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What Do Social Workers Need to Know About Mental Health Courts?

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ABSTRACT. Mental health courts are an emerging strategy to engage mentally ill offenders in treatment and to avoid unnecessary incarceration. These courts began in 1997 based upon the drug court model; there are currently over 70 courts nationwide. These courts are heterogeneous in structure, work with interdisciplinary teams, and seek to engage the consumer in treatment rather than use judicial sanctions. Social workers are integral members of these teams; yet, no research has been published in social work journals on mental health courts. This article explains the background and context of the courts, describes their features, discusses what social workers need to know about mental health courts, and concludes with ideas for how social workers may work effectively with mental health courts. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]

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While the bulk of the literature on mental health courts uses the term “client,” this article uses the term “consumer” in keeping with social work standards and values in the field of mental health.

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BACKGROUND/RATIONALE

A recent search of Social Work Abstracts, PsycInfo, Social Sciences Citation Index and Sociofile (April, 2004) revealed no articles in peer-reviewed social work journals about mental health courts. Given that the first mental health court was implemented in 1997 and that there are currently more than 70 mental health courts nationwide, it is crucial that social workers understand this growing phenomenon (Bureau of Justice Assistance, 2004). The goal of this article is to alert the reader to the phenomenon of mental health courts, to explain how social workers can interface with the courts, and to suggest future directions for research that will better define and describe the heterogeneity of currently existing mental health courts.

Mental health courts address the needs of persons with severe mental illness (defined as major depression, schizophrenia, and bipolar disorder) who have committed crimes by requiring compliance in a mental health treatment program instead of sentencing a defendant to confinement with substandard treatment. Compliance may require taking medications, cooperating with a caseworker, entering inpatient care, or participating in a day treatment program (Welch, 2003). Courts use rewards and positive reinforcement for consumers who meet or exceed court expectations in the areas of treatment and behavioral changes (Boothroyd, Poythress, McGaha, & Petrila, 2003).

The goal of mental health courts is to divert a non-violent offender from jail and into mental health treatment. Diversion can be pre- or post-plea, and models for mental health courts vary widely from one jurisdiction to another. These courts are based upon the notion of "therapeutic jurisprudence," whereby courts and treatment teams work together to engage consumers in mental health services (Slate, 2003; Steadman, Davidson, & Brown, 2001; Wexler & Winick, 1991).

Mental health courts seem to be cost effective (Bazelon Center, 2003; Consensus Project, 2004; Kondo, 2001). Research has shown that they save money by avoiding inpatient mental health stays, jail and/or prison stays, emergency and crisis services, and the costs to society associated with crimes such as vandalism, theft, and trespassing. By linking con-

sumers to mental health treatment and case management, these costs savings are realized as mental health issues get necessary treatment (Slate, 2003). While costs may initially increase (as consumers are “hooked into” more services than they were previously receiving), preliminary research indicates that long-term costs will be decreased via the savings mentioned above.

Mental health courts have such different legal structures, target populations, and operational emphases that the diversity is nearly overwhelming when trying to find commonality (Slate, 2003; Steadman, Davidson, & Brown, 2001). For example, some mental health courts are truly diversion courts—they offer engagement in a treatment program before a defendant must plead guilty or not guilty. Others are “post-plea” (offering treatment in the mental health court rather than incarceration), and still others are construed as “alternative sentencing” courts. However, there are some common features and best practices of mental health courts. This article discusses features in the broadest terms, as an in-depth discussion of the commonalities and diversities of mental health court models is beyond the scope and purpose of this work.

THE INCARCERATED MENTALLY ILL

There are close to 2 million people imprisoned in the United States, 16 percent of whom have mental illnesses. Almost half of those with mental illnesses (who are incarcerated) are convicted for nonviolent crimes. These crimes include offenses such as trespassing, disorderly conduct and other behaviors indicative of untreated mental illness (National Mental Health Association, 2003). Further, many of these inmates are not receiving adequate mental health treatment. Limitations to treatment include: lack of or misdiagnosing inmates’ mental illness, lack of therapeutic options in the jail, lack of appropriate medication management, and a basic misunderstanding of behavioral “acting out” due to symptoms of a serious mental illness. Jail-based services are often short term, as the inmate population is often quite transient, and there is often a lack of emphasis upon discharge planning. Inmates are sent back into society without ready access to a mental health treatment center, medications, and housing (American Psychological Association, 2003; Santini, 2004).

Lack of treatment increases the risk for a “revolving door phenomenon” with corrections, as those with mental illnesses recidivate at higher levels than those without mental illnesses. For example, one

study found that 72% of individuals with mental illness were re-arrested within 36 months of their release from jail (Ventura, Cassel, Jacoby, & Huang, 1998). The President's New Freedom Commission on Mental Health recognized the scope of the problem when it stated that:

. . . the commission recommends widely adopting adult criminal justice and juvenile justice diversion and re-entry strategies to avoid the unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illnesses. (President's New Freedom Commission on Mental Health, 2003, pp. 43-44)

HISTORY AND DEVELOPMENT OF MENTAL HEALTH COURSES

The first mental health court in the United States was established in Broward County, Florida in 1997 (Finkelstein & Brawley, 1997). Mental health courts were modeled after drug courts (Finkelstein & Brawley, 1997; Hasselbrack, 2001; Steadman, Davidson, & Brown, 2001). However, some sources cite mental health courts as being part of a larger movement, the trend of "problem-solving courts" (Hasselbrack, 2001). There are many problem-solving courts around the country addressing problems such as mental illness, drug use, prostitution, and domestic violence. These courts are based on the idea of new correctional approaches when "social, human, and legal problems intersect" (Center for Court Innovations, 2004). Problem solving courts depart from the traditional adversarial relationship between the court and the defendant; instead, they work together as a team to help the defendant succeed in treatment (Center for Court Innovations, 2004).

However, a strong argument can be made that mental health courts most directly evolved from drug courts. There are approximately 1,500 drug courts nationwide, described by the National Association of Drug Court Professionals (NADCP) as:

a special court given the responsibility to handle cases involving substance-abusing offenders through comprehensive supervision, drug testing, treatment services and immediate sanctions and incentives. (NADCP, 2004)

Drug courts offer diversionary treatment for drug-offenders, rather than incarceration. They can be seen as a partnership between criminal justice and social service agencies. The drug court program combines treatment with oversight and monitoring by the court. If the offender completes treatment successfully, they will avoid incarceration.

These courts originated due to overcrowding of jails with substance-related offenders, the costs of prosecution and incarceration, the evidence of successful community treatment for drug offenders, and the shifting social and judicial priority from punishment for crimes to rehabilitation of offenders. The key outcomes of drug courts include: decreased recidivism, enhanced drug treatment success, crime reduction, and increased cost effectiveness (Fielding, Tye, Ogawa, Iman, & Long, 2002; Listwan, Sundt, Holsinger, & Latessa, 2003; NADCP, 2004; National Institute of Justice, 2000).

Because drug courts were determined to be successful (Kondo, 2001), support for mental health courts increased. In fact, one recent study found very high rates of psychiatric illness among drug court clients, establishing a need for mental health courts to specifically address psychiatric symptoms (Hagedorn & Willenbring, 2003). Thus, "America's Law Enforcement and Mental Health Project Act" was approved in 2000 by the United States Congress to recognize the purpose of mental health courts and to fund these courts with \$4 million secured for demonstration projects (National Mental Health Association, 2001; O'Reilly, 2003).

FEATURES OF MENTAL HEALTH COURTS

Key features of mental health courts include: (1) promoting positive professional relationships within the legal and mental health systems; (2) providing legal advocacy for defendants with mental illness; and (3) determining best treatment alternatives. The mental health court system also oversees the effectiveness of mental health treatment, seeks offender and family member involvement, and offers opportunities for those with mental illness to receive mental health services rather than incarceration (Consensus Project, 2004; Finkelstein & Brawley, 1997). In addition to these three major features listed above, this section also discusses access to mental health services, the structured nature of mental health courts, factors influencing participation in mental health court, and the key role of stakeholders in the success of these court programs.

A crucial feature of mental health courts is that they help consumers who might not otherwise gain access to treatment. In particular, these courts serve a large number of dually-diagnosed consumers (Consensus Project, 2004). In this sense, the courts function almost as an outreach mechanism to connect a consumer with services such as housing, food, and physical/mental health treatment. Research has shown that these courts improve access and involvement to mental health treatment (Boothroyd, Poythress, Norman, McGaha, & Petrila, 2003), particularly for these dually-diagnosed consumers for whom coordinated services for their substance abuse and mental health needs are often difficult to locate.

Mental health court consumers typically proceed through a structured program. They move from phase to phase when their behavior, symptoms, and agreement with the court and treatment team dictates that they do so. Phases typically include an orientation/stabilization/engagement phase, an active treatment phase, and a transition/community re-adjustment phase. Graduation from mental health court, like that from drug court, is often marked with a ceremony for participants and their friends/loved ones. Mental health court involvement varies, and may range from 6 months to several years. Participants may drop out of the court program at any time, and depending upon court structure, may then be required to serve out the remainder of the criminal sentence they would have received if they had not elected to join a court program (Bureau of Justice Assistance, 2000). Another key element of mental health courts is the use of sanctions and rewards to manage compliance with treatment (as determined by the court, the treatment team, and the consumer). Sanctions can range from mild rebukes from the judge (anecdotally shown to be effective) to the extreme (but rare) use of jail time. Rewards can include movie tickets, certificates, medallions, and praise from the judge (Bureau of Justice Assistance, 2004; Griffin, Steadman, & Petrila, 2002).

Key domains that affect participation in mental health court are: severity of mental illness, severity of substance abuse problems, severity and history of criminal charges, individual motivation for recovery and change, ancillary mental health court program resources (such as housing assistance, medications, etc.), close monitoring by the court treatment team, a longitudinal perspective (understanding that change may take years and understanding the likelihood of relapse), a stable living situation for the consumer, culture competency and consumer-centeredness, use of evidence-based practices for court programs, and the presence of optimism and hope for recovery on the part of the consumer and the treatment team (Bureau of Justice Assistance, 2004).

Having the buy-in of key stakeholders is an essential commonality of all court models. No court will succeed without the cooperation of the public defender's office, the prosecutor's office, treatment and correctional professionals. Further, building and maintaining the involvement of the key stakeholders in the community will help ensure the sustainability of the court model (Consensus Project, 2004; Watson, Hanrahan, Luchins, & Lurigio, 2001).

SOCIAL WORK VALUES AND ETHICS INHERENT IN THE MENTAL HEALTH COURT MODEL

Mental health courts are built upon social work principles of consumer autonomy, consumer strengths, consumer choice, reduction of labeling, voluntary treatment, and coordinated team approaches to services (Boothroyd, Poythress, McGaha, & Pettila, 2003; Consensus Project, 2004; O'Reilly, 2003). In fact, the primary Federal grant mechanism funding mental health courts mandates the "coordinated delivery of services" and the case management approach to treatment, both long-standing emphases of the social work profession (Consensus Project, 2004).

Social workers play an integral role in most mental health courts, ranging from treatment providers, case managers, members of mental health court teams, to members of advisory boards. Perhaps more importantly for our profession, a key element of the mental health court team is the "boundary spanner": the team member who works together with the interdisciplinary team to ensure that linkages are made and that the consumer receives coordinated services (Steadman, 1992; Steadman, Davidson, & Brown, 2001). The natural coordinator or "boundary spanner" is the social worker, by virtue of our training and strengths in multidisciplinary teams and case management.

Another key role for social workers is that of program evaluators. Social workers-as-evaluators are likely to consider not only the "bottom line" issues of cost effectiveness and jail days saved, but also quality of life indicators of program success, such as consumer satisfaction, consumer socialization opportunities, symptom reduction, and adequate housing. Again, this allows social work ethics to be prominent in the outcome evaluation as well as interim process evaluations.

From the standpoint of social work practice values and ethics, mental health courts have much to offer our profession. They bring treatment teams together around a consumer's case—offering a variety of viewpoints from various disciplines such as law, social work, medicine, and psychol-

ogy. Mental health courts also work collaboratively with consumers to determine their treatment plan (Boothroyd, Poythress, McGaha, & Petrila, 2003). Although the judge is the ultimate authority under the mental health court model, many courts work with the consumers to determine “best fit” in terms of treatment, housing, and other services (Steadman, Davidson, & Brown, 2001). Further, many judges defer to the expertise of mental health providers in determining a consumer’s treatment plan and case disposition.

As described earlier, emerging research on mental health courts shows perceived coercion to be low (Poythress, Petrila, McGaha, & Boothroyd, 2002). This fits well with social work values of independence and autonomy. Coercion also is lessened by the fact that a common feature of mental health courts is that participation is voluntary (O’Reilly, 2003). However, it has been noted that there is some discrepancy in how courts define and treat the legal notion of “voluntary” status (Boothroyd, Poythress, McGaha, & Petrila, 2003).

Mental health courts can also help link participants to consumer-operated services, which are increasingly being shown to be effective and complementary to professional mental health services (Hodges & Segal, 2002; Hodges, Markward, Keele, & Evans, 2003; Segal, Hodges, & Hardiman, 2002). Further, the consumer’s “voice” and point of view are considered crucial to continued consumer participation in mental health court (Bureau of Justice Assistance, 2004), just as they are to any other form of mental health treatment.

PERSPECTIVES FOR SOCIAL WORKERS AS PROVIDERS AND REFERRAL SOURCES

With compliance come issues of coercion and control. As social workers, we are especially concerned with consumer rights, dignity, and autonomy. This can be looked at in three ways regarding compliance in a mental health court setting. First, it is more humane to work toward compliance with mental health treatment than to leave a mentally ill offender in a correctional setting, which may label them as a criminal and offer less treatment than they need. Secondly, research on mental health courts has shown levels of perceived coercion to be very low (Poythress, Petrila, McGaha, & Boothroyd, 2003). Finally, participation in mental health court is voluntary in nearly all court models.

Perhaps most importantly, mental health courts seem to address the problem of criminalizing the mentally ill. Traditionally, those with mental illnesses who committed crimes were incarcerated with little fo-

cus on their mental health needs. Mental health courts, on the other hand, recognize the priority of mental health issues in the crime at the same time that they bring various treatment providers together to best determine a course of action in conjunction with the consumer (Boothroyd, Poythress, McGaha, & Petrila, 2003).

Mental health courts can “give voice” to the consumer who would ordinarily be presented with one option: incarceration. The consumer can choose to serve a sentence or enter the court program with its treatment emphasis. In fact, “consumer-centeredness” and cultural competency are two of the key variables for ensuring continuing consumer participation with mental health court (Bureau of Justice Assistance, 2004). This is consistent with research in other areas of mental health that finds better outcomes for those who are given a stronger role in their treatment decisions (Elbeck & Fecteau, 1990; Hodges, Markward, Keele, & Evans, 2003).

While we must consider issues of competence to enter mental health court when dealing with someone with a mental illness (particularly a severe mental illness), the court/treatment option still seems much more humane than the incarceration option. In fact, the “humaneness” of mental health courts (Thomas, 2003) may be one of the key features of which social workers should be aware. These courts can be seen as an alternative to the ongoing criminalization of the mentally ill, an unfortunate by-product of the changing face of institutional care for the mentally ill over the latter half of the 20th century. In all, mental health courts are “a common sense” way of diverting mentally ill offenders from the criminal system (Slate, 2003). The stigma of mental illness still lingers in our society. However, if we can avoid adding the stigma of “criminal” to that burden, it seems ethical and appropriate to do so.

Social workers also need to be aware that many mental health courts must rely upon existing community mental health and substance abuse treatment services. Even those courts with Federal grants do not always get funding for increased treatment services. These costs often go toward operation of the court and other resources. Thus, we must keep in mind the availability of mental health services when considering mental health courts. If community mental health services are already overburdened, there will be no services to which the courts can refer their consumers. However, anecdotal evidence is showing that many consumers seen in mental health court are already being seen in community mental health agencies, thus the impact on caseloads may not be as great as some have predicted.

Social workers would also do well to consider a potential unintended policy consequence of mental health courts, related to the above point of service availability and affordability. In some jurisdictions, mental health courts have funding to pay for services for their consumers. When this occurs, these consumers often receive priority treatment compared to non-mental health court consumers at the agency. For example, due to court pressure for early case disposition, these mental health court consumers may get a psychosocial assessment, be assigned a caseworker, and be seen by a psychiatrist earlier than non-mental health court consumers. While on the one hand this is a benefit of the mental health courts—connecting consumers more quickly to services—there is also the risk of preferential treatment. In communities where community mental health agencies have long waiting lists for treatment, it would be unwise for consumers to be given the impression that in order to obtain services quickly and efficiently, one must first commit a crime.

***SUGGESTIONS FOR THE SOCIAL WORKER:
HELPING TO LAUNCH MENTAL HEALTH COURTS
IN THE COMMUNITY***

First and foremost, social workers need to understand that mental health courts are a new innovation and that each court will have very distinct features, consumers, and procedures. This is an ideal time for social work to become involved with this movement and help advocate for an increased voice for our consumers as the standards and best practices of mental health courts begin to coalesce. There are several key steps social workers can take in relation to mental health courts:

1. Find out if a court exists in your area.
2. If so, learn to utilize it effectively. Learn when consumers you work with will be good referrals. Learn the legal system and how it works—this will make you a more effective team member, community stakeholder, and advocate for your mental health court consumers.
3. If no court exists, advocate for the establishment of one. As these courts are being shown to be cost-effective, humane, and efficient at connecting consumers to needed resources, it is our ethical duty to support progressive models such as these.
4. Advocate for continued research on mental health courts to ensure that they are indeed providing quality services and to determine

best practice models. Further, we must continue to advocate for evidence-based practice in mental health and substance abuse treatment, as these are the foundations upon which mental health court rests (along with the unique element of court “power” and status).

5. Educate the community about the needs for mental health courts and the need for better, more integrated treatment for those with severe mental illnesses (and often substance abuse issues) in general.
6. Participate in interdisciplinary trainings to better educate court and legal personnel about mental health issues. These cross-trainings are essential to the effective functioning of mental health courts.
7. Advocate for greater availability of mental health services, as well as funding for these services. Mental health courts cannot operate with available community resources and services to treat their consumers.
8. Finally, social workers should understand that a good mental health court is a mechanism of social justice via more humane treatment of those with mental illnesses and de-criminalization of the mentally ill. These courts take advantage of our natural social work skill set of interdisciplinary work, strengths-based approaches, and knowledge of community resources.

CONCLUSIONS

Mental health courts are a unique new model that gives greater “voice” and increased autonomy to those with mental illnesses who commit non-violent crimes. These courts help engage consumers in services to a degree not previously seen in this population. The social worker is integral to this court model and must be well informed of the variety of roles played by our profession (O’Reilly, 2003).

While a new phenomenon, mental health courts are increasing quickly in number. It will not be long before every state has one, nor long until every mental health social worker will need to learn how mental health courts operate, which consumers are appropriate for mental health courts, and how to work with the various professionals involved in the courts. This article is an attempt to alert social workers to this new model for engaging consumers in treatment, particularly those consumers who have been the most difficult to engage in the past. At the same time, we must

keep our ethical principles in mind while considering issues such as consent, coercion, just distribution of resources, and equitable provision of services.

Future research needs to address the need for mental health court outcomes (Consensus Project, 2004). If this new model is to remain viable and continue to be funded, positive outcomes must be demonstrated. Despite the diversity of features and models among mental health courts, outcome-oriented research will need to arrive at best practices for this model. Several national agencies are currently working together in an effort to determine best practices for mental health courts: A good first step toward better understanding this new phenomenon and measuring its outcomes.

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