before Court

Prior to each bi-monthly court session, the team meets to discuss the participants and their progress.[175] All team members are present. This discussion of participants by the whole team is referred to as "staffing."[176] The team is updated about how participants are doing in the community and the progress with their treatment plan. Participants' progress in the community and with their case manager is often regarded as the real work of RCMHC, because it takes place between court sessions and is about participants' real lives. Participants have the most communication with their case manager and, to a lesser extent, their probation officer.[177] Although email communications concerning challenges that arise between court sessions are common, the team relies most upon staffing and the written report on each participant sent out prior to staffing.[178] In addition to the written report on each participant, the team receives the drug and alcohol testing results for each participant and pending participant.[179]

Due to time limitations and the existence of the written report discussing each participant, only the more challenging cases are the subject of in-depth discussion during staffing.[180] The team considers whether the progress of each participant is satisfactory, whether to give incentives or sanctions, whether to grant phase-move applications, and whether a participant is ready to graduate.[181] Decisions are arrived at collaboratively and in a non-adversarial fashion. However, as to any sanctions or formal changes in a participant's RCMHC conditions, the presiding judge makes the final decision.[182] All decisions are communicated to the

175. RCMHC P&P MANUAL, *supra* note 58, at 133.

176. *Id.*

177. *Id.* at 37–39, 42–44.

178. *Id.* at 133.

179. *Id.* at 21–22.

180. *Id.* at 133.

181. *Id.* at 133–34.

182. *See, e.g.*, *id.* at 29 (noting that RCMHC conditions may be waived by the judge under special circumstances); *id.* app. I, at 62, para. 4 (showing the Waiver of Probation Violation Hearing form to be signed by the participant accepting that if RCMHC conditions are violated, the judge may impose a consequence). A problem-solving court judge serves multiple roles. A problem-solving court judge has been described as "a leader, a communicator, an educator, a community collaborator, [and] an institution builder." CARY ET AL., *supra* note 8, at 48. In RCMHC, the judge motivates and monitors participants, works to develop and

participant in open court after counsel for the State and for the participant are heard.

Individuals who are making progress are provided incentives to encourage further success.[183] For example, one incentive may be to hear the more successful participants' cases at the beginning of the court calendar.[184] An early calendar call decreases the time in court and serves as an incentive to others. Another incentive is to receive tickets to pro-social activities, such as baseball games, from case management.[185] Other incentives include praise or approval in court, a reduction in the number of court appearances, waiver or reduction of previously imposed fees, a reduction in the frequency of drug testing, and even early discharge from the program.[186]

If a person fails to comply with court requirements, a sanction will be considered. Research demonstrates that sanctions must be swift and certain or they will lose effectiveness.[187] The application of sanctions is graduated and linked to the nature of the transgression and whether the conduct to be sanctioned is isolated or part of a behavioral pattern. Sanctions include increased court appearances, assignments for court, journaling, increased frequency of drug testing, additional community service hours, sentence to service, and jail time.[188]

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maintain resources, improves interagency relationships, acts as a spokesperson for RCMHC in the community, and serves as an active member of the team. RCMHC P&P MANUAL, *supra* note 58, at 35–36. The judges must handle their role with care. Some problem-solving court judges have been the subject of discipline, with *ex parte* communications being particularly problematic. *See* Cynthia Gray, *When Roles Collide: Judicial Ethics and Problem-Solving Judges*, 24 EXPERIENCE, Spring 2014, at 38, 38. In part due to concern over *ex parte* communications, internal emails are broadcast to the entire RCMHC team, sometimes to the chagrin of a team member not centrally involved in the discussion.

183. RCMHC P&P MANUAL, *supra* note 58, at 31.

184. *Id.*

185. *Id.* at 25–26.

186. *Id.*

187. *See, e.g.*, CARY ET AL., *supra* note 8, at 141 ("[I]f one's goal is to improve adaptive functioning and reduce antisocial behavior on the part of drug offenders, then it is essential to closely monitor their conduct and impose certain and immediate rewards for achievements and sanctions for infractions.").

188. RCMHC P&P MANUAL, *supra* note 58, at 30, 32. Sentence to service is a work crew program offered by Ramsey County Correctional Facility. For more information, see *Sentence to Service (STS)*, RS EDEN, http://www.rseden.org/index.asp?SEC=1EBE6EE7-7060-4F2C-80F4-DCF8ED0A64F2&Type=B_BASIC (last visited Feb. 4, 2015).

G. *Court Sessions*

Court is convened after participants check in and communicate with case management and their attorney about the results of staffing, as needed. Graduating participants are called first so everyone on the calendar can witness the event. Graduates are given a certificate and congratulations card signed by the entire team. A discharge plan is reviewed and graduating participants are given an opportunity to reflect on their time in RCMHC. Graduates are always recognized with applause.

When the rest of the calendar is called, the participants and each member of their team engage in a dialogue. Without delving into detail concerning confidential features of the participants' mental health diagnosis and treatment, the participants learn how each team member appraises their progress or lack thereof. Face time with the judge provides the participants with an opportunity to articulate their level of satisfaction with a particular aspect of the RCMHC program or the headway they are making on a day-to-day basis.[189] Once everyone on the team has spoken and the judge has listened to any concerns raised by the participants, the judge delivers a message of encouragement for the more successful participants. Other participants are challenged with additional short-term goals or requirements that must be met by the next court session. For example, participants may be ordered to find a new Alcoholics Anonymous sponsor, schedule a key appointment, or write a statement explaining the importance of sobriety or taking prescribed medications. Court sessions are also where incentives and sanctions are announced.

H. *RCMHC Participant Profile*[190]

RCMHC serves a diverse population. Participants range in age from eighteen to sixty-three, with an average age of thirty-six.[191] Women comprise 61% of RCMHC participants.[192] With regard to race, 54% identify as Caucasian, 28% as African American, 7% as

189. According to research conducted with drug courts, defendants with three or more minutes of face time with a judge have better outcomes. CARY ET AL., *supra* note 8, at 52.

190. The percentages presented throughout the remainder of this Article have all been rounded to the closest whole number.

191. RCMHC 2010 TO 2012 REPORT, *supra* note 86, at 9.

192. *Id.*

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Native American or Hawaiian, 5% as Hispanic, 3% as Asian, and 3% as Multiracial.[193]

With regard to education, 44% report a high school diploma or General Education Development certificate.[194] Another 31% report some post-high school education without an additional degree.[195] Only 15% of RCMHC participants report an eleventh-grade education or less.[196] On the other end of the educational spectrum, 3% report having a four-year college degree, another 3% report a post-graduate degree, and 3% report a technical degree or certificate.[197]

Employment and housing are often challenges for RCMHC participants. Most participants (87%) state that they are unemployed when they enter the program.[198] Another 7% are employed part-time, 3% are employed full-time, and 3% are stay-at-home parents.[199] With regard to housing, 44% of participants report living independently.[200] However, 23% live with parents or an adult relative and 12% are homeless.[201] The rest live in corporate foster care (8%), board and lodge care (5%), an Intensive Residential Treatment Services Facility (3%), with friends (3%), or in jail (2%).[202]

With regard to the mental health of program participants, RCMHC admits persons with a variety of diagnoses.[203] Many participants have multiple diagnoses.[204] The predominant "diagnoses are Mood Disorders (59%), Anxiety Disorders (43%), Personality Disorders (39%), and Psychosis/Thought disorders (38%)."[205] In addition, 51% of participants had an Axis I chemical health diagnosis at the time of acceptance.[206] A significant

193. *Id.*
194. *Id.*
195. *Id.*
196. *Id.*
197. *Id.*
198. *Id.*
199. *Id.*
200. *Id.*
201. *Id.*
202. *Id.*
203. *Id.* at 11.
204. *Id.*
205. *Id.*
206. *Id.* at 12. The DSM-V has moved to a nonaxial assessment system and no longer uses the Axis designations (Axis I, II, III, IV, and V). For more information

percentage of RCMHC participants have a history of civil commitment.[207]

VI. RCMHC PROGRAM OUTCOMES

No program is worth the investment unless it produces results. Research demonstrates that mental health courts effectively reduce recidivism.[208] To document whether RCMHC achieves its goals, an evaluation methodology was developed by the Second Judicial District Research Department.[209] Using the methodology, a one- and three-year study was conducted.[210]

A. *Components of the Methodology*

RCMHC's effectiveness is validated when the following question is posed: "Do accused offenders with a mental illness have better outcomes by participating in RCMHC?"[211] To answer the query, a comparison group of similarly situated offenders who did not participate in RCMHC was identified.[212] The comparison group was isolated by culling from court records non-participating individuals who affirmatively responded to the mental health questions that are asked as a part of Ramsey County's bail evaluation process.[213] The group was further refined based upon age, sex, race, and criminal offense characteristics.[214] The purpose

on the former use of Axis designations, see DSM-V, *supra*, note 1, at 16.

207. RCMHC 2010 TO 2012 REPORT, *supra* note 86, at 11.

208. ALMQUIST & DODD, *supra* note 59, at 23–27. In addition, a long-term research study conducted by Policy Research Associates (PRA), with funding provided by the MacArthur Foundation, showed that mental health courts can "lead to cost savings through lower recidivism and the associated jail and court costs and through a reduction in use of the most expensive types of mental health treatment." *Id.* at 26.

209. *See* RCMHC 2010 TO 2012 REPORT, *supra* note 86, at 18–20.

210. *See generally id.* at 17–19 (presenting recidivism results from the original 2010 to 2012 study); RAMSEY CNTY. MENTAL HEALTH COURT, SECOND JUDICIAL DIST. OF MINN., RECIDIVISM SUMMARY (unpublished study) [hereinafter RECIDIVISM SUMMARY] (on file with author) (presenting the recidivism results from the updated 2013 study).

211. *See generally* ALMQUIST & DODD, *supra* note 59, at 27.

212. *See* RECIDIVISM SUMMARY, *supra* note 210, at 1.

213. *See id.* at 5 (noting that individuals were asked if "they had self-reported a mental illness at the time of booking").

214. *See id.*

was to mirror, as closely as possible, RCMHC's participant population.[215]

With a comparison group identified, the re-offense rate of the comparison group was compared with the re-offense rate of RCMHC participants.[216] The study was conducted using a one- and three-year follow-up time frame.[217] In other words, the analysis included only those "who had at least one [or three] year[s] pass since leaving the program."[218] Accordingly, the study did not include one hundred percent of RCMHC participants.[219] Current participants and those who had left the program without reaching the one- or three-year benchmarks were not included.[220] Otherwise, the data tracks everyone who has participated in RCMHC since its inception.[221]

Both the one- and three-year data sets identify RCMHC "non-completers" as "individuals who were accepted into the program, but did not complete the program because they were terminated [from the program], opted out, or had their case dismissed."[222] "Graduates" are those who successfully completed RCMHC and graduated from the program.[223] When accounting for new charges or convictions, the analysis excluded petty misdemeanors or traffic offenses other than driving after revocation, suspension, or cancellation.[224]

For RCMHC participants, the study defines a "new charge" as a new offense occurring within either the first year or three years after leaving RCMHC.[225] For the comparison group, a "new charge" is within the first year or three years after case disposition.[226]

215. *See id.* A more complete description of the comparison group and the process used to identify the comparison group may be found in Appendix A of the RECIDIVISM SUMMARY. *Id.* The RECIDIVISM SUMMARY cited herein updated the data contained in the RCMHC 2010 to 2012 Report through the end of 2013. *Id.*; *see also* RCMHC 2010 TO 2012 REPORT, *supra* note 86.

216. *See* RECIDIVISM SUMMARY, *supra* note 210, at 2.

217. *See id.* at 1, 3.

218. *See id.*

219. *See id.*

220. *See id.*

221. *See generally id.* (listing the number of graduates and non-completers involved in the study).

222. *Id.* at 1.

223. RCMHC P&P MANUAL, *supra* note 58, at 29.

224. RECIDIVISM SUMMARY, *supra* note 210, at 1.

225. *Id.* at 1, 3.

226. *Id.*

Similarly, for RCMHC participants, "a new conviction is defined as a new offense with an offense date that occurs within the first year" or three years after leaving RCMHC.[227] For the comparison group, a "new conviction" occurs within the first year or three years after the case was disposed of with a conviction.[228] "Individuals may not be convicted of a charge because their case was dismissed[,] . . . they may be on warrant status, or their cases may still be active."[229] "Individuals who are [both] charged *and* convicted" appear in both tabulations.[230]

The study also accounts for jail or prison time.[231] Using the same populations as the recidivism analysis, the same individuals were reviewed in the Minnesota "Statewide Supervision System to determine whether they spent time in jail or prison within one or three years of leaving the Mental Health Court (participants) or within one or three years of case disposition (comparison group)."[232] "For example, if a person spent [three] days in jail during the one year window, three days [were] added so that recidivism rates included one full year of time available to re-offend."[233]

B. *One-Year Follow-Up*[234]

The one-year cohort of RCMHC participants was compared to forty individuals in the comparison group. The RCMHC participant group consisted of sixty-four graduates who had at least one year pass since leaving the program, sixty non-completers who had at least one year pass since leaving the program, and 124 total participants (graduates and non-completers combined) who had at least one year pass since leaving the program.

227. *Id.* at 2, 3.

228. *Id.*

229. *Id.* at 2. If a defendant successfully completes a diversion program, the charges are usually dismissed.

230. *Id.*

231. *See id.* at 2, 4.

232. *Id.*

233. *Id.* at 1.

234. The data reported in Parts VI.B and VI.C of this Article are derived from the RECIDIVISM SUMMARY. *See generally id.*

First, the study examined new charges.[235] Second, the evaluation looked at new convictions.[236] Finally, incarceration data was reviewed.[237] The one-year results are significant. RCMHC graduates were three-times less likely to be charged with a new offense than those in the comparison group. Moreover, RCMHC graduates were five times less likely to be convicted. Finally, the graduate cohort was seven times less likely to spend time in jail.

Even former participants who did not successfully complete the program had better outcomes in two of the three metrics. Those in the comparison group were more likely to be charged or convicted than the group of RCMHC non-completers. However, a

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235. *Id.* The results are graphed as follows:

Percentage with a New Charge			
Comparison Group	**Graduates**	**Non-Completers**	**All RCMHC Participants**
60%	17%	43%	30%

RCMHC tracks all participants, even those who do not graduate. While non-completers also appear to benefit from RCMHC participation, they are not a homogeneous group. Some participants request discharge for reasons unrelated to program compliance, some are out of compliance but remain law-abiding, and others have a new offense. Moreover, the amount of time non-completers are RCMHC participants varies greatly. Accordingly, until categories of non-completers can be studied in more detail, the data should not be viewed as reliable or predictive. Nevertheless, the data appears to suggest a relationship between time spent participating in RCMHC and better outcomes for both graduates and non-completers.

236. *Id.* at 2. The new conviction data is graphed as follows:

Percentage with a New Conviction			
Comparison Group	**Graduates**	**Non-Completers**	**All RCMHC Participants**
45%	9%	37%	23%

237. *Id.* The jail data is graphed as follows:

Percentage Who Spent Time in Jail			
Comparison Group	**Graduates**	**Non-Completers**	**All RCMHC Participants**
65%	9%	70%	39%

slightly higher percentage of non-completers spent time in jail as opposed to the comparison group.

C. *Three-Year Follow-Up*

The three-year cohort of RCMHC participants was compared to thirty-eight individuals in the comparison group.[238] The RCMHC participant group consisted of fifty-three graduates who had at least three years pass since leaving the program, forty-five non-completers who had at least three years pass since leaving the program, and ninety-eight total participants (graduates and non-completers combined) who had at least three years pass since leaving the program.[239]

Once again, the analysis began with a review of new charges.[240] Next was the three-year look at new convictions.[241] The three-year evaluation concluded with a study of incarceration data.[242]

The outcome for RCMHC graduates remained substantially better than the comparison group in the three-year study. RCMHC

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238. *Id.* at 3.

239. *Id.*

240. *Id.* The results are graphed as follows:

Percentage with a New Charge			
Comparison Group	**Graduates**	**Non-Completers**	**All RCMHC Participants**
71%	30%	64%	46%

241. *Id.* The new conviction data is graphed as follows:

Percentage with a New Conviction			
Comparison Group	**Graduates**	**Non-Completers**	**All RCMHC Participants**
60%	26%	66%	39%

242. *Id.* at 4. The jail data is graphed as follows:

Percentage who Spent Time in Jail			
Comparison Group	**Graduates**	**Non-Completers**	**All RCMHC Participants**
68%	25%	84%	52%

graduates were nearly two and a half times less likely to be charged with a new offense than those in the comparison group. The graduate group was just over two times less likely to be convicted of a new charge. In the case of jail time, RCMHC graduates were nearly three times less likely to be incarcerated.

Former participants who did not successfully complete the program did not fare as well in the three-year analysis. They continued to receive fewer charges than the comparison group. But, they were slightly more likely to be convicted or spend time in jail after three years than the comparison group.

D. *Other Significant Outcomes*

In addition to recidivism and jail statistics, other data demonstrates the effectiveness of RCMHC. RCMHC has served 341 participants with serious mental illness since 2005.[243] With the assistance of RCMHC, ninety-nine percent of participants had mental health community supports and programs in place at program completion.[244] At program entry, only thirty percent had such supports in place.[245] A total of 2070 hours of community work service have been completed by all RCMHC participants.[246]

Many RCMHC participants have a history of repeated mental health related hospitalizations and other crisis treatment. However, since the inception of RCMHC, there have only been twenty-eight psychiatric inpatient hospitalizations and seventeen psychiatric crisis outpatient, emergency room, or acute psychiatric crisis visits by court participants.[247] Not surprisingly, only forty-one percent of participants are medication compliant at program entry.[248] However, upon graduation, one hundred percent of RCMHC participants are in compliance with their prescribed medication.[249]

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243. RCMHC 2010 TO 2012 REPORT, *supra* note 86, at 3.

244. *Id.* at 13. The data reported in this Part is derived from the Second Judicial District of Minnesota database. This data has not been updated since 2012, but is scheduled for update following the 2015 program year. The same outcomes are examined in the RCMHC 2010 TO 2012 REPORT, but the data published in the report only runs through 2012.

245. *Id.*

246. *Id.*

247. RCMHC, *supra* note 106.

248. RCMHC 2010 TO 2012 REPORT, *supra* note 86, at 15.

249. *Id.*

As already discussed, co-occurring disorders are frequent among the population of mentally ill offenders. In fact, the vast majority, or seventy-seven percent, of RCMHC participants had a history of substance abuse at program entry.[250] While fifty-four percent of RCMHC participants reported current substance abuse when they were accepted to RCMHC, all were chemically free at program completion.[251]

Among the chemical health community supports to which participants are connected during the program are chemical health assessments, drug testing, structured outpatient programs, inpatient treatment, and Alcoholics Anonymous / Narcotics Anonymous / Dual Recovery Anonymous Support Groups.[252] Only five percent of participants had such supports in place at program entry.[253] At program exit, eighty-three percent had chemical health community supports and programs in place.[254] Similarly, only thirty percent of new participants had mental health supports in place compared to ninety-nine percent of those completing the RCMHC program.[255]

E. Future Evaluation Plans

The continued evaluation of RCMHC will go beyond the examination of recidivism and jail data. Mental health courts represent a significant taxpayer investment. While it is important to show improved recidivism outcomes to demonstrate a public-safety benefit, studying the cost of RCMHC compared to traditional court is equally important.

A RCMHC cost study is currently underway. Results should be available sometime in 2015. Court costs are only a small component of the expenses under review. Every court contact by a defendant with mental illness also involves the expense of processing an arrest or ticket and possible jail time before the person ever reaches court. In addition, many defendants with a mental illness undergo substantial levels of medical care, visits to the emergency room, or detox admissions without any direction, treatment plan, or

250. *Id.* at 12.
251. *Id.*
252. *Id.* at 13.
253. *Id.*
254. *Id.*
255. *Id.*

compliance with medical recommendations.[256] Anecdotally, RCMHC participants utilize publically funded health care systems less often or more efficiently. If research confirms the observations, successful participation in RCMHC may also bring with it substantial cost savings that further justify the public investment. The results of the cost study will be published as soon as they are available.

VII. CONCLUSION

Mental health courts are but one approach to challenges presented by the influx of persons with mental illness into the court system. The only true solution will involve using prevention approaches that vastly reduce the likelihood of persons with mental illness getting in trouble with the law. In the meantime, a panoply of solutions is needed. One commentator suggests that the very existence of mental health courts hinders development of the political will necessary to address what is causing the proliferation of mentally ill defendants in the court system.[257] Such criticism offers no present alternative to the court system other than building larger revolving doors. Others argue that problem-solving courts work only because their voluntary participation approach admits those more likely to succeed.[258] These voices would have individuals who are unable to help themselves but are ready, willing, and able to take advantage of an offered resource languish in hopelessness. Anchorage Alaska Mental Health Court Judge Stephanie Rhoades sums up the importance of active court involvement in the lives of mentally ill defendants:

> These folks are people who have lost all their natural supports. They don't have advocates any longer, they don't have family members to take them in, and they've burnt all their bridges with treatment and everyone else.

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256. *See id.* at 11.

257. *See generally* Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses*, 11 PSYCHOL. PUB. POL'Y & L. 570 (2005).

258. *Interviews with Judges Across the Globe*, *in* 1 TRENDS IN THE JUDICIARY 227 (Dilip K. Das, Cliff Roberson & Michael M. Berlin eds., 2014); Jenni Ward, Middlesex Univ., *Are Problem-Solving Courts the Way Forward for Justice?* 6 (Howard League for Penal Reform, Working Papers 2, 2014), *available at* https://d19ylpo4aovc7m.cloudfront.net/fileadmin/howard_league/user/pdf/Research/What_is_Justice/HLWP_2_2014.pdf.

> They're the tough customers, and their lifestyles are really dissonant with the medical model of mental health and substance abuse treatment delivery. They tend to be more likely than not homeless, co-occurring disordered, without money. They don't show up for appointments, and they often have complicating medical issues. On top of all that they often have a criminal history that makes them look in many ways worse than they are to the treatment system. So I think that the resource of a boundary-spanner and a linker, the case coordinator [manager] who can actually take the individual and hook them up with services appropriate to their condition is a tremendous resource. And what I've found is that the treatment system is far more likely to serve an individual who's being monitored in the mental health court.
>
> . . . .
>
> And I think that what this tells me is to never give up. Don't give up on anybody because there may be a time in anyone's life where they are ready, and readiness for change is so critical because you could meet a person four times during their life or even during the course of a couple of years, and if they're not ready it's not going to happen.[259]

While mental health courts are not the only answer, they are an important part of the answer. RCMHC has a proven record of success.[260] With continued public support, RCMHC and other

259. *Stephanie Rhoades, Judge, Anchorage Mental Health Court*, CENTER FOR CT. INNOVATION, http://www.courtinnovation.org/research/stephanie-rhoades-judge-anchorage-mental-health-court#.TzUp91caRb0.email (last visited Mar. 10, 2015).

260. Members of the RCMHC team have received a number of awards and recognitions. In 2014, RCMHC Program Coordinator Brandi Stavlo received the Unsung Legal Hero Award from *Minnesota Law and Politics* for her local, statewide, and national efforts on behalf of mental health courts. *See Mental Health Court Program*, MINN. JUD. BRANCH, http://www.mncourts.gov/district/2/?page=1576 (last visited Nov. 14, 2014). In 2013, Ms. Stavlo was selected for specialized training by the Council of State Governments Justice Center, so she could deliver training to Minnesota court personnel in judicial districts that are interested in starting a mental health court or improving their existing program. *Id.* In 2013, Briggs & Morgan lawyers Alan Maclin, W. Knapp Fitzsimmons, Michael Wilhelm, and Ankoor Bagchi were recognized by the Minnesota Justice Foundation for their outstanding commitment to pro bono work with RCMHC. *Id.* In addition, Suzula Bidon, a RCMHC legal intern, received the Law Student Award from the

mental health courts in Minnesota and around the country will continue to enhance public safety, reduce recidivism, and help individuals with mental illness who commit crimes improve their lives.

Minnesota Justice Foundation. *Id.* In 2009, Warren Maas, RCMHC's first pro bono defense attorney, received the Ramsey County Bar Association's Pro Bono Award, which recognized his outstanding commitment to pro bono work and extraordinary contributions to the criminal justice system. *Id.*