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Mental Health Courts: Serving Justice and Promoting Recovery

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Broward County Mental Health Court

Mental Health Courts: Serving Justice and Promoting Recovery

Honorable Ginger Lerner Wren[*]

I. INTRODUCTION

A. Prevalence of mental health problems and disorders in the United States

Mental health problems and disorders are common in the United States and internationally. An estimated 18 to 26 percent of Americans ages 18 and older— approximately one in five adults — suffer from a diagnosable mental disorder in any given year.[1] When applied to the 2004 U.S. Census

[*] Based on her expertise in mental health and disability law gained in her capacity as Public Guardian of the 17th Judicial Circuit and as staff attorney for Florida's protection and advocacy system (The Advocacy Center For Persons With Disabilities, inc.), Judge Lerner-Wren was selected by former Chief Judge Dale Ross to serve as the Mental Health Court Judge for the nation's first court dedicated to the decriminalization and treatment of the mentally ill in the criminal justice system. Hailed as a national model and best practice, Broward's innovative Mental Health Court was the model for Congress as it passed Criminal Reduction and Diversion Legislation in 1999. Broward's Mental Health Court was profiled at the White House Conference on Mental Health in 1999. In July, 2002, former President George W. Bush appointed Judge Lerner-Wren to The President's New Freedom Commission on Mental Health, where Judge Lerner-Wren chaired the Criminal Justice Subcommittee. Judge Lerner-Wren speaks nationally and internationally on a wide array of subjects; including mental health courts, therapeutic jurisprudence and public policy matters related to the criminal justice system. Presently, Judge Lerner-Wren serves on the National Advisory Council for The Substance Abuse and Mental Health Services Administration (SAMHSA) to continue efforts in implementing the Commission's work across the country. Judge Wren previously served on the Florida National Alliance for the Mentally Ill (NAMI) and currently serves on the Nova Southeastern University Center for Psychological Studies, Board of Advisors. Judge Lerner Wren is an Adjunct Professor at the New York Law School, Center for Disability Law and Human Rights. The Broward County Mental Health Court has been featured on National Public Radio, Good Morning America, and CNN, and profiled in countless articles and publications nationally and internationally. Judge Lerner-Wren has received numerous awards and has been honored for her innovative work in the promotion of justice and human rights for the mentally ill in the criminal justice system. She is a graduate of the University of Miami, 1980 (BA) and received her JD in 1983 from Nova University Center for the Study of Law. Judge Lerner-Wren lives in Fort Lauderdale, is happily married, and is the mother of two beautiful children and a stepson who lives in Australia.

1. Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month*

residential population estimate for ages 18 and older, this figure equates to approximately 44 million people.[2] Although mental health problems are prevalent in the population, the main burden of serious illness is concentrated in a much smaller proportion — approximately 6 percent, or 1 in 17.[3] In addition, mental health problems are the leading cause of disability in the U.S. and Canada for individuals ages 15 to 44.[4] Further, many individuals are affected by more than one mental health problem at any given time. Nearly half (45 percent) of persons with mental health problems meet the criteria for two or more disorders, with severity of disorder being strongly correlated to dual diagnosis.[5]

The impact of mental health issues on wellness and productivity in the United States and throughout the world has long been understated. Data developed by the Global Burden of Disease study conducted by the World Health Organization, the World Bank, and Harvard University, suggest that mental illness, including suicide, accounts for over 15 percent of the burden of disease in conventional market economies; this is more than the disease burden caused by all forms of cancer.[6]

B. The public policy perspective on mental health and recovery

The 2007 United Nations Convention on the Rights of Persons with Disabilities is an international treaty that identifies the rights of persons with disabilities as well as the obligations on States party to the Convention to promote, protect and ensure those rights. There are eight guiding principles that underlie the Convention and each of its specific articles:

- Respect for inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons;
- Non-discrimination;
- Full and effective participation and inclusion in society;
- Respect for differences and acceptance of persons with disabilities as part of human diversity and humanity;

DSM-IV Disorders in the National Comorbidity Survey Replication, 62 ARCHIVES OF GEN. PSYCHIATRY 617, 619 (June 2005).

2. U.S. CENSUS BUREAU, ANNUAL ESTIMATES OF THE POPULATION BY SELECTED AGE GROUPS AND SEX FOR THE UNITED STATES: APR. 1, 2001 TO JULY 1, 2004 1 (2005).

3. Kessler et al., *supra* note 1, at 624.

4. THE WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2004: CHANGING HISTORY, ANNEX TABLE 3 128 (2004), *available at* http://www.who.int/whr/2004/annex/topic/en/annex_3_en.pdf.

5. Kessler et al., *supra* note 1, at 622.

6. CHRISTOPHER J. L. MURRAY & ALAN D. LOPEZ, THE GLOBAL BURDEN OF DISEASE: A COMPREHENSIVE ASSESSMENT OF MORTALITY AND DISABILITY FROM DISEASES, INJURIES, AND RISK FACTORS IN 1990 AND PROJECTED TO 2020 21 (1996).

- Equality of opportunity;
- Accessibility;
- Equality between men and women; and
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

States negotiated the Convention with the participation of civil society organizations, national human rights institutions and inter-governmental organizations. The United Nations General Assembly adopted the Convention on December 13, 2006, and it was opened for signature on March 30, 2007. States that ratify the Convention are legally bound to respect the standards in the Convention. For non-ratifying States, the Convention represents an international standard to which they should aspire.[7]

Prior to the convention, in February 2001, former President George W. Bush announced his New Freedom Initiative to promote increased access to educational and employment opportunities for persons with disabilities. The New Freedom Commission on Mental Health is a key component of the New Freedom Initiative, seeking to address the problems in the current mental health service delivery system that allow Americans to fall through the system's cracks. The Commission identified the following six goals as the foundation for transforming mental health care in America:[8]

- Americans understand that mental health is essential to overall health;
- Mental health care is consumer and family driven;
- Disparities in mental health services are eliminated;
- Early mental health screening, assessment, and referral to services are common practice;
- Excellent mental health care is delivered and research is accelerated; and
- Technology is used to access mental health care and information.

Fundamental to these policy statements is an emphasis on population mental health care, including recovery as a core principle. Recovery is a

7. Secretary-General, United Nations, Final Report of the Ad Hoc committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, delivered to the General Assembly (Dec. 6, 2006).

8. NEW FREEDOM COMM'N ON MENTAL HEALTH, THE DEP'T OF HEALTH AND HUMAN SERVICES, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA (2003) [hereinafter ACHIEVING THE PROMISE].

treatment concept whereby mental health services are designed such that individuals have principal control over decisions related to their own care. This is in contrast to the more traditional models of service delivery, in which individuals are instructed about their care with a minimum level of consultation, including minimum input from families and caretakers. The concept of recovery is based on strengths and empowerment, suggesting that if individuals with mental health problems have better control and choice over their treatment and care, they will be able to take greater control and initiative in their lives.[9]

C. Prevalence of mental illness in the criminal justice system

According to the Justice Department's Bureau of Justice Statistics,[10] more than half of all inmates, including 56 percent of state prisoners, 45 percent of federal prisoners and 64 percent of local jail inmates, are affected by mental health problems and disorders. This includes:

- 54 percent of local jail inmates with symptoms of mania, 30 percent major depression and 24 percent psychotic disorder, such as delusions or hallucinations;
- 43 percent of state prisoners with symptoms of mania, 23 percent major depression and 15 percent psychotic disorder;
- 35 percent of federal prisoners with symptoms of mania, 16 percent major depression and 10 percent psychotic disorder;
- Female inmates with higher rates of mental health problems than male inmates - in state prisons, 73 percent of females and 55 percent of males; in federal prisons, 61 percent of females and 44 percent of males; and in local jails, 75 percent of females and 63 percent of males;
- Among inmates with mental health problems, 13 percent of state prisoners and 17 percent of jail inmates say they were homeless in the year before their incarceration. About a quarter of both state prisoners (27 percent) and jail inmates (24 percent) with a mental health problem report past physical or sexual abuse.

Mental health problems are primarily associated with violence and past criminal activity. An estimated 61 percent of state prisoners and 44 percent of jail inmates with mental health problems have a current or past violent

9. U. S. DEP'T OF HEALTH & HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, CENTER FOR MENTAL HEALTH SERVICES. MENTAL HEALTH TRANSFORMATION TRENDS: A PERIODIC BRIEFING (2005).

10. U.S. DEP'T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006).

offense. Approximately a quarter of both state prisoners and jail inmates have served three or more prior sentences to incarceration. Inmates with mental health issues also have high rates of substance dependence or abuse in the year before their admission.

Of the numerous prisoners with mental health problems, only a relatively small portion receives treatment; approximately one in three state prisoners, one in four federal prisoners, and one in six jail inmates receive mental health treatment during incarceration. The most common form of treatment is prescription medication, received by 27 percent of inmates in state prisons, 19 percent in federal prisons, and 15 percent in local jails.[11]

D. In summary

There are numerous probable explanations for the large number of mentally ill inmates, including: the stigma surrounding mental illness, unfair treatment limitations and financial requirements placed on mental health benefits by private health insurers, and the fragmented mental health service delivery systems.[12]

The consequences of untreated mental illness and the resulting criminalization of the mentally ill can be attributed to a number of factors, including: severely underfunded community based systems of care, lack of adequate housing and the prevalence of homelessness, and the overall lack of specialized forensic services and supports for those reentering the community. Further, the increased use of illicit substances in the general population and among the mentally ill has likely made a significant contribution to an increase in all types of offenses.[13]

The mentally ill often revolve through jails and prisons, with periods of incarceration interspersed with limited times spent in the community; this places great demand on related services. Mentally ill offenders are doubly stigmatized, suffering from both mental illness as well as being labeled as 'offenders.' They are often disenfranchised, frequently itinerant, suffer chronic illness with acute symptoms, have poor physical health, lack adequate social supports, have co-morbid substance abuse, and are frequently without community care.[14]

Internationally and nationally, strategies with emphasis on recovery have been adopted to address the disproportionately high number of offenders suffering from mental illness. These include: diverting mentally ill

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11. *Id.* at 9.

12. ACHIEVING THE PROMISE, *supra* note 8, at 20-22.

13. Jeremy W. Coid, *Mentally Abnormal Prisoners on Remand: I – Rejected or Accepted by the NHS?*, 296 BRIT. MED. J. 1779, 1780 (2003).

14. Luke Birmingham, *Between Prison and the Community: The 'Revolving Door Psychiatric Patient' of the Nineties*, 174 BRIT. J. PSYCHIATRY 378, 378 (1999).

offenders charged with minor offenses out of the criminal justice system and the admission of inmates requiring involuntary mental health treatment who have been deemed legally incompetent to stand trial to the appropriate forensic mental health facilities and/or other court mandated conditional release plans.

II. LEGAL RESPONSES TO MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

A. Therapeutic Jurisprudence: A mental health approach to law

The traditional criminal justice system "tends to look backward, finding fault, assessing blame, and meting out punishment with little if any thought about the future consequences wrought by the imposition of a sanction on the perpetrator or society."[15] In general, attorneys are focused on their clients' immediate desires when involved in the adversarial process, and tend to ignore the long term consequences of a legal decision on both their clients and society.[16]

It is now widely recognized that the traditional criminal defense model does not promote the effective assessment of treatment needs for individuals with mental health problems and disorders, and is in fact anti-therapeutic. Therapeutic jurisprudence is an interdisciplinary perspective that focuses on the law's impact on the emotional and psychological health of the participants. The goal is to bring sensitivity into law practice and promote an awareness of the psychological and emotional issues affecting the client, including stress, confidence, and trust. Therapeutic jurisprudence also looks at the court system and how it impacts society. It is a context for the legal system which can be applied to almost any practice and incorporated into other approaches.[17]

Therapeutic jurisprudence decisions are made in consideration of the future impact on individuals, relationships, and the community at large.[18] In the spirit of therapeutic jurisprudence, mental health and criminal justice systems, including law enforcement agencies across the country, have developed and implemented programs in an attempt to divert mentally ill offenders away from the criminal justice system and towards treatment

15. Risdon N. Slate, *From the Jailhouse to Capitol Hill: Impacting Mental Health Court Legislation and Defining What Constitutes a Mental Health Court*, 49 CRIME & DELINQ. 6, 15 (2003).

16. David Finkelman & Thomas Grisso, *Therapeutic Jurisprudence: From Idea to Application*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 243, 245-46.

17. *See generally* Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*. 3 PSYCHOL. PUB. POL'Y & LAW, at 184 (1997).

18. *Id.* at 186-87.

options in the community.

The primary goals of these programs are to ensure consumer, staff and community safety, and to prevent the mentally ill offender from entering a recurring cycle within the criminal justice system.[19]

B. The concept of diversion, generally

Diversion from the criminal justice system is a significant application of therapeutic jurisprudence and generally refers to specific programs that screen detainees for the presence of mental disorders. Diversion is difficult to precisely define because many alternatives have been incorporated within the mainstream criminal justice system, including the use of mediation, other forms of alternative dispute resolution, and offender rehabilitation programs. Also, a number of measures sometimes described as 'diversionary' may be more appropriately termed "alternative penalties."

However, the following useful definition has been offered: "Diversion is commonly defined as any deviation from the ordinary criminal justice process before an actual prosecution which suspends the case without the court actually making a judgment, and which makes the offender participate in some type of non-penal program."[20]

Characteristics of diversion

Typically, the mechanisms for diversion are as follows:

- The identification or screening of detainees with suspected severe mental health problems and disorders, usually by 'non-health' staff such as police, solicitors, and corrections staff;
- Assessment and triage by a mental health professional
- Diversion to mental health services, which involves negotiation with the courts and the integration of the individual into care by appropriate mental health services that can deliver an alternative to jail or prisons. Where this is not possible, court diversion staff will ensure continuity of care through the correctional system.[21]

Hence, diversionary programs consist of two broad categories of intervention. First is the identification, screening and diversion mechanisms, or the means by which an individual is identified at some

19. RISDON N. SLATE & W. WESLEY JOHNSON, THE CRIMINALIZATION OF MENTAL ILLNESS: CRISIS & OPPORTUNITY FOR THE JUSTICE SYSTEM 5 (2008).

20. RON SNASHALL, AUSTL. INST. OF CRIMINALITY, PRE-TRIAL DIVERSION FOR ADULT OFFENDERS: PROCEEDINGS 20-22, at 2 (1985).

21. David Greenberg & Ben Nielsen. *Court Diversion in NSW for People with Mental Health Problems and Disorders.* 13 NSW PUB. HEALTH BULL. 158, 160 (2002).

point in the arrest or criminal justice process and diverted into mental health services. Second is the integration and collaborative process by which individuals in the criminal justice system are connected with the once parallel community based mental health systems to which diversion is possible.[22]

What makes diversion unique is that such programs within the criminal justice system provide an immediate alternative to incarceration. The mentally ill offender may be identified for diversion from the criminal justice system at any point, including pre-booking interventions (before formal charges are brought) and post-booking interventions (after the individual has been arrested and imprisoned).[23]

Pre-booking diversion

Pre-booking diversion occurs at the point of contact with specially trained law enforcement officers and/or specialized mobile crisis teams and relies heavily on effective interactions between police and community mental health services. Common in both Europe and Australia, diversion from the criminal justice system can occur at the police level, at some stage during the investigation of an alleged offense the police must make a decision whether or not to arrest the suspect. The police have considerable discretion in this regard under local legislation. Warnings and informal cautions may be given in a variety of circumstances.[24]

Examples of pre-booking diversion programs in the United States include the community service officer program in Birmingham, Alabama, and the crisis intervention team in Memphis, Tennessee. The Birmingham community service officer program is a police department-based program staffed with in-house social workers; the Memphis crisis intervention team is a police-department-based cadre of specially trained officers who handle mental health crisis calls when the police are the first line of response.[25]

22. Henry J. Steadman et al., *A National Survey of Jail Diversion Programs for Mentally Ill Detainees*. 45 HOSP. & COMMUNITY PSYCHIATRY 1109, 1110 (1994) [hereinafter *National Survey*].

23. Henry J. Steadman et al., *The Diversion of Mentally Ill Persons From Jails to Community-Based Services: A Profile of Programs*, 85 AM. J. PUB. HEALTH 1630, 1630-32 (1995).

24. Ben Nielsen, Acting Deputy Dir., Statewide Forensic Mental Health, Address at the NDA Research Conference in Dublin, Ireland: An Overview of the Types of Diversion for People with Mental Health Difficulties in the Criminal Justice System in New South Wales (Oct. 13, 2008).

25. Martha Williams Deane et al., *A SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons*, 50 PSYCHIATRIC SERV. 1620, 1621 (1999).

Post-booking diversion

Many diversion efforts in the United States are post-booking models, which can take place upon arrest and/or at various points during the criminal justice process, including during discharge and release from custody.[26] A post-booking diversion program is generally situated in either the court or the jail setting, and may include specialized parole or probation officers or units. Such programs either provide mental health support to magistrates and judges directly at the court, or identify and screen individuals with potential mental health problems in the correctional setting; in both cases, these actions are taken with a view towards subsequent diversion into appropriate treatment facilities and/or intensive mental health service provision.[27]

These models are also an emerging trend internationally. Examples of post booking programs include local court diversion schemes in metropolitan London and similar decentralized programs throughout New Zealand and Australia.[28] In the U.S, a new generation of Mental Health Courts have emerged which focus on felons as well as other violent offenders;[29] in other words, they consider both defendants charged with felonies as well as those charged with misdemeanors for acceptance into the program.

C. In Summary

As jail and prison populations expand, costs to states are on the rise. During 2007, states spent more than $49 billion on corrections, which is up from $11 billion twenty years prior. However, the national recidivism rate remains virtually unchanged, with approximately half of released inmates returning to prison within three years. Further, while violent criminals and other serious offenders account for some of this growth, many inmates are low-level offenders or individuals who have violated the terms of their probation or parole.[30] International experience has shown that mental health diversion can be a powerful and effective alternative.

While diversion programs have attracted increasing attention, resources, and funding, little has been done to fully evaluate the effect of these

26. BERNARD S. ARONS, DIR., SAMHSA CENTER FOR MENTAL HEALTH SERVICES, TESTIMONY TO ASSISTANT SEC'Y FOR LEGISLATION, DEP'T OF HEALTH & HUMAN SERV. (2000).

27. SLATE & JOHNSON, *supra* note 19, at 139.

28. David V. James, *Court Diversion in Perspective*, 40 AUSTL. & N.Z. J. PSYCHIATRY 529, 529 (2006).

29. SLATE & JOHNSON, *supra* note 19.

30. PEW CTR. ON THE STATES, ONE IN 100: BEHIND BARS IN AMERICA 2008 3-4 (2008).

services on long-term outcomes, including recidivism and re-hospitalization. Notwithstanding, the following benefits of diversion programs are amongst those identified in the literature:

- Improved mental health outcomes for participants, including reduced pressures on the criminal justice system;[31]
- Reduced rates of re-hospitalization and recidivism;[32]
- Improved access to mental health services;[33] and
- Reduced levels of substance abuse and reduced costs to governments.[34]

Hence, the success of mental health diversion programs can be measured in terms of public health and public safety outcomes, consumer satisfaction, and fiscal impact. A program is accountable to its stakeholders and its community for each of these outcomes, not the least of which is the expectation that the scarce resources devoted to the program will be applied as efficiently as possible to achieve the most desirable results.[35]

There is growing evidence to suggest that diversion programs do work when applied through accurate screening and assessment of individuals who are clinically appropriate for diversion, and linking those diverted individuals to the right services at the right level. There is, however, no substitute for the delivery of comprehensive, properly funded community based systems of care which yield real choices to consumers and their families, which are culturally sensitive, accessible and recovery-oriented.

III. MENTAL HEALTH COURTS

A. Background and rationale

The innovation of mental health courts was a direct judicial response to the trend known as the "criminalization of the mentally ill." While many varied models of mental health courts currently exist, this post booking diversionary model seeks to identify offenders with mental illnesses and link them to community-based mental health and substance abuse treatment

31. Alexander J. Cowell, Nahama Broner & Randolph Dupont, *The Cost Effectiveness of Criminal Justice Diversion Programs for People with Serious Mental Illness Co-Occurring with Substance Abuse*, 20 J. CONTEMP. CRIM. JUST. 292, 293 (2004).

32. R.S. Swaminath et al., *Experiments in Change: Pretrial Diversion of Offenders with Mental Illness*, 47 CAN. J. PSYCHIATRY 450, 456 (2002).

33. *National Survey*, *supra* note 22, at 1112.

34. Richard D. Schneider, *Mental Health Courts*, 21 CURRENT OPINION IN PSYCHIATRY 510, 511 (2008).

35. CTR. FOR JAIL DIVERSION, HUMAN SERV. RES. INST., JAIL DIVERSION COST SIMULATION MODEL – BETA TEST 1 (2007).

and services, rather than simply remanding them to custody. These courts rely on mental health assessments, individualized treatment plans, and ongoing judicial monitoring to address both the mental health needs of offenders and the public safety concerns of communities.[36] Like other problem-solving courts, mental health courts seek to address the underlying problems that contribute to the incarceration of this complex population.[37]

The Nation's first mental health court was established in Broward County, Florida, in 1997. In the late 1990s, only a handful of such courts were in existence; however, as of 2007, there were more than 175 mental health courts in operation.[38] Funding from the Federal government has lead to the spread of mental health courts throughout the U.S.[39]

In theory, mental health courts are intended to follow the therapeutic jurisprudence model used in many preceding problem solving types of specialized courts. Based upon the application of therapeutic jurisprudence and procedural justice, the court process is highly individualized and consumer focused. Principles of psychiatric rehabilitation are integrated into the court process with emphasis on recovery and stabilization.

The mental health court is highly specialized and centralized in its application. Goals and objectives include the promotion of recovery, reduction of the recidivism rate, and diversion of individuals away from the criminal justice system. Complex and challenging considerations rest upon often competing tensions, including the protection of individual substantive due process rights, and the promotion of public safety and treatment. Common elements of a mental health court include: a strong judge as leader, voluntary participation, a therapeutic team approach, individualized treatment planning, a non-adversarial court process, and cross agency and mental health system collaboration.[40]

Often, the court has a mental health judge with a particular interest in this area. Typically, cases are referred from multiple sources, including family members, jail staff, attorneys, mental health providers, and other judges. Often, the accused agree voluntarily to participate. "The court will liaise with mental health agencies and mandate participation in treatment programs, mainly in the community."[41]

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36. Council of State Governments, *Mental Health Courts: A National Snapshot* (2006), http://www.ojp.usdoj.gov/BJA/pdf/MHC_National_Snapshot.pdf.

37. ROBERT V. WOLF, PRINCIPLES OF PROBLEM-SOLVING JUSTICE 1 (2007).

38. The Justice Center catalogues mental health court programs on its Criminal Justice/Mental Health Information Network (InfoNet) website, http://www.cjmh-infonet.org.

39. America's Law Enforcement and Mental Health Project, 42 U.S.C. § 1865 (2000).

40. COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS 7 (2008) [hereinafter PRIMER].

41. James, *supra* note 28, at 533.

Many courts retain control and monitor the progress of cases for specified periods of time. If the accused fails to comply with the court's instructions, the court can apply sanctions, either by resuming prosecution in cases where the process has been suspended at the pre-adjudication stage, or by adopting another form of sentence in post-plea cases. The overall goal is to provide a positive and therapeutic experience to those who participate.[42]

B. The evidence base

Mental health courts typically deal with minor offenses; cases involving violence are generally excluded. The courts do not have any resources of their own, instead relying upon other agencies for the assessment and treatment of patients. Several studies have evaluated the output and outcomes of individual U.S. Mental Health Courts, including their impact on recidivism rates and health outcomes, as well as fiscal impacts from a systems perspective. Some of these studies findings include:

- Participation in the mental health court will result in comparatively fewer episodes of re-incarcerations and better access to health care, relative to the period prior to program participation;[43]
- Participants are less likely to incur new charges or be arrested, compared to individuals who do not enter the mental health court program;[44]
- Participants reported more favorable interactions with the judge and perceived that they were treated with greater fairness and respect than in traditional courts;[45]
- Over time, the mental health court system will result in net financial savings for the government.[46]

There have been some difficulties in evaluating the effectiveness and outcomes of the courts, particularly with regard to improvement in mental state, although measuring outcome variables such as social situation may be more appropriate in the chronically psychotic population concerned.[47] There

42. *Id.*

43. PRIMER, *supra* note 40, at 14.

44. Marlee E. Moore & Virginia Aldige Hiday, *Mental Health Court Outcomes: A Comparison of Re-arrest and Re-arrest Severity between Mental Health Court and Traditional Court Participants*, 30 LAW HUM. BEHAV. 659, 661-70 (2006).

45. PRIMER, *supra* note 40, at 14.

46. M. SUSAN RIDGELY ET AL., JUSTICE, TREATMENT, AND COST: AN EVALUATION OF THE FISCAL IMPACT OF ALLEGHENY COUNTY MENTAL HEALTH COURT 33 (2007).

47. Annette McGaha et al., *Lessons from the Broward County Mental Health Court*

is evidence to suggest that those passing through the Broward County Mental Health Court spent significantly fewer days in jail than similar individuals passing through a traditional court system, a fact which is of both humanitarian and financial interest. A previous study, however, reported no significant differences in re-arrest rates or the number of violent acts committed during an 8 month follow-up period at this Court.[48]

It has also been pointed out that the length of time from referral to diversion is much longer in mental health courts than in other types of diversion programs.[49] If the courts are dealing only with violators who have committed minor offenses, then it should be possible to divert such cases at the pre-booking stage or at least before they reach court. This would, however, remove the advantage of enforcing treatment in the community, which mental health courts provide.[50]

C. Broward County Mental Health Court[51]

Founded in June 1997, the Broward County Mental Health Court is a part time court[52] that was intended as a social justice and human rights strategy to respond to the criminalization of Broward's citizens with mental illnesses. Its mission is to address the unique needs of the mentally ill in the Broward County criminal justice system. The Court was conceived of through a community mental health and criminal justice task force, searching for consensus on how to streamline the criminal justice system for persons arrested with mental illness or developmental disorders.

The Honorable Judge Ginger Lerner-Wren was specially selected for this assignment upon her election to the bench, based upon her unique professional work experience. Primary objectives include absolute diversion, humane treatment, and a trauma informed recovery model which honors choice and is client-centered.

The court was designed to divert misdemeanor defendants with mental illnesses, arrested for nonviolent offenses, from jail to appropriate treatment facilities. It remains a voluntary, part-time court that convenes three times a week to address the specialized needs of these individuals.

Evaluation, 25 EVALUATION & PROGRAM PLANNING 125, 125-26 (2002).

48. Annette Christy et al., *Evaluating the Efficiency and Community Safety Goals of the Broward County Mental Health Court,* 23 BEHAV. SCI & L. 227, 239 (2005).

49. Henry J. Steadman & Michelle Naples, *Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders,* 23 BEHAV. SCI & L. 163, 166 (2005).

50. James, *supra* note 28, at 533.

51. The following paragraphs represent an account of the goals, objectives and core values of the Broward County Mental Health Court as designed and implemented by the author.

52. The Hononorable Ginger Lerner Wren presides over a regular criminal docket in addition to her mental health court duties.

Family members, lawyers, jail staff, or county criminal court judges usually refer potential clients to the court within 24 hours of arrest. The defendants are screened in the court room by a licensed clinical social worker who is the mental health court clinician. This screening determines whether the defendant is eligible to participate in the mental health court, is legally competent, or needs to be admitted involuntarily to a hospital. If eligible to participate, the defendant, the family, court personnel, and clinicians determine what treatment services are appropriate.

Most often, the defendant is referred to a community mental health center, while homeless defendants are sent to a residential facility. Treatment providers supply progress reports to court monitors who can, if necessary, go to the court to make adjustments in the treatment plan. Defendants with minor charges and no criminal history may have their charges dismissed with the prosecutor's consent. In most cases, adjudication is withheld, meaning that a record is made of the arrest and court disposition, but no judgment is entered.[53]

A core principle in the Broward County Mental Health Court, which is common to all existing U.S. specialty courts, is a strong commitment by the presiding judge to therapeutic jurisprudence, which views the court as a therapeutic intervention for people with mental illnesses.[54] It is closely aligned to the idea of procedural justice, which views the court process from the defendant's standpoint and recognizes that when defendants with mental illnesses feel that they are given a "voice" in the court process, they feel less coerced, regardless of how much involuntary supervision and treatment may be ordered by the court.

The Broward County Mental Health Court implements the concept of therapeutic jurisprudence through relatively informal proceedings that allow ample time for disposition and provide a direct link between mental health court defendants and appropriate community services. To date, more than 10,000 individuals have appeared before the court.

It is important to note that the Broward County Mental Health Court was based and designed on strict principles and values related to true diversion and the protection of individual substantive legal rights. The court model differs greatly from a drug court and other types of problem solving courts. All elements of the Broward County Mental Health Court model are intended to support those important fidelities; for example, the court has no standard requirement for court participation. The primary objective is

53. NEW FREEDOM COMM'N ON MENTAL HEALTH, SUBCOMMITTEE ON CRIMINAL JUSTICE: BACKGROUND PAPER,
DHHS PUB. NO. SMA-04-3880 11 (2004).

54. Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 443 (1999).

diversion out of the criminal justice system, whenever possible. That goal is balanced against other considerations, primarily that of public safety. The court, recognizing that it is not a crime to have a mental illness, strives to not punish a disability. Therefore, sentencing and case disposition is carefully balanced against constitutional considerations of equal protection, ADA and consumer oriented considerations related to personal choice and preference. The court is voluntary and operates on a pre-trial basis. It does not require the defendant to enter a plea in exchange for court participation.

The Broward County Mental Health Court is not a "program," and as such there are no standardized requirements for either patient monitoring or court participation. The court strives to promote diversion, and determinations of court participation are based upon a matrix that takes into account issues of public safety, the nature of the offense, the complexity of the needs of the individual, the availability of treatment, and the level of support needed to assist the individual and family with treatment planning and coordination.

It is important to recognize the highly individualized and often complex analysis related to this model. The Broward court balances many interests and considerations against the realities of highly fragmented, underfunded systems of care. When viewed against the fundamental mission of the court, however, it can be argued that this type of approach and level of individualization is essential to ensure the protection of civil rights and public safety.

The overarching goals of recovery and treatment are often sacrificed in consideration of risk management, personal choice, and the protection of constitutional rights. All proceedings require protection of privacy and all court participants are represented by legal counsel.

For those being monitored by the mental health court, timelines for participation are intentionally kept flexible, with the court relying upon clinical input as to an individual's progress through treatment in order to determine a suitable duration. Such factors include indicators such as the depth of personal responsibility felt by the offender and evidence of wellness.

The court process in the Broward model is restorative in nature; it strives to promote a humanistic quality and empathic understanding that the plight of those with mental illness is real and that the messages to counter and reduce stigmatization are clear and strong. Psychosocial education is a major focus within the court process and provides a voice, hope and the abiding belief in recovery as a consistent theme.

D. In Summary

Mental health courts offer powerful, effective alternatives to sending

more people with mental illness to jail. With more than 175 mental health courts now operating around the country, current research suggests that participation in mental health court programs result in increased access to mental health services and a decrease in jail time during the first year after entry into the program. The greater initial costs incurred in providing mental health care are balanced by the avoided long-term costs of keeping the individual incarcerated within the correctional system.[55]

Communities start mental health courts with the hope that effective treatment will address the unique needs of mentally ill offenders within the criminal justice system. Within this framework, policy makers and planners cite specific program goals, which usually fall into these categories:[56]

- To create effective interactions between the criminal justice and mental health systems, including legal advocacy for the mentally ill defendant
- To ensure that mentally ill offenders do not languish in jail because of their illness
- To balance the rights of the defendant with the need for public safety by recommending the least restrictive and most appropriate, workable disposition
- To divert mentally ill offenders to community based mental health services, including monitoring of mental health care delivery
- A focus on recovery by promoting consumer and family participation in the court process

Hence, the overall purpose of the mental health court continues to be to expedite the mentally ill offender through the criminal justice system by balancing the needs of both the defendant and the community.

IV. CONCLUSION

In the United States and abroad, jails and prisons have become the largest de facto hospitals for those who suffer from mental illness and other forms of psychiatric disorders. For decades, civil rights lawyers have fought to deliver justice and healing to human beings who have been inflicted with mental illnesses. Ironically, the Federal Courts have not, in the majority of their landmark decisions, resolved one of the greatest social crises facing our civilization; that of the criminalization of mental illness.

Arguably, the development of the Therapeutic Jurisprudence movement

55. RIDGELY ET AL., *supra* note 46, at 24-25.

56. BROWARD COUNTY OFFICE OF JUSTICE SYSTEM SERVICES, MENTAL HEALTH COURT PROGRESS REPORT 2000-2001.

and the development of problem solving courts has allowed for important social justice and legal reform which, under traditional legal process, may have never emerged. Mental health courts, if implemented with competence and extreme care, can save countless lives, prevent undue suffering and trauma, and lead to transformative health outcomes and recovery. However, these models must be tempered by a clear understanding and respect for individual constitutional and due process rights, mental health care policy, and public safety considerations.

As a result of these initiatives, legal actors, judges, law enforcement, jail personnel and others are gaining awareness as to the plight of the mentally ill. The expansion of diversionary strategies such as mental health courts has made a positive difference in altering attitudes and shattering myths.

A New York Judge who presides over his own mental health court in Brooklyn stated, "No one gets into jail or gets sentenced to jail without first passing by a judge." That comment underscores the profound need for this type of strategy within our court system.

In its final report to the President, the New Freedom Commission on Mental Health noted that the family members of mentally ill inmates almost universally share a profound lack of hope, a sentiment acquired during their often futile struggle to obtain mental health care for their family members.

Furthermore, the guiding principles and values articulated in the United Nations Convention on the Rights of Persons with Disabilities should be implemented and fully integrated into every mental health court process in order to ensure the promotion of dignity, civil rights and human rights. These strategies are important, cost effective, and necessary. They are not however, substitutes for the development of a quality mental health care system, such as that envisioned by the President's New Freedom Commission. The end to the criminalization of the mentally ill remains one of our civilizations greatest challenges as it relates to social justice and human rights.