# Mental Health Courts: Their Promise and Unanswered Questions

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Over the past few years there has been a burst of enthusiasm for mental health courts, culminating with the signing by President Clinton of U.S. Senate bill S. 1865 in November 2000. This bill authorizes the creation of up to 100 mental health courts and $10 million a year for a period of four years for their maintenance. However, no funds have been appropriated for the current federal fiscal year. The bill marked the federal affirmation of an entity with a very brief history, an unclear conceptual model, and unproven effectiveness.

Since the much-publicized inception in 1997 of the Broward County mental health court in Ft. Lauderdale, Florida, newspapers, advocacy groups, elected officials, and authors of articles in professional journals have enthusiastically embraced mental health courts. In their enthusiasm, supporters and commentators have often ignored core questions about what constitutes a mental health court and how such courts are related to other types of jail diversion programs and specialty courts. As actually implemented, mental health courts operate somewhat idiosyncratically. Even so, the strong support for mental health courts seems to assume that there is a structured model that provides their conceptual underpinnings.

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The idea of mental health courts flows directly from the success of the drug court model, first introduced in 1989 in Dade County, Florida. Drug courts were developed as a joint response by the court and the community to the overwhelming volume of drug-related cases. They embodied the practical need for treatment of offenders to reduce recidivism and to respond to addiction as a disease and a compulsion. Drug courts embraced a team approach to decision making in the treatment and evaluation of offenders who came before the court—hence the presence of caseworkers in the courtroom.

Drug courts vary in their organization by jurisdiction as a result of their implementation at the local level. However, their key components include judicial supervision of structured community-based treatment, identification of defendants for treatment and referral shortly after arrest, regular hearings to monitor treatment progress and compliance, a series of graduated sanctions, and mandatory drug testing (1).

Both mental health and drug courts have their genesis in the concept of specialty courts and the idea of therapeutic jurisprudence (2). The latter concept reflects a focus on "the extent to which legal rule or practice promotes the psychological and physical well-being of a person subject to legal proceedings" (3) as well as an "exploration of ways mental health and related disciplines can help shape the law" (4) and concern with "the roles of lawyers and judges [in] produc[ing] therapeutic and antitherapeutic consequences for individuals involved in the legal process" (5). Both drug courts and mental health courts embrace a therapeutic approach.

The first comprehensive description of the four most visible mental health courts now operating in the United States was published in April 2000 (6). The four courts are in King County (Seattle); Broward County (Ft. Lauderdale); San Bernardino, California, and Anchorage, Alaska. The report addressed the operational similarities and differences among these problem-solving courts. It clearly demonstrated the lack of any common model other than a hybrid of drug court principles and use of existing community-based services for persons with mental illness.

Despite an initial scattered start, drug courts rapidly moved to a common model aided by technical assistance and information on program models from national sources—the Office of Justice Programs' Drug Courts Program Office of the U.S. Department of Justice, American University's National Technical Assistance Center, and the National Association of Drug Court Professionals. Unlike drug courts, mental health courts have no such infrastructure or model. Any similarities among current mental health courts occur more or less by chance at the implementation level and stem mostly from mirror-imaging by new jurisdictions seeking to replicate recently visited mental health courts or to duplicate drug courts.

Although not usually acknowledged, the first mental health court in name and identifiable form was established in 1980 in Marion County, Indiana (7). This specialty court

operated until 1992, when it was temporarily suspended. It was revived as the PAIR Mental Health Diversion Project in 1996 and continued to serve only mentally ill persons after arrest and booking.

As we have found from our contacts with existing programs and from examination of data from the report by Goldkamp and Irons-Guyn (6), almost any special effort by the courts to better address the needs of persons with serious mental illness who engage with the criminal justice system can qualify as a mental health court by current standards. In its diffusion, the concept has come to have little meaning.

Because there is no formal definition of a mental health court, we suggest that using the following criteria might be helpful for labeling a court as such. First, all persons with mental illness identified for referral to community-based services on initial booking are handled on a single court docket. Second, a courtroom team approach is used to arrive at recommended treatment and supervision plans with a person specifically designated as a "boundary spanner" (8) to ensure actual linkage. Third, assurance of existing appropriate treatment slots is necessary before the judge rules. Fourth, appropriate monitoring occurs under court aegis with possible criminal sanctions for noncompliance, such as reinstituting continued charges or sentences.

On the basis of these criteria, a mental health court may be a diversion program with all staff and services circulating around a single judge, or, as in Marion County, it could simply be the court of jurisdiction within a broader jail diversion program.

Comprehensive outcome evaluations of the effectiveness of mental health courts are under way in Broward County and in King County. However, the lack of any outcome data to date has barely impeded a rush to propagate mental health courts.

The combined elements that supported the expansion of drug courts included the empirically demonstrated effectiveness of early assessment, treatment, and monitoring accompanied by intensive court supervision and follow-through of services. The team approach to decision making and holistic treatment of the offender—rather than treatment of the addiction only—necessitated the inclusion of other ancillary services to facilitate continued compliance with treatment and to establish the appropriate support once the offender was released from the court's oversight.

Until similar evidenced-based conclusions about appropriate structures and interventions are available for mental health courts, some pause may be advisable before widespread implementation. For example, one of the policy questions that has been raised is whether mental health courts have actually increased the availability of services for persons with mental illness and co-occurring disorders to a previously underserved population or whether they have simply moved a particular group of people to the head of the line. The effect of the latter would be to leave another group of previously served people now unserved in a system with the same fixed resources as existed before the implementation of a mental health court.

The first major mental health phenomenon of the 21st century may be little more than the latest edition of the mental health shell game. Until we can ascertain how many shells and how many peas there are, we may wish to proceed cautiously.

In contrast to drug courts, existing mental health courts appear strapped for resources to follow through on their service linkages, to ensure that appropriate services are actually available and provided, and to supervise participation in the services mandated.

The mental health courts operating today are led by innovative judges looking for creative alternatives for the defendants and the community. However, most have limited access to new resources or the reallocation of current community-based resources for the treatment of mental illness and co-occurring disorders, including housing, health services, and entitlement assistance. Without the ability to command these resources, collection of mental health cases onto a single docket heard by a particularly invested and sophisticated judge may gain little for some of our neediest people. These are but a few of the many unanswered questions about mental health courts that await some empirical answers. ♦

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