

# EMERGING MENTAL HEALTH COURTS: THE INTERSECTION OF MENTAL ILLNESS, SUBSTANCE USE, POVERTY, AND INCARCERATION

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## INTRODUCTION

Within the last two decades, mental health courts (hereinafter “MHCs”) have emerged in the United States as a revolutionary type of problem-solving court that offers support, stability, and treatment to defendants with diagnosable mental illnesses.<sup>1</sup> When compared to more traditional criminal court models, the use of MHCs leads to lower rates of recidivism<sup>2</sup> and other positive outcomes<sup>3</sup> for both the individual participant and society more

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\* J.D. Candidate, 2022, University of Louisville Brandeis School of Law; Bachelor of Science in Psychology, 2017, Centre College. This Note is dedicated to improving the lives of those experiencing mental illness, and it was written in an effort to spark positive, compassionate change in the criminal justice system. I am endlessly grateful to my support system who has encouraged me throughout the drafting and editing process. My parents, David and Sharon Harbison, have cheered me on throughout my entire life, and I am so grateful for their infinite love and support. Sincerest thanks, as well, to all the past and present *Law Review* members and advisors who helped me to edit this Note. Finally, to all my family and friends who have encouraged and uplifted me throughout my life, you are deeply appreciated and loved.

<sup>1</sup> See John Petrila et al., *Preliminary Observations from an Evaluation of the Broward County Mental Health Court*, 37 CT. REV. 14, 15 (2001).

<sup>2</sup> See, e.g., Greg Goodale et al., *What Can We Say About Mental Health Courts Today?*, 64 PSYCH. SERVS. 298 (Apr. 1, 2013), <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300049> [<https://perma.cc/JA7S-D3FW>] (stating: “Looking at criminal justice outcomes, we found that MHC participants had significantly lower arrest rates after enrollment than before enrollment and lower postenrollment arrest rates than the comparison group; the MHC participants also had significantly fewer postenrollment jail days than the comparison group. When the reduced recidivism rate in this and other MHC studies was compared with the most recent results from drug court research, MHCs were more successful at reducing recidivism—recidivism rates of 25% versus 10%–15%.”); see also Woojae Han & Allison D. Redlich, *The Impact of Community Treatment on Recidivism Among Mental Health Court Participants*, PSYCH. SERVS. (Nov. 15, 2015), <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201500006> [<https://perma.cc/R6GL-867V>] (stating: “We found that increases in medication compliance and mental health service use were associated with significant reductions in the likelihood of arrests in the MHC sample. But in the treatment-as-usual group, treatment-related variables were not associated with rearrests. Of note, both groups received a similar amount of mental health services during the postenrollment period, but treatment use was found to be associated with arrests only for the MHC sample. This finding suggests that treatment itself may not lead to meaningful criminal justice outcomes (for example, reduced arrests) but that treatment combined with court monitoring decreases arrests for offenders with mental illness.”).

<sup>3</sup> See COUNCIL STATE GOV’TS JUST. CTR., *MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS* 14 (2008), <https://csgjusticecenter.org/wp-content/uploads/2020/02/mhc-primer.pdf> [<https://perma.cc/VF4D-KGDA>] [hereinafter MENTAL HEALTH COURTS PRIMER].

broadly. The traditional adversarial court system fails to provide adequate resources, services, and support to defendants with diagnosable mental illnesses, who often also experience substance use disorders and housing insecurity, thereby creating a repetitive, detrimental effect wherein this population cycles in and out of incarceration, often even dying behind bars.<sup>4</sup> For example, swift admittance to a MHC program could have saved Rodney Bock—a grandfather arrested in a California restaurant for making threats—who was detained in custody without receiving any psychiatric evaluation or treatment despite showing clear signs of mental distress.<sup>5</sup> Following this failure by the criminal justice system, Bock repeatedly struck his head against the wall, splattering blood across his cell.<sup>6</sup> Bock then hung himself, resulting in his death while in the care and custody of the state.<sup>7</sup> If Bock had received any type of mental health care, attention, or treatment—as he would have had he been quickly admitted into a MHC program—he would likely still be here to celebrate birthdays, graduations, and anniversaries with his family who reports a profound absence left in the wake of his death.<sup>8</sup>

Moreover, there is an undeniable intersection between mental illness, poverty, addiction, and incarceration within the American criminal justice system.<sup>9</sup> The structure, function, and purpose of mental health courts are perfectly poised to help defendants experiencing some or all of these intersectional factors. The Mentally Ill Offender Treatment and Crime

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<sup>4</sup> See FRED OSHER ET AL., COUNCIL STATE GOV'TS JUST. CTR., ADULTS WITH BEHAVIORAL HEALTH NEEDS UNDER CORRECTIONAL SUPERVISION: A SHARED FRAMEWORK FOR REDUCING RECIDIVISM AND PROMOTING RECOVERY viii (2012), [https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG\\_BehavioralFramework.pdf](https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_BehavioralFramework.pdf) [<https://perma.cc/85M4-6TTQ>]; see generally DEREK DENCKLA & GREG BERMAN, CTR. FOR CT. INNOVATION, RETHINKING THE REVOLVING DOOR, A LOOK AT MENTAL ILLNESS IN THE COURTS (2001), <https://www.courtinnovation.org/sites/default/files/rethinkingtherevolvingdoor.pdf> [<https://perma.cc/DXB8-DFTA>].

<sup>5</sup> Paul Tullis, *When Mental Illness Becomes a Jail Sentence*, THE ATLANTIC (Dec. 6, 2019), <https://www.theatlantic.com/politics/archive/2019/12/when-mental-illness-becomes-jail-sentence/603154/> [<https://perma.cc/XW8P-EDRE>].

<sup>6</sup> *Id.*

<sup>7</sup> *Id.* (Bock's family filed a lawsuit against the staff at Sutter County Jail in which they alleged the staff "held him there despite being aware of the gravity of his condition and knowing that the jail was not capable of providing, or legally authorized to provide, mental-health treatment for patients under such an order." As such, "[t]he lawsuit was settled in 2014 for \$800,000. Sutter County Jail has since taken steps to improve its mental-health services, such as increasing its medical staff.")

<sup>8</sup> *Id.* (When asked for a comment via email, Kimberly, Bock's daughter, said, "I have missed him every single day for the past nine years ... It's not just the big events like graduations, weddings, and the births of his many grandchildren that come to mind. It's also the small moments and day to day living where his loss is evident and painful.")

<sup>9</sup> See Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. No. 108-414, 118 Stat. 2327, 2332–33 (2005).

Rehabilitation Act of 2004 authorized the disbursement of federal grants to fund MHCs, among other designated mental health services.<sup>10</sup> However, this federal legislation falls short of meeting its intended goal of increasing public safety and serving criminal defendants who are affected by comorbid factors of mental illness, extreme poverty, and addiction. By examining how these intersectional factors are inextricably interconnected, this Note will illuminate the urgent need to establish operational and effective MHCs in every state, advocate for increased federal funding for MHCs specifically, and encourage the adoption of a set of comprehensive, uniform guidelines for the creation and operation of local MHCs to best serve some of the most vulnerable, at-risk members of our nation.

This Note begins with an overview of the history and development of MHCs in the United States over the last two decades, with specific attention given to the concept of therapeutic jurisprudence; the central purposes and goals of MHCs; and how MHCs operate on national, state, and local levels. Second, brief analysis of the intersectional factors of mental illness, substance use, homelessness, and incarceration are examined in conjunction with one another. Third, this Note presents the historical context of federal funding allocated toward MHCs, as well as the resulting limitations to the present framework governing such funding. This section will also highlight the significant benefits of MHCs to both participants, and society more broadly, evidencing why additional investments into MHC programs at the federal and state levels would be incredibly beneficial for participants and our communities. Finally, a solution is proposed to the relevant problem that would unify the conflicting jurisdictional approaches to provide fairer, more compassionate care and treatment to those in contact with the criminal justice system who are experiencing serious mental illnesses, and often other co-morbid factors, to ultimately reduce recidivism and increase public safety.

## I. BACKGROUND

### *A. The History, Purpose, and Operation of Mental Health Courts*

In this section, specific focus is first given to the foundational concept of therapeutic jurisprudence and how that concept is reflected in the exercise of compassion, accountability, and individualized treatment plans in existing MHCs. This specialized care and attention from court staff, in

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<sup>10</sup> *Id.* at § (b)(5)(C)(ii)(V)–(VII), 2332–33.

combination with trained mental health professionals, results in lower rates of recidivism when compared to more traditional, adversarial court models. This has subsequently saved the public countless tax dollars by diverting mentally ill defendants away from incarceration and toward valuable services like housing, education, and treatment. Additionally, the disjointed way MHCs operate on a national, state, and local level is discussed with emphasis placed on the discrepancies in various eligibility requirements for participation in a MHC program. While current MHCs are undoubtedly helping participants to live healthier lives without further contact with the criminal justice system, a unified, cohesive set of guidelines for the creation and maintenance of all United States MHCs would resolve many of the problems existing in current MHCs, and this solution is described in-depth in Part IV below.

*1. Creation and Purpose.* — Recent data revealed that an estimated 48 million Americans struggled with mental illness in 2018, yet a majority did not receive treatment,<sup>11</sup> highlighting the enduring mental health crisis that continues to exist broadly in the United States. MHCs were established in the late 1990s as a unique form of progressive jurisprudence intended to address the intersection of serious mental illness and disproportionate incarceration.<sup>12</sup> The term “therapeutic jurisprudence” was first coined by David Wexler in a presentation he gave to the National Institute of Mental Health in 1983,<sup>13</sup> and he subsequently defined therapeutic jurisprudence as “the study of the role of the law as a therapeutic agent,” noting that this approach requires the assumption “that the law itself can function as a therapist” in accordance with due process.<sup>14</sup> In a commentary on therapeutic jurisprudence, Bruce Winick expands on this principle by articulating, “[l]egal rules, legal procedures, and the role of legal actors (such as lawyers and judges) constitute social forces that, whether intended or not, often produce therapeutic or antitherapeutic consequences.”<sup>15</sup> Thus, therapeutic jurisprudence requires legal actors to weigh the value of proposed rewards, sanctions, and punishments for defendants.<sup>16</sup> This method uses an intersectional approach in order to measure the impact of the law on both

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<sup>11</sup> Tullis, *supra* note 5.

<sup>12</sup> Pettila et al., *supra* note 1, at 15.

<sup>13</sup> *See id.*

<sup>14</sup> David Wexler, *Therapeutic Jurisprudence and the Criminal Courts*, 35 WM. & MARY L. REV. 279, 280 (1993).

<sup>15</sup> Bruce Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCH. PUB. POL’Y & L. 184, 185 (1997).

<sup>16</sup> *Id.* at 187.

the mental and physical health of the person facing charges.<sup>17</sup> Further, this approach emphasizes that legal actors should conduct themselves as therapeutic agents in their “helping profession” by attempting to promote general societal well-being and safety while also minimizing any direct harm to those facing legal charges.<sup>18</sup>

MHCs were modeled off drug treatment courts (hereinafter “DTCs”), and both court systems actively embrace the concept of therapeutic jurisprudence by prioritizing both rehabilitative goals and legal fairness when engaging with participants.<sup>19</sup> MHCs were established as unique problem-solving courts to alleviate the disproportionately high number of mentally ill inmates who reside in American jails and prisons for low-level or nuisance crimes,<sup>20</sup> largely due to historical factors like deinstitutionalization and the war on drugs.<sup>21</sup> As the first court to apply the principles of therapeutic jurisprudence in the context of mental health, Broward County, Florida created the first MHC in the United States in July of 1997 to combat increasing incarceration levels of the mentally ill in their local community and overpopulation in the jail generally.<sup>22</sup> This landmark specialty court emphasized the importance of therapeutic jurisprudence in applying the law by trying to “give [a] ‘voice’ to the individual” facing charges, allowing the person to have some feeling of control over his or her court proceeding.<sup>23</sup> In an evaluation conducted on this introductory MHC, participants consistently reported a desire to engage in such a treatment diversion plan.<sup>24</sup> Subsequent research has established that Broward

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<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at 202.

<sup>19</sup> See COUNCIL STATE GOV'TS, A GUIDE TO MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION 5 (2005) <https://csgjusticecenter.org/wp-content/uploads/2020/01/Guide-MHC-Design.pdf> [<https://perma.cc/8QMM-4ASR>] [hereinafter GUIDE TO MENTAL HEALTH COURT].

<sup>20</sup> LAUREN ALMQUIST & ELIZABETH DODD, COUNCIL STATE GOV'TS JUST. CTR., MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 1, 3 (2009) [https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG\\_MHC\\_Research.pdf](https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_MHC_Research.pdf) [<https://perma.cc/4J5Y-JRQF>].

<sup>21</sup> HUM. RTS. WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 5 (2003) <https://www.hrw.org/reports/2003/usa1003/usa1003.pdf> [<https://perma.cc/6KND-YM6Y>]; see also SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. HEALTH AND HUM. SERVS., FISCAL YEAR 2021 JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES 69, [https://www.samhsa.gov/sites/default/files/about\\_us/budget/fy-2021-samhsa-cj.pdf](https://www.samhsa.gov/sites/default/files/about_us/budget/fy-2021-samhsa-cj.pdf) [<https://perma.cc/2JBJ-2FYE>] (“Approximately 250,000 individuals with serious mental illness (SMI) are incarcerated at any given time—about half arrested for non-violent offenses, such as trespassing or disorderly conduct. In addition, during street encounters, police officers are almost twice as likely to arrest someone who appears to have a mental illness.”).

<sup>22</sup> See Petrila et al., *supra* note 1, at 16.

<sup>23</sup> *Id.* at 20.

<sup>24</sup> *Id.* at 19.

County's first MHC achieved its intended goals of reducing recidivism, increasing public safety, and providing greater access to services and treatment for participants.<sup>25</sup> This success marked the dawn of a new and revolutionary problem-solving court, and it continues to serve as a model MHC framework still today.<sup>26</sup>

There are three goals that are broadly shared among all existing MHCs: (1) "to improve public safety by reducing the recidivism rates of people with mental illnesses," (2) "to reduce corrections costs by providing alternatives to incarceration," and (3) "to improve the quality of life of people with mental illnesses by connecting them with treatment and preventing re-involvement in the criminal justice system."<sup>27</sup> To accomplish these goals, MHCs have evolved from traditional court models (hereinafter "TCMs") in four significant ways: (1) creation of a specialized court docket, which applies a problem-solving approach in the courtroom; (2) development of "judicially supervised, community based treatment programs" requiring individualized treatment plans for each participant be created in collaboration between court staff and mental health professionals; (3) requirement of regular status hearings that provide participants with incentives or sanctions based on their adherence to court orders; and, (4) existence of criteria to define the meaning of "graduating" from the MHC program.<sup>28</sup> The three main goals at the heart of all MHC programs, the four important variations from TCMs, and increased emphasis on enhanced access to treatment and services allow MHCs to actively engage in therapeutic jurisprudence in a way that fosters the individual's well-being through a rehabilitative framework, while also protecting and promoting public safety.

According to the Substance Abuse and Mental Health Services Administration's (hereinafter "SAMHSA") "Adult Mental Health Treatment Court Locator," more than 475 MHCs, as well as other treatment diversion programs that attempt to accomplish similar goals under different titles, have been established in forty-eight of the fifty states as of the

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<sup>25</sup> Annette Christy et al., *Evaluating the Efficiency and Community Safety Goals of the Broward County Mental Health Court*, 23 BEHAV. SCI. & L. 227, 241-42 (2005).

<sup>26</sup> *Id.* at 229.

<sup>27</sup> ALMQUIST & DODD, *supra* note 20, at 1-2; *see also* NAT'L CTR. FOR STATE CTS., MENTAL HEALTH COURT PERFORMANCE MEASURES INTRODUCTION & OVERVIEW (2010), <https://cdm16501.contentdm.oclc.org/digital/collection/spcts/id/221> [<https://perma.cc/WUY5-8AJ4>].

<sup>28</sup> MICHAEL THOMPSON ET AL., COUNCIL STATE GOV'TS JUST. CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT vii (2009) [https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/MHC\\_Essential\\_Elements.pdf](https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/MHC_Essential_Elements.pdf) [<https://perma.cc/3CT3-KUV2>].

publishing of this Note.<sup>29</sup> The number of MHCs varies widely by jurisdiction, with several states having only one MHC,<sup>30</sup> and California having the highest number with forty-three MHCs in the state.<sup>31</sup> Nonetheless, this explosion of MHCs across nearly the entire nation reflects the desire of the legal community, as well as society more broadly, to treat mentally ill defendants in a more compassionate and constructive fashion. This shift will require considerable access to resources like treatment, housing, education, and employment, which are more readily available to MHC participants in comparison to the more adversarial TCM that should continue to govern the trial and potential punishment for defendants not experiencing serious mental illness.<sup>32</sup>

2. *Operation and Effectiveness.* — The current resources available for guidance on how to create and operate a MHC are disjointed and ineffective. The leading sources providing this outdated information are the National Center for State Courts<sup>33</sup> and the Council of State Governments.<sup>34</sup> The organizations' websites provide guides and seminars on how to establish and maintain a successful MHC, yet almost all of the available resources are over a decade old or contain broken website links,<sup>35</sup> thereby making the existing educational materials outdated and largely unhelpful.<sup>36</sup> It is already past time to supply local MHCs with up-to-date resources to handle issues as they arise, as well as provide more recent resources to aid in the establishment of new MHCs. By providing cohesive, uniform guidelines on the creation and maintenance of MHCs at the local level, MHCs will be even more effective in assisting and advocating for those in contact with the criminal justice system and experiencing serious mental illness, as many of the problems discussed in the section below would be eliminated.

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<sup>29</sup> *Adult Mental Health Treatment Court Locator*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/gains-center/mental-health-treatment-court-locator/adults> [https://perma.cc/8U8A-63ZS] (This website provides a list of MHCs by state, and it provides contact information for the MHC, the year the MHC was established, the MHC's target population, and the approximate annual enrollment in the MHC. There is no government-sponsored website that contains similar information on all MHCs in the United States. According to this website, New Jersey and North Dakota are the only two states that do not have MHCs.).

<sup>30</sup> *Id.* (Delaware, Hawaii, Maine, Mississippi, and Vermont are all reported to have only one MHC.).

<sup>31</sup> *Id.*

<sup>32</sup> See ALMQUIST & DODD, *supra* note 20.

<sup>33</sup> See generally NAT'L CTR. FOR STATE CTS., <https://www.ncsc.org> [https://perma.cc/X8PU-UVTF].

<sup>34</sup> See generally COUNCIL STATE GOV'TS, <https://www.csg.org> [https://perma.cc/R8U3-SD3K].

<sup>35</sup> See generally *Mental Health*, NAT'L CTR. FOR STATE CTS. <https://www.ncsc.org/topics/alternative-dockets/problem-solving-courts/mental-health-courts/resource-guide> [https://perma.cc/MDE5-PXCL] [hereinafter *Mental Health Courts Resource Guide*].

<sup>36</sup> See, e.g., THOMPSON ET AL., *supra* note 28, at vii.

Almost all factors necessary for participation in a MHC vary considerably among different jurisdictions,<sup>37</sup> which has created a fractured national approach to battling the urgent mental health crisis that presently exists in America.<sup>38</sup> Such MHC participation requirements are even further varied within state courts when implemented locally.<sup>39</sup> For example, some programs only accept non-violent misdemeanor offenses,<sup>40</sup> while others admit participants with violent felony records.<sup>41</sup> Additionally, states and individual counties vary on their possible enrollment capacity; whether a defendant is required to plead guilty and waive his or her right to trial to participate; and the severity of possible sanctions for noncompliance with court orders.<sup>42</sup> Rewards for completion of the program are also inconsistent as some courts choose to dismiss or reduce the charges, while others simply eliminate jail time for the defendant.<sup>43</sup> This inconsistent approach to participation in state MHCs causes disparate effects for mentally ill defendants who are facing similar charges across the United States, which is discussed in more detail in section II.

However, it is notable that there are two eligibility requirements that remain consistent across all states and jurisdictions. First, participants must have a diagnosable mental illness<sup>44</sup> according to the criteria established in the Diagnostic and Statistical Manual of Mental Disorders (hereinafter “DSM”).<sup>45</sup> “Serious mental illness” (hereinafter “SMI”) is “[a] term that generally applies to mental disorders that significantly interfere with some area of social functioning (e.g., work, school, family, leisure),” and all MHCs require participants to be formally diagnosed with an SMI.<sup>46</sup> However, many courts further require the individual’s mental illness to be

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<sup>37</sup> *See id.*

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* at 7–8.

<sup>40</sup> *Id.* at 7.

<sup>41</sup> *Id.*

<sup>42</sup> *Id.* at 12–13; *see also* GUIDE TO MENTAL HEALTH COURT, *supra* note 19.

<sup>43</sup> *See generally* Nancy Wolff et al., *Mental Health Courts and Their Selection Processes: Modeling Variation for Consistency*, 35 L. & HUM. BEHAV. 402 (2011); *see also* GUIDE TO MENTAL HEALTH COURT, *supra* note 19.

<sup>44</sup> ALMQUIST & DODD, *supra* note 20, at 11.

<sup>45</sup> *DSM–5-TR: Frequently Asked Questions*, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions> [https://perma.cc/7FCJ-DAKC] (“The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. *DSM* contains descriptions, symptoms, and other criteria for diagnosing mental disorders.”).

<sup>46</sup> ALMQUIST & DODD, *supra* note 20, at 11 (“Most mental health courts require participants to have an Axis I diagnosis, but many mental health courts also accept individuals who have a co-occurring Axis II disorder.”).



“serious and persistent” in a way that impedes his or her day-to-day functioning, necessitating “the highest levels of clinical need.”<sup>47</sup> This first set of varied participation requirements in different jurisdictions limit participant eligibility and frustrates access to local MHCs as well as related services provided to participants. Second, MHC participants must voluntarily consent to the diversion program.<sup>48</sup> Once the two requirements of diagnosis and consent are established, in every jurisdiction, defendants are then offered graduated sanctions at regular status hearings in the form of a variety of incentives, rewards, or punishments depending on how they have complied with court orders.<sup>49</sup> Status hearings become less frequent as the participant progresses with treatment, but a typical MHC program ranges from one to two years in duration to allow the participant time to develop healthy coping strategies to permanently better his or her life.<sup>50</sup>

Possible rewards or incentives given during status hearings include praise from the judge, applause in court, increased time between status hearings, a certificate of completion, his or her favorite food or candy, gift certificates, extended or augmented privileges, and a graduation ceremony upon completion of the program.<sup>51</sup> According to a recently published Best Practices report on Michigan MHCs, “incentives should be tangible, symbolic, and personalized to the participant.”<sup>52</sup> The report also recommends giving participants “certificates of completion after each phase advancement,” as well as clearly displaying the names of those who are receiving incentives for good behavior at each status hearing, thereby uplifting the participant and encouraging others to follow court orders as well.<sup>53</sup> Conversely, potential punishments or sanctions include judicial reprimand; increased frequency of status hearings; increased supervision or

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<sup>47</sup> *Id.* (“Severe mental illness or severe and persistent mental illness (SPMI): Terms that apply to more seriously affected individuals. This category includes schizophrenia, bipolar disorder, severe forms of depression, panic disorder, and obsessive-compulsive disorder. These terms are often used to describe clients with the highest levels of clinical need.”)

<sup>48</sup> *Id.* at 7–8.

<sup>49</sup> GUIDE TO MENTAL HEALTH COURT, *supra* note 19, at 71.

<sup>50</sup> CHEYNEY DOBSON ET AL., QUATTRONE CTR. FOR THE FAIR ADMIN. OF JUST., UNIV. OF PA. CAREY SCH. OF L., IMPROVING CRIMINAL JUSTICE OUTCOMES THROUGH MENTAL HEALTH COURT DEVELOPMENT 29 (Aug. 17, 2020), <https://www.law.upenn.edu/live/files/10736-buckscountymentalhealth> [<https://perma.cc/FSC8-6L45>] (“Program participation ranges from approximately one to one and a half years. During this time, participants are stabilized, compliant with medication when needed, and working toward improved family relationships, potential employment opportunities, and stable housing.”).

<sup>51</sup> *Id.* at 72–73.

<sup>52</sup> MICH. SUP. CT., FY 2020 PROBLEM-SOLVING COURTS ANNUAL REPORT 40 (2019), <https://courts.michigan.gov/Administration/SCAO/Resources/Documents/Publications/Reports/PSCAnnualReport.pdf> [<https://perma.cc/AZP9-ED9S>].

<sup>53</sup> *Id.*

oversight; restriction of privileges; community service; expulsion from the program; and, in rare cases, jail time.<sup>54</sup> All methods of motivation and penalty are specifically tailored to each defendant, within the state or jurisdiction's limits, to ensure his or her basic and emotional needs are met.<sup>55</sup> This individualistic approach reinforces the therapeutic jurisprudence model upon which MHCs were founded.<sup>56</sup> Through these various methods of motivation, MHCs attempt to provide a more dignified, positive, and rehabilitative experience for the mentally ill defendant when compared to TCMs. Simultaneously, MHCs serve to lower rates of recidivism, reduce costs to the average taxpayer, and increase public safety.

The MHC system alone does not comprise comprehensive treatment to participants. Instead, court staff work closely with community providers to “motivate individuals to connect to community-based treatment services while the court monitors their progress and ensures public safety.”<sup>57</sup> Successful MHC teams require several actors, and they generally include a combination of judges, prosecutors, defense attorneys, case managers, court support staff, criminal justice staff (including probation, police, and jail representatives), and mental health professionals.<sup>58</sup> More so than under the TCM framework, a MHC judge is expected to take an active role in the participants' rehabilitation process, as status hearings are frequent, and treatment plans are regularly amended.<sup>59</sup> This approach allows the judge to form deeper bonds with those appearing in front of the court.<sup>60</sup>

MHC judges must also educate themselves on mental health and demonstrate compassion within the courtroom to effectively assist the participants. For example, Kathleen Lynch—a district court judge in Wyandotte County, Kansas who presides over the local “care and treatment docket”—chose to abandon the signature black robe to humanize herself.<sup>61</sup> She chose to engage in this symbolic act to decrease the stress of those appearing before her and create a more encouraging, relaxed, and welcoming atmosphere.<sup>62</sup> Lynch even went a step further upon realizing her

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<sup>54</sup> GUIDE TO MENTAL HEALTH COURT, *supra* note 19, at 75–76.

<sup>55</sup> See ALMQUIST & DODD, *supra* note 20, at 16.

<sup>56</sup> *Id.*

<sup>57</sup> See *id.* at 5; see also THOMPSON ET AL., *supra* note 28, at 5.

<sup>58</sup> See ALMQUIST & DODD, *supra* note 20, at 14; OSHER ET AL., *supra* note 4, at 9–11; THOMPSON ET AL., *supra* note 28, at 8.

<sup>59</sup> ALMQUIST & DODD, *supra* note 20, at 16.

<sup>60</sup> *Id.*

<sup>61</sup> Tim Carpenter, *Advocates of Kansas Mental Health Courts Say Lives Improved, Taxpayer Dollars Saved*, KAN. HEALTH INST. (Oct. 25, 2016), <https://www.khi.org/news/article/advocates-of-kansas-mental-health-courts-say-lives-improved-taxpayer-dollar> [<https://perma.cc/6PNX-DEVA>].

<sup>62</sup> *Id.*

open courtroom lacked privacy during what she affectionately termed the “wellness docket” and divided the space into cubicles so the participants could discuss the progression of their case with more discretion.<sup>63</sup> Lynch’s behavior is a perfect example of therapeutic jurisprudence in action, as she has gone above and beyond to provide her participants with the best possible foundation for achieving successful reentry to society upon graduating the program.<sup>64</sup>

*B. Intersectionality: Mental Illness, Poverty, Substance Use, and Incarceration*

In this section, brief emphasis is placed on the unique yet intersectional elements of mental illness, addiction, poverty, and incarceration, as the purpose and structure of MHCs are perfectly poised to address this unique combination of factors that disproportionately contribute to the elevated population and cost associated with widespread mass incarceration. The connectedness of these factors is well documented in both social science and government-sponsored research as well as legislative intent, which is covered in more depth in section II below.

*1. Mental Illness, Substance Use, and Incarceration.* — The significant connection between the co-occurrence of mental illness and substance abuse has been firmly linked through decades of comprehensive research, and the impact of such comorbidity on one’s likelihood of coming into contact with the criminal justice system is similarly staggering. One Special Report released in 2006 by the Bureau of Justice Statistics (hereinafter “BJS”), an agency of the U.S. Department of Justice, indicated approximately 74% of state prisoners, 76% of local jail inmates, and 64% of federal prisoners who experienced a mental illness also satisfied the necessary criteria for diagnosis of substance dependence or abuse.<sup>65</sup> To explain this connection, one group of researchers suggested such a person’s contact with the criminal justice system triggers a “whirlpool fueled by relapse and an inability to comply with their requirements of incarceration, supervision, and release” due to a deficit of “effective integrated treatment and supervision,” leading to a strong probability of reincarceration for this

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<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> DORIS L. JAMES & LAUREN E. GLAZE, BUREAU JUST. STAT., OFF. JUST. PROGRAMS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 6 (2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> [<https://perma.cc/CGE8-TCMR>].

population under the current TCM framework.<sup>66</sup> The impact of this harsh, mentally-taxing cycle in and out of custody, often termed the “revolving-door” effect or cycle,<sup>67</sup> directly contributes to high levels of relapse and recidivism among those who experience both mental illness and substance abuse.

Thus, the well-documented connection between mental illness, substance abuse, and repeated incarceration suggests that MHCs may be perfectly poised to alleviate the high levels of recidivism among this population. In a report issued by the BJS in 2002 regarding the severity of the comorbid relationship between mental illness and substance abuse in incarcerated individuals, researchers found that the “results highlight the importance of treating more people who have co-occurring substance use and mental health disorders for both disorders.”<sup>68</sup> MHCs achieve this goal by viewing relapse or other slip-ups as bumps in the road rather than an automatic ticket to jail.<sup>69</sup> This approach allows participants to learn from their mistakes, while still actively working toward reform within the more flexible and forgiving structure of MHCs.<sup>70</sup> A study conducted in 2014 found that two-fifths of MHC participants reported using illicit drugs at the time of their relevant arrest and roughly half of those individuals were required to undergo drug testing during the program as a condition of treatment.<sup>69</sup> MHC graduates from this study averaged 2.5 positive drug tests throughout the duration of the program.<sup>70</sup> However, participants had to receive a negative drug test before graduating which motivated many participants to overcome their addiction(s) and cope in healthier ways to regulate their mental illness long-term.<sup>71</sup> Rather than removing a participant from the diversion program if they relapsed, approximately 37% of those who had a positive drug test during the program were still able to

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<sup>66</sup> OSHER ET AL., *supra* note 4, at 1 (“Their conditions tend to deteriorate, and they often get ensnared in the system again and again because they lack effective integrated treatment and supervision. The costs to states, counties, and communities in excessive expenditures of scarce resources that have a limited effect on public safety, recidivism, and recovery are unacceptable.”).

<sup>67</sup> *See generally* DENCKLA & BERMAN, *supra* note 4.

<sup>68</sup> JOAN EPSTEIN ET AL., OFF. APPLIED STUD., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., SERIOUS MENTAL ILLNESS AND ITS CO-OCCURRENCE WITH SUBSTANCE USE DISORDERS 35 (2002).

<sup>69</sup> FRED C. OSHER & IRENE S. LEVINE, COUNCIL STATE GOV'TS, NAVIGATING THE MENTAL HEALTH MAZE, A GUIDE FOR COURT PRACTITIONERS 1, 36 (2005), <https://csgjusticecenter.org/wp-content/uploads/2020/02/Navigating-MHC-Maze.pdf> [<https://perma.cc/6X8B-R7UW>].

<sup>70</sup> *Id.*

<sup>69</sup> Virginia Aldigé Hiday, *Predictors of Mental Health Court Graduation*, 20 PSYCH. PUB. POL'Y. & L. 191, 197 (2014).

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

graduate,<sup>72</sup> highlighting the rehabilitative goal and forgiving nature of the MHC approach to criminal justice.

In conclusion, the researchers of the 2014 study suggested their findings indicated that offenders with substance use disorders are “viable candidates for MHC admission in that a MHC program with treatment, services, monitoring, and supports that addresses substance use as well as mental illness can assist [participants] to new law-abiding behavior patterns.”<sup>73</sup> The key to success is treating both disorders at the same time, as truly effective treatment of such comorbid factors requires integration and coordination between the court and various support systems available to most MHC participants.<sup>74</sup> Thus, integrating simultaneous treatment for those experiencing both mental illness and substance use disorders via the unique form of justice offered by the purpose and framework of MHCs would effectively address this unfortunate intersection.<sup>75</sup> Use of MHCs, rather than more adversarial and retributionist TCMs, will subsequently lead to lower levels of disproportionate incarceration and recidivism in this specific population, as well as increased public safety through providing treatment, services, and compassion to inmates experiencing personal challenges and public legal charges.

2. *Mental Illness, Homelessness, and Incarceration.* — Several researchers have also demonstrated the significant connection between mental illness and homelessness, as social factors, like prolonged financial and environmental disadvantage, can profoundly influence a person’s behavior, way of thinking, and opinion of self and society.<sup>76</sup> Sustained exposure to such conditions often results in high rates of offenders who experience mental illness and housing insecurity, repeatedly cycling in and out of the system simply for a place to live,<sup>77</sup> similar to individuals with both mental illness and substance use disorders discussed above. A 1999 BJS Special Report found that homeless individuals with serious mental illness were more than twice as likely to be arrested than homeless people without mental illness.<sup>78</sup> More recently, the aforementioned 2006 BJS Special Report indicated that both state prisoners and local jail inmates

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<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> OSHER & LEVINE, *supra* note 69, at 25.

<sup>75</sup> *See generally id.*

<sup>76</sup> *Id.* at 7–8.

<sup>77</sup> *Id.*

<sup>78</sup> PAULA M. DITTON, BUREAU JUST. STAT., OFF. JUST. PROGRAMS, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 1 (July 1999), <https://bjs.ojp.gov/content/pub/pdf/mhtip.pdf> [<https://perma.cc/WM7H-BXPC>].

suffering from mental illness were twice as likely to have been homeless in the year prior to their incarceration when compared to inmates without mental illness.<sup>79</sup> To alleviate the high number of homeless offenders with mental illnesses sitting in correctional facilities, the underlying issue of long-term and sustainable housing must be addressed, as it is in most state MHCs.

Correctional facilities can provide temporary shelter for offenders, but, once released, finding and maintaining stable housing on their own is often complicated by their criminal record, leaving them on the streets once again.<sup>80</sup> The absence of stable housing can make participation in both in-court and out-of-court services very challenging,<sup>81</sup> as a lack of a permanent address, access to reliable transportation, and/or consistent access to technology makes maintaining contact between the court, service providers, and the defendant rather difficult. This can create the cyclical or “revolving door” effect in which homeless individuals miss court dates during their probationary period due to lack of a permanent address; thus, never receiving notice of their hearing, potentially landing them back behind bars. Once incarcerated again, many people with mental illnesses are unable to supply even small bail amounts,<sup>82</sup> leaving them locked up until their court date in a traditional court setting, which can cause issues with employment and family. Moreover, studies have indicated that, if convicted, inmates with mental illness are more likely to serve the entirety of their sentence,<sup>83</sup> thus costing taxpayers considerable money to incarcerate individuals for longer periods of time when compared to inmates without mental illnesses.

One way to help break this cycle is to divert eligible defendants into MHC programs in which services and resources relating to housing are generally made available to all participants. Similar to the success of treating the comorbidity of mental illness and substance abuse, the participants’ underlying relationship with mental illness and housing insecurity should be simultaneously addressed in consideration of rehabilitative goals and effectiveness.<sup>84</sup> Accordingly, a guide to MHCs published by the Bureau of Justice Assistance (hereinafter “BJA”) in 2005

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<sup>79</sup> JAMES & GLAZE, *supra* note 65, at 4.

<sup>80</sup> See OSHER & LEVINE, *supra* note 69, at 26.

<sup>81</sup> *Id.*

<sup>82</sup> ALMQUIST & DODD, *supra* note 20, at 15.

<sup>83</sup> Kelli Canada et al., *Bridging Mental Health and Criminal Justice Systems: A Systematic Review of the Impact of Mental Health Courts on Individuals and Communities*, 25 PSYCH. PUB. POL’Y AND L. 73, 73 (2019) (citing Jamie Fellner, *A Corrections Quandry: Mental Illness and Correction Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 398 (2006)).

<sup>84</sup> OSHER & LEVINE, *supra* note 69, at 7–8.

suggests that MHC participants “should be prioritized for community housing placements, because their residential stability is both a clinical and public safety concern.”<sup>85</sup> Giving participants access to stable housing helps them to achieve stability of their basic needs,<sup>86</sup> allowing focus to shift to bettering their life through participation in both in-court and out-of-court treatment measures, rather than simply surviving day to day. These “supportive housing” programs generally combine access to housing with an “appropriate level of professional and peer support to allow a person with mental illness to live independently within the community.”<sup>87</sup> Additionally, MHCs typically provide educational programming and resources relating to employment, thereby ensuring the participants will be able to maintain stable housing upon completion of the program.<sup>88</sup> Therefore, MHCs are also well suited to address the specific intersection between mental illness, poverty, and repeated incarceration since the focus on enhanced access to treatment, services, and community resources within the MHC framework is better suited for rehabilitation when compared to TCMs.

*3. Mental Illness, Poverty, Addiction, and Incarceration.* — Those experiencing the intersection of mental illness, homelessness, and addiction are substantially more prone to coming into contact with the criminal justice system during their lives than those not facing such intense personal challenges.<sup>89</sup> According to a report issued by the Human Rights Watch, offenders who experience these interconnected factors are most likely to commit minor public order or nuisance crimes,<sup>90</sup> meaning a majority of offenders are nonviolent, thus may have better rehabilitative success. However, the same report cautioned that while there is mounting national recognition that treatment diversion programs keep taxpayer costs low and are better suited for rehabilitation, this population’s incarceration rate will remain high unless social attitudes and policies concerning mental health, substance abuse, and homelessness change.<sup>91</sup> While the law alone cannot reduce the stigma around mental illness, substance use, and homelessness, it can work to positively alter the systems in which such stereotypes are construed and actively embraced, thereby challenging common misconceptions relating to this population while also encouraging broad

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<sup>85</sup> *Id.* at 26.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> See HUM. RTS. WATCH, *supra* note 21.

<sup>90</sup> *Id.*

<sup>91</sup> *Id.* at 6.

systematic reform. As such, the allure of a MHC is that the program would allow the inmate to be released from confinement and require them to meet several conditions relating to treatment before graduating. Upon graduating the program, the graduate will be armed with new coping skills, interpersonal abilities, and a second chance at creating and maintaining healthy family, professional, and community relationships.

Another, more recent Special Report produced by the BJA in 2017 detailed that approximately half of state prisoners and two-thirds of local jail inmates reported either recent “serious psychological distress” or a history of mental illness in the past.<sup>92</sup> However, only one-third of both groups reported receiving treatment for their mental illness, which could undoubtedly exacerbate any substance abuse or housing insecurity one may have.<sup>93</sup> Of this small group receiving treatment, prescription medication was the most common form of treatment, yet only 13% of prisoners reported receiving any type of therapy or counseling.<sup>94</sup> This clearly demonstrates that our current system is failing mentally ill inmates who also experience substance use disorders and homelessness by restricting access to vital resources from inmates.<sup>95</sup> Notably, the recent 2017 BJS Special Report is the first governmental update on the connection between mental illness and incarceration since the 2006 BJS Special Report. Regardless, the takeaway of the report ten years later remains the same: “U.S. prisons and jails are filled with people who have a current or past mental health problem, and facilities are still not meeting the demand for treatment.”<sup>96</sup>

## II. ANALYSIS OF HISTORICAL CONTEXT, EXISTING FEDERAL LEGISLATION, AND BENEFITS TO PARTICIPANTS AND SOCIETY

Current federal funding allocations for MHCs are insufficient and fail to protect offenders experiencing mental illness, addiction, and/or poverty, thereby failing to fulfill the intended goal of federal legislation. The first subsection will explain the creation and maintenance of state MHCs through federal grant allocations authorized by the Mentally Ill Offender

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<sup>92</sup> JENNIFER BRONSON & MARCUS BERZOFKY, BUREAU JUST. STAT., OFF. JUST. PROGRAMS, INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011–12, at 1, 8 (2017), <https://www.bjs.gov/content/pub/pdf/imhprj1112.pdf> [<https://perma.cc/4BGS-GWCV>].

<sup>93</sup> *See id.*

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

<sup>96</sup> Wendy Sawyer, *New Government Report Points to Continuing Mental Health Crisis in Prisons and Jails*, PRISON POL’Y INITIATIVE (June 22, 2017), [https://www.prisonpolicy.org/blog/2017/06/22/mental\\_health/](https://www.prisonpolicy.org/blog/2017/06/22/mental_health/) [<https://perma.cc/5REP-PGCL>].



Treatment and Crime Reduction Act (hereinafter “MIOTCRA” or “the Act”) of 2004,<sup>97</sup> and continuing today.<sup>98</sup> The second subsection covers several limitations of MIOTCRA, including the lengthy, overbearing, and restrictive application process applicants must go through to receive MIOTCRA funding. The third subsection will examine how the limitations of MIOTCRA fracture the availability of and potential participants’ access to MHC programs, which undermines the Act’s ultimate goal of increasing public safety by addressing the disproportionately high numbers of incarcerated mentally ill people in the United States. Despite these limitations, the last section highlights the significant benefits of MHCs for both participants and society more broadly.

#### A. Creation of MIOTCRA and Continued Renewal of Funding

The Mentally Ill Offender Treatment and Crime Reduction Act was originally passed in 2004, taking effect in 2005 and authorizing funding up to 2009.<sup>99</sup> The stated purpose of the Act “is to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems.”<sup>100</sup> Congress listed multiple findings that spurred the creation of the Act, several of which are relevant to this analysis because they highlight the intersection of mental illness, poverty, addiction, and incarceration.<sup>101</sup> First, Congress noted up to 40% of adults who suffer from serious mental illnesses come into the criminal justice system within their lifetime.<sup>102</sup> Additionally, Congress acknowledged “a significant portion of adults with a serious mental illness who are involved in the criminal justice system are homeless or at imminent risk of homelessness, and many of these individuals are arrested and jailed for minor, nonviolent offenses.”<sup>103</sup> Importantly, Congress found that those who are in contact with the criminal justice system and suffer from a mental illness “are responsive to medical and psychological interventions that integrate treatment, rehabilitation, and support services.”<sup>104</sup> Finally, Congress concluded that collaborative efforts between mental health,

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<sup>97</sup> Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. No. 108-414, § 2991(h), 118 Stat. 2327, 2335–36 (2005).

<sup>98</sup> See *infra*, notes 127–28.

<sup>99</sup> Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(h)(1)–(2).

<sup>100</sup> *Id.* § 3.

<sup>101</sup> *Id.* § 2(1)–(7).

<sup>102</sup> *Id.* § 2(3).

<sup>103</sup> *Id.* § 2(5).

<sup>104</sup> *Id.* § 2(6).

substance abuse, and criminal justice staff can provide services and assistance to those with comorbid disorders to reduce the high number of mentally ill individuals that are incarcerated, while also improving public safety.<sup>105</sup>

The Act lists the eligibility requirements for obtaining federal funding through MIOTRCA, and the first section specifically designates that such grants can be spent to establish or expand “mental health courts or other court-based programs for preliminary qualified offenders.”<sup>106</sup> Such funding is also available for the incorporation and facilitation of substance abuse treatment services for offenders experiencing mental illness and addiction.<sup>107</sup> In order to apply for funding, applicants must define their target population and present proposed guidelines, including: eligibility of individuals; detailed methods of supervision; provisions supplying proof of available treatment programs; provisions supplying proof of available support services; and, descriptions of how they will disperse the funds, among other factors.<sup>108</sup> The Act also details the necessary “matching requirements” that a state must provide in the first five years of receiving this federal funding, and, after five years, the state is solely responsible for financing their MHC program.<sup>109</sup> Congress authorized an astounding \$50,000,000 for the 2005 fiscal year and such sums “as may be necessary” for fiscal years 2006 through 2009.<sup>110</sup> In 2008, Congress reauthorized MIOTCRA through 2014, again allotting up to \$50,000,000 in federal funding each during that period.<sup>111</sup> In 2013, President Barack Obama declined to request funding for MIOTCRA specifically, opting to instead integrate the funding into existing mental health and substance abuse programs.<sup>112</sup> However, the 21st Century Cures Act, passed in 2016, reinstated funding for the MIOTCRA for 2018 through 2022.<sup>113</sup>

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<sup>105</sup> *Id.* § 2(7).

<sup>106</sup> *Id.* § 2991(b)(2)(A).

<sup>107</sup> *Id.* § 2991(b)(2)(C)(i).

<sup>108</sup> *Id.* § 2991(b)(5)(C)–(E).

<sup>109</sup> *Id.* § 2991(b)(5)(d)(1)–(2).

<sup>110</sup> *Id.* § 2991(b)(5)(h)(1)–(2).

<sup>111</sup> Mentally Ill Offender Treatment and Crime Reduction Reauthorization Act of 2008, Pub. L. No. 110-416, § 2991(h), 122 Stat. 4352, 4352–53 (2008).

<sup>112</sup> *President's Budget Proposes Continued Funding for Second Chance Act and Justice Reinvestment Initiative*, COUNCIL STATE GOV'TS JUST. CTR. (Feb. 13, 2017), <http://csgjusticecenter.org/jc/presidents-budget-proposes-continued-funding-for-second-chance-act-and-justice-reinvestment-initiative/> [https://perma.cc/4SU5-C46H].

<sup>113</sup> 21st Century Cures Act, Pub. L. No. 114-255, § 8001(f)(1)–(2), H.R. 34, 114th Cong. 1, 196 (2016).

As noted above, up to \$50,000,000 of federal funding was designated for allocation through MIOTCRA grants from the years 2004 to 2009<sup>114</sup> and again from 2008 to 2013,<sup>115</sup> yet the actual amount dispersed in those years never even got close to the maximum allocation.<sup>116</sup> In 2006 and 2007, only \$5,000,000 was dispersed toward MIOTCRA.<sup>117</sup> In 2008, \$6,500,000 was authorized, while the amount increased to \$10,000,000 in 2009 and \$12,000,000 in 2010.<sup>118</sup> Funding decreased for MIOTCRA in the following years, with \$9,900,000 allocated in 2011 and \$9,000,000 in 2012.<sup>119</sup> A total of \$9,000,000 was allotted in 2013,<sup>120</sup> \$8,250,000 in 2014,<sup>121</sup> and \$8,500,000 in 2015.<sup>122</sup> Subsequently, funding began to increase for MIOTCRA with \$10,000,000 distributed in 2016<sup>123</sup> and \$12,000,000 allocated in 2017.<sup>124</sup> Funding then skyrocketed in 2018, as a record \$30,000,000 was authorized for MIOTCRA.<sup>125</sup> Amounts have incrementally increased since then, as \$31,000,000 was dispersed in 2019<sup>126</sup> and \$33,000,000 was earmarked for 2020.<sup>127</sup> For the year of 2021, \$35,000,000 was allocated toward MIOTCRA.<sup>128</sup> However, not all of the money allocated for MIOTCRA goes to MHCs since funding for various other mental health services is available under this Act as well.<sup>129</sup> Still, an inference can be drawn from the significant increase in funding allocations

<sup>114</sup> Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(h)(1)–(2).

<sup>115</sup> Mentally Ill Offender Treatment and Crime Reduction Reauthorization Act of 2008 § 2991(h).

<sup>116</sup> See *infra* notes 119–28.

<sup>117</sup> *The Mentally Ill Treatment and Crime Reduction Act*, COUNCIL STATE GOV'TS JUST. CTR. (2016), [https://csgjusticecenter.org/wp-content/uploads/2020/02/MIOTCRA\\_Fact\\_Sheet.pdf](https://csgjusticecenter.org/wp-content/uploads/2020/02/MIOTCRA_Fact_Sheet.pdf) [<https://perma.cc/7AHA-3GBM>].

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> Consolidated and Further Continuing Appropriations Act, 2013 § 7, Pub. L. No. 113-6, 127 Stat. 198, 253 Enacted H.R. 933, 253 (2013).

<sup>121</sup> Consolidated Appropriations Act, 2014, § 6, Pub. L. No. 113-76, 128 Stat. 5, 128, 2014 Enacted H.R. 3547, 113 Enacted H.R. 3547 (2014).

<sup>122</sup> Consolidated and Further Continuing Appropriations Act, 2015, § 5, Pub. L. No. 113-235, 2014 Enacted H.R. 83, 113 Enacted H.R. 83, 128 Stat. 2130, 2192 (2014).

<sup>123</sup> Consolidated Appropriations Act, 2016, § 5, 114 Pub. L. No. 113, 129 Stat. 2242, 2015 Enacted H.R. 2029, 114 Enacted H.R. 2029, 2307 (2015).

<sup>124</sup> Consolidated Appropriations Act, 2017, § 16(B), Pub. L. No. 115-31, 131 Stat. 135, 205, 2017 Enacted H.R. 244, 115 Enacted H.R. 244 (2017).

<sup>125</sup> Consolidated Appropriations Act, 2018, §18(b), Pub. L. No. 115-141, 132 Stat. 348, 422, 2018 Enacted H.R. 1625, 115 Enacted H.R. 1625 (2018).

<sup>126</sup> Consolidated Appropriations Act, 2019, § 16(B), Pub. L. No. 116-6, 2019 Enacted HJR 31, 116 Enacted HJR 31, 133 Stat. 13, 102 (2019).

<sup>127</sup> Consolidated Appropriations Act, 2020, § 16(B), Pub. L. No. 116-93, 2019 Enacted H.R. 1158, 116 Enacted H.R. 1158, 133 Stat. 2317, 2409 (2019).

<sup>128</sup> Consolidated Appropriations Act, 2021, § 15(b), Pub. L. No. 116-260, 2020 Enacted H.R. 133, 116 Enacted H.R. 133, 134 Stat. 1182, 78 (2020).

<sup>129</sup> Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(b)(2)(A)–(D).

for MIOTCRA over the last five years that there is considerable government and public interest regarding the intersection of mental health, poverty, substance use, and incarceration. This increased interest in such a complex relationship reflects the urgent and considerable need to establish operational MHCs in every state in America, as these courts are best suited to combat the high number of such individuals behind bars. With the establishment of additional MHCs, existing limitations related to receiving funding will become even more strained and additional investments at the state and federal level will be necessary to ensure MHCs can be both successfully created and maintained.

### *B. Limitations of MIOTCRA*

Beginning in 2006, the BJA began releasing competitive grant announcements that list pre-determined projects for which applicants can receive federal funding through MIOTCRA.<sup>130</sup> BJA allocates funding earmarked for MIOTCRA by issuing grants through the Justice and Mental Health Collaboration Program (hereinafter “JMHC”).<sup>131</sup> The goal of JMHC is to “promote innovative cross-collaboration” by providing “grants directly to states, local governments, and federally recognized Indian tribes” in an effort to “improve responses to people with mental illnesses who are involved in the criminal justice system.”<sup>132</sup> Applicants must also demonstrate that they are engaging in a cross-systems effort through the partnership between a criminal justice agency and a mental health agency to jointly administer the grant.<sup>133</sup> The Center for State Governments reported that 531 JMHC grants were awarded between 2006 and 2019, for a sum totaling more than \$121,000,000.<sup>134</sup> While this is undoubtedly great progress for the mental health community, the arduous and narrow application process, as well as the limited chance of receiving funding, are enough to discourage any applicant who is attempting obtain such a grant.

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<sup>130</sup> See BUREAU JUST. ASSISTANCE, OFF. JUST. PROGRAMS, JUSTICE AND MENTAL HEALTH COLLABORATION PROGRAM: FY 2006 COMPETITIVE GRANT ANNOUNCEMENT (2006), <https://bja.ojp.gov/funding/opportunities/bja-2006-1381> [<https://perma.cc/VG29-MXCC>].

<sup>131</sup> *Justice and Mental Health Collaboration Program*, COUNCIL STATE GOV'TS JUST. CTR., <https://csgjusticecenter.org/projects/justice-and-mental-health-collaboration-program-jmhcp/> [<https://perma.cc/C6EQ-PTSL>].

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

Each year's competitive grant announcement contains a myriad of hoops applicants must jump through to even submit their application for review, including devising their own guidelines for eligibility and screening; suggesting methods of obtaining and analyzing data; providing data on availability of housing, education, and employment; and offering budgetary information, including proof of necessary matching requirements.<sup>135</sup> Further, federal funding in recent years has been limited to three categories of projects that are pre-selected by the BJA, thereby failing to consider the needs of individual MHCs more broadly by denying them the opportunity to develop and submit their own unique, creative project for approval.<sup>136</sup> Shockingly, applicants are given only between one and three months to develop a competitive and compelling application after the BJA announces the pre-selected projects.<sup>137</sup> This simply does not give applicants adequate time to meet the numerous requirements specific to each of the three pre-determined grants.

Additionally, it is counterproductive and inefficient to require applicants to put in such hard work, especially when reports indicate that only a fraction of applicants receive funding. For example, one report indicates that only 11% of applicants were selected to receive grants between the years of 2006 and 2008.<sup>138</sup> Even with considerable increases in funding in recent years, the percentage of applicants who receive funding is still quite low, and "many applicants remain unfunded and communities remain in need of assistance."<sup>139</sup> As such, despite a 150% increase in

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<sup>135</sup> See generally BUREAU JUST. ASSISTANCE, OFF. JUST. PROGRAMS, JUSTICE AND MENTAL HEALTH COLLABORATION PROGRAM FY 2016 COMPETITIVE GRANT ANNOUNCEMENT 19–35 (2016), <https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/BJA-2016-9205.pdf> [<https://perma.cc/3VKV-M8GX>]; BUREAU JUST. ASSISTANCE, OFF. JUST. PROGRAMS, JUSTICE AND MENTAL HEALTH COLLABORATION PROGRAM FY 2017 COMPETITIVE GRANT ANNOUNCEMENT 23–49 (2017), <https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/BJA-2017-11380.pdf> [<https://perma.cc/2R3P-JDH4>].

<sup>136</sup> See, e.g., BUREAU JUST. ASSISTANCE, OFF. JUST. PROGRAMS, JUSTICE AND MENTAL HEALTH COLLABORATION PROGRAM FY 2018 COMPETITIVE GRANT ANNOUNCEMENT 5–8 (2018), <https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/BJA-2018-13605.PDF> [<https://perma.cc/2B3J-XNRF>] [hereinafter 2018 GRANT ANNOUNCEMENT]; BUREAU JUST. ASSISTANCE, OFF. JUST. PROGRAMS, JUSTICE AND MENTAL HEALTH COLLABORATION PROGRAM FY 2019 COMPETITIVE GRANT ANNOUNCEMENT 4–9 (2019), <https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/BJA-2019-15099.PDF> [<https://perma.cc/J5HD-MT32>].

<sup>137</sup> See *supra* note 133.

<sup>138</sup> *Mentally Ill Offender Treatment and Crime Reduction Act*, NAT'L CTR. ON DOMESTIC & SEXUAL VIOLENCE, [http://www.ncdsv.org/images/JMHCP\\_MIOTCRA\\_Fact\\_Sheet.pdf](http://www.ncdsv.org/images/JMHCP_MIOTCRA_Fact_Sheet.pdf) [<https://perma.cc/8WSW-GZKW>].

<sup>139</sup> BUREAU JUST. ASSISTANCE, OFF. JUST. PROGRAMS, IMPROVING JUSTICE AND MENTAL HEALTH COLLABORATION: TRAINING AND TECHNICAL ASSISTANCE TO GRANTEEES AND THE FIELD FY 2019 COMPETITIVE GRANT ANNOUNCEMENT 4 (2019), <https://bja.ojp.gov/sites/g/files/xyckuh186/files/media>

MIOTCRA funding between fiscal year 2017 and fiscal year 2018, less than half of the 109 applications submitted in 2018 were selected for funding, with forty-seven total awards distributed.<sup>140</sup> Notably, the BJA estimated that it would give a total of fifty-eight awards in their 2018 Competitive Grant Announcement,<sup>141</sup> yet they expended all available funding with just forty-seven grants.<sup>142</sup> This discrepancy emphasizes the urgent need to further increase federal and state funding in order to fulfill the mental health needs of those coming into contact with the criminal justice system in their respective local and state communities.

Ultimately, although funding for MIOTCRA has increased significantly over last five years, demonstrating the considerable relationship between mental health and incarceration, the Act fails to achieve its goals of increasing public safety and better serving those who suffer from comorbid factors of mental illness, poverty, and substance abuse. This unfortunate reality exists because the allocated federal funding through MIOTCRA for MHCs is relatively minimal and limited to pre-assigned projects designated by the BJA in an arduous, lengthy application process. This process is unduly restrictive and stifles applicants' creativity to imagine new solutions to persistent systemic issues, thereby depriving both MHC staff and participants the full benefits of such a revolutionary problem-solving court.

### *C. Impact of Legislation on State Courts and Potential Participants*

MHCs developed through a grassroots movement to decrease recidivism in the target population, increase public safety, and improve the overall quality of life for participants by connecting them to resources and treatment.<sup>143</sup> As such, there is considerable variation in eligibility requirements, rewards upon completion, and the overall structure of MHCs between states or even within a single jurisdiction.<sup>144</sup> The disproportionate treatment of participants appearing in different jurisdictions may stem from a discrepancy of community resources and services accessible to the court and participant; as a 2020 report indicated, "the outcomes mental health courts produce depend on how they are designed and the resources available in their local jurisdiction."<sup>145</sup> As such, the number of MHCs per

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/document/BJA-2019-15123.PDF [hereinafter 2019 ANNOUNCEMENT] [<https://perma.cc/DS47-5E3B>].

<sup>140</sup> *Id.*

<sup>141</sup> 2018 GRANT ANNOUNCEMENT, *supra* note 138, at 11.

<sup>142</sup> 2019 ANNOUNCEMENT, *supra* note 141, at 4.

<sup>143</sup> See Petrila et al., *supra* note 1.

<sup>144</sup> ALMQUIST & DODD, *supra* note 20, at 12–13.

<sup>145</sup> DOBSON ET AL., *supra* note 50, at 10.

state,<sup>146</sup> as well as the enrollment capacity for each program,<sup>147</sup> varies widely and many local programs only have enough resources, funding, and staff to assist very few participants per year.<sup>148</sup> Further, due to the arduous application process and limitations on sufficient funding discussed above, entities seeking to establish a local MHC typically face an uphill battle due to the fact that they are required to submit their own guidelines to screen eligible participants<sup>149</sup> with few up-to-date resources to consult on the matter.<sup>150</sup> Taken together, the current approach toward state MHCs ultimately isolates countless potential participants from available services and resources due to its disjointed approach in design and implementation.<sup>151</sup> However, this problem could be effectively resolved with a Model Act that includes a set of cohesive, uniform MHC guidelines that states can choose to do adopt in part or entirely, which is discussed in more depth in section III below.

Additionally, in some circumstances, the same crime may be charged differently across and even within jurisdictions. One jurisdiction may categorize that crime as a felony, while it may be deemed only a misdemeanor in another jurisdiction.<sup>152</sup> This contributes, in part, to the somewhat varied outcomes of studies measuring MHC success rates across various programs.<sup>153</sup> Moreover, this results in widely disparate treatment of possible MHC participants across different jurisdictions, as those seeking to enter such programs may be denied access due to a felony charge on their record that would have only been a misdemeanor if the crime occurred in a different state or jurisdiction.<sup>154</sup> State MHCs often lack discretion as to whether to include participants charged with misdemeanors and/or

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<sup>146</sup> See *Adult Mental Health Court Treatment Locator*, *supra* note 29.

<sup>147</sup> *Id.*

<sup>148</sup> *Id.* (According to the SAMHSA “Adult Mental Health Court Locator,” California has the most MHCs with forty-seven, yet six states have only one MHC. This can result in participants having to travel significant distances to engage with the program, which may be a considerable barrier to those who are homeless or transient and lack reliable transportation, thereby further fracturing access to local MHCs and critical services to those experiencing mental illness.)

<sup>149</sup> Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(b)(5)(C)(i)(II).

<sup>150</sup> See *Mental Health Courts Resource Guide*, *supra* note 35 (This website contains what appears to be very helpful links for those contemplating establishing a state MHC, yet over half of the website links on this page are broken, making the resource incredibly unhelpful.)

<sup>151</sup> See DOBSON ET AL., *supra* note 50.

<sup>152</sup> ALMQUIST & DODD, *supra* note 20, at 8 (stating: “[T]here is often great variation in how the same criminal action can be charged across jurisdictions and even within a jurisdiction. An act considered to be a felony in one jurisdiction may be charged as a gross misdemeanor in another. Furthermore, as law enforcement officers and prosecutors become more aware of the availability and utility of a mental health court they may be more apt to use their discretion in deciding what charges to file.”)

<sup>153</sup> *Id.* at V.

<sup>154</sup> *Id.* at 9.

felonies.<sup>155</sup> For example, “a [MHC] that operates within a municipal court with jurisdiction primarily over misdemeanor charges will limit the program’s target participants to individuals with misdemeanor charges. Similarly, a trial court with jurisdiction over felonies will generally lead the related [MHC] to focus on individuals with felony charges.”<sup>156</sup> This jurisdictional limitation further restricts participant access to and utilization of MHC services, thereby excluding a large number of otherwise eligible candidates from receiving treatment and other community services concerning successful re-entry upon completion of the program.<sup>157</sup>

This is especially unfortunate in the case of those with non-violent felony charges because research indicates more taxpayer money would ultimately be saved by including participants with felony charges.<sup>158</sup> More specifically, after reviewing the impact of MHCs on participants and the public, the authors of a 2019 meta-analysis concluded “felony MHCs experience the greatest success in outcomes.”<sup>159</sup> Accordingly, these recent findings also emphasize that MHC participants with felony charges are no more likely to reoffend when compared to others in the program who committed less serious offenses.<sup>160</sup> The observed savings and lowered recidivism is likely due to the fact that participants with felony charges face longer periods of possible incarceration than those charged with misdemeanors, and they are also able to interact with the provided services and resources for longer periods of time.<sup>161</sup> Thus, as confirmed by the above analysis and highlighted in the cases of Dennis Cortopassi<sup>162</sup> and Jesse Fiero<sup>163</sup> discussed below, MHCs are capable of producing substantial, enduring effects for both participants with non-violent felony charges and the local community more generally in terms of taxpayer dollars saved via lowered rates of recidivism.<sup>164</sup>

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<sup>155</sup> *Id.* at 7.

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.* at 8; *see also* M. SUSAN RIDGELY ET AL., RAND CORP., JUSTICE, TREATMENT, AND COST: AN EVALUATION OF THE FISCAL IMPACT OF ALLEGHENY COUNTY MENTAL HEALTH COURT 20 (2007), [https://www.rand.org/content/dam/rand/pubs/technical\\_reports/2007/RAND\\_TR439.pdf](https://www.rand.org/content/dam/rand/pubs/technical_reports/2007/RAND_TR439.pdf) [<https://perma.cc/HB8W-EEPK>] (When evaluating one New York county’s MHC, researchers found “that more seriously distressed subgroups (participants charged with felonies, participants suffering from psychotic disorders, and those with high psychiatric severity and low functioning) had larger estimated cost savings.”).

<sup>159</sup> Canada et al., *supra* note 85, at 88.

<sup>160</sup> *Id.*

<sup>161</sup> *See* ALMQUIST & DODD, *supra* note 20, at 8.

<sup>162</sup> *See* Keene, *infra* note 238.

<sup>163</sup> *See* Keene, *infra* note 257.

<sup>164</sup> *See infra* notes 180–83.



#### D. Benefits to Participants and Society

Reduced recidivism is the foremost benefit of MHCs to both the individual participant and the general population, yet several other advantages exist and are discussed in depth in this section below. Public taxpayers face the brunt of the high costs of mass incarceration,<sup>165</sup> which has only increased as the disproportionate number of mentally ill individuals who are incarcerated continues to climb.<sup>166</sup> Although crime rates have decreased dramatically in the last thirty years, mass incarceration played a minor role in this reduction, as studies suggest this strategy does little to deter would-be offenders, reduce recidivism rates, and increase public safety.<sup>167</sup> Reports indicate both mental illness and substance use disorders largely go untreated in jails and prisons,<sup>168</sup> thereby failing to arm inmates with the resources and coping skills they need to facilitate their successful reintegration into society as productive citizens upon release. More specifically, studies reveal that only roughly a third of both prisoners and jail inmates diagnosed with serious psychological stress or mental illness receive treatment while incarcerated.<sup>169</sup> Of those inmates receiving treatment, a majority are simply given prescription medication,<sup>170</sup> and cost of medication correspondingly accounts for a considerable portion of mental health care funding allocations.<sup>171</sup>

Prescription medication should not be the immediate answer in all cases, as negative side effects of these medications are well-documented.<sup>172</sup>

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<sup>165</sup> See SENT'G PROJECT, TRENDS IN U.S. CORRECTIONS 1 (May 17, 2021), <https://www.sentencingproject.org/wp-content/uploads/2021/07/Trends-in-US-Corrections.pdf> [<https://perma.cc/K36M-H3MQ>] (State expenditures on corrections costs have consistently risen in the previous three decades, with the following amounts being reported in billions for each year: 6.7 in 1985; 16.9 in 1990; 26.1 in 1995; 36.4 in 2000; 42.3 in 2005; 51.4 in 2010; and 56.6 in 2019.).

<sup>166</sup> *Id.* at 2 (“The United States is the world’s leader in incarceration with 2.2 million people currently in the nation’s prisons and jails—a 500% increase over the last forty years.”).

<sup>167</sup> *Id.* (“Changes in sentencing law and policy, not changes in crime rates, explain most of this increase. These trends have resulted in prison overcrowding and fiscal burdens on states to accommodate a rapidly expanding penal system, despite increasing evidence that large-scale incarceration is not an effective means of achieving public safety.”).

<sup>168</sup> See BRONSON & BERZOFKY, *supra* note 94, at 7–8; see also Sawyer, *supra* note 98.

<sup>169</sup> Sawyer, *supra* note 98.

<sup>170</sup> BRONSON & BERZOFKY, *supra* note 94, at 1.

<sup>171</sup> See E. FULLER TORREY, M.D. ET AL., TREATMENT ADVOC. CTR., NAT’L SHERIFFS’ ASS’N, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 17 (Apr. 8, 2014), <https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf> [<https://perma.cc/3F8S-AUXX>].

<sup>172</sup> *Frequently Asked Questions*, NAT’L ALL. ON MENTAL ILLNESS, <https://www.nami.org/FAQ/Mental-Health-Medication-FAQ/What-are-the-long-term-effects-of-taking-medication> [<https://perma.cc/T67Q-EXB4>].

Further, adapting to such negative side effects would no doubt be extremely challenging when confined to a cell, which may in turn result in disciplinary action against the mentally ill individual if he or she acts erratically.<sup>173</sup> Conversely, only 13% of jail inmates and 26% of prisoners reported receiving any type of therapy while behind bars.<sup>174</sup> Consistent therapy can provide lasting skill development that inmates could use to their advantage after serving their time; whereas, prescription medication is a temporary fix that may not be accessible to all who are being released from confinement due to issues with transportation, income, employment, insurance, and a myriad of other factors.<sup>175</sup> Ultimately, this is a failure to provide inmates at all levels of incarceration with appropriate access to mental health services, specifically therapy, that inmates could use to develop healthy coping mechanisms to aid in their efficacious reintegration into society upon release, so that they can be successful, productive citizens in their community after serving their time.<sup>176</sup>

The United States is currently collectively spending over approximately \$50,000,000,000 on corrections a year,<sup>177</sup> vastly exceeding funding as budgeted.<sup>178</sup> However, between the years of 2007 and 2011, states spent on average only 14% of their total prison health care budget on mental health care for inmates.<sup>179</sup> For the fiscal year of 2015, the Pew Research Center (hereinafter “Pew”) reported that the national average of health care cost per inmate—including mental health treatment—was \$5,720 a year, yet

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<sup>173</sup> Kelli E. Canada & Alana J. Gunn, *What Factors Work in Mental Health Court? A Consumer Prospective*, J. OFFENDER REHAB. (Jul. 1, 2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3972816/pdf/nihms562180.pdf> [<https://perma.cc/DDA3-8352>].

<sup>174</sup> BRONSON & BERZOFKY, *supra* note 94, at 8.

<sup>175</sup> Sarah Sheppard, *Mental Health Effects Facing Recently Released Prisoners*, VERY WELL MIND (Aug. 29, 2021), <https://www.verywellmind.com/mental-health-effects-facing-former-inmates-5195312> [<https://perma.cc/U37W-VY4V>].

<sup>176</sup> *See id.*

<sup>177</sup> PEW CTR. ON THE STATES, PEW CHARITABLE TRS., STATE OF RECIDIVISM: THE REVOLVING DOOR OF AMERICA’S PRISONS 5 (Apr. 2011), [https://www.pewtrusts.org/-/media/legacy/uploadedfiles/pes\\_assets/2011/pewstateofrecidivism.pdf](https://www.pewtrusts.org/-/media/legacy/uploadedfiles/pes_assets/2011/pewstateofrecidivism.pdf) [<https://perma.cc/BWY6-JX3S>] [hereinafter STATE OF RECIDIVISM].

<sup>178</sup> CHRISTIAN HENRICHSON & RUTH DELANEY, CTR. ON SENT’G AND CORR., INST. OF JUST., THE PRICE OF PRISONS: WHAT INCARCERATION COSTS TAXPAYERS (July 20, 2012), [https://www.pewtrusts.org/-/media/legacy/uploadedfiles/pes\\_assets/2012/httpwwwveraorgdownloadfile3495thepriceofprisonsupdatedpdf.pdf](https://www.pewtrusts.org/-/media/legacy/uploadedfiles/pes_assets/2012/httpwwwveraorgdownloadfile3495thepriceofprisonsupdatedpdf.pdf) [<https://perma.cc/GV56-HLCL>] (stating: “Vera researchers found that the total taxpayer cost of prisons in the 40 states that participated in this study was 13.9 percent higher than the cost reflected in those states’ combined budgets. The total price to taxpayers was \$39 billion, \$5.4 billion more than the \$33.5 billion reflected in corrections budgets alone.”).

<sup>179</sup> *See id.* (Note that only ten states—Florida, Illinois, Minnesota, Nebraska, Ohio, Oregon, Rhode Island, Utah, and Washington—submitted disaggregated data on yearly spending to allow the referenced average to be calculated).

individual state averages vary widely.<sup>180</sup> However, one financial consequence of the TCM approach remains consistent across jurisdictions: State taxpayers spend hundreds of thousands more per year incarcerating inmates experiencing mental illness in comparison to the yearly costs associated with incarcerating inmates not experiencing mental illness.<sup>181</sup> In a separate report published in 2011, Pew emphasized that “[i]f states could reduce their recidivism rates by just [ten] percent, they could save more than \$635 million combined in one year alone in averted prison costs.”<sup>182</sup> One way to accomplish such a reduction in recidivism is to use MHCs. As an alternative to the TCM framework, MHCs hold mentally ill offenders accountable for their crimes through legitimate, effective channels of the judicial system in which the goals of both deterrence and rehabilitation are achieved.<sup>183</sup>

Critics of MHCs argue that effective implementation and management of local alternative treatment programs to help the target population would be too costly because, in comparison with TCMs, they require extended periods of intensive supervision, additional court staff, and an increased frequency of status hearings.<sup>184</sup> This added cost may lead opponents to suggest the MHC approach is a waste of valuable resources, like time, labor, and money.<sup>185</sup> However, building stable, functional habits and routines is not a rapid process, especially for those with mental illness who may require extra care and supervision to ensure their basic and emotional needs are met.<sup>186</sup> More succinct MHC programs would deprive participants of extended access to community resources and court services, thereby reducing their ability to challenge the root cause of their illicit behavior in a monitored, controlled environment before they are expected to function on their own as productive citizens in society.<sup>187</sup> Thus, although MHC program

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<sup>180</sup> PEW CHARITABLE TRS., PRISON HEALTH CARE: COSTS AND QUALITY 1, 6, 94 (Oct. 18, 2017), <https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality> [<https://perma.cc/T333-37RU>] (“Health care spending per inmate varied dramatically in fiscal 2015, as it had in past years—from \$2,173 in Louisiana to \$19,796 in California.”).

<sup>181</sup> See, e.g., E. FULLER TORREY, M.D. ET AL., *supra* note 173, at 17 (The Broward County, Florida County Jail reported that it cost an additional \$50 per day to house mentally ill inmates when compared to neurotypical inmates, which results an additional cost of roughly \$18,000 more per year per inmate in 2007. In Texas in 2003, it cost approximately an additional \$8,000 to \$28,000 per year to house mentally ill inmates. Astoundingly, in Washington in 2009, this increased cost charged state taxpayers an additional \$70,000 per year for each mentally ill inmate.).

<sup>182</sup> STATE OF RECIDIVISM, *supra* note 179, at 26.

<sup>183</sup> See generally *id.* (highlighting the inadequacies of the TCM model).

<sup>184</sup> See ALMQUIST & DODD, *supra* note 20, at 4; DOBSON ET AL., *supra* note 50, at 12.

<sup>185</sup> See ALMQUIST & DODD, *supra* note 20, at 4.

<sup>186</sup> See DOBSON ET AL., *supra* note 50, at 12.

<sup>187</sup> See *id.* at 29.

terms are lengthy, the extended time period is essential because it allows participants to develop healthy habits and routines in relation to medication compliance; to strengthen coping skills; to improve or build family relationships; to seek employment and educational opportunities; and to locate safe, stable housing, all of which help ensure that the individual will not be arrested again which ultimately saves taxpayer money.

Further, the notion of increased cost for MHCs compared to TCMs has been refuted. As a 2007 study of one New York MHC demonstrated, in the court's first year, engagement with mental health treatment services increased and days spent in jail per participant decreased.<sup>188</sup> This offset the additional cost associated with the MHC, thereby costing taxpayers no additional money.<sup>189</sup> The same authors also note that because a majority of prison mental health care is supported by Medicaid, the federal government shares approximately half of the financial burden with the state providing such treatment, further reducing taxpayer costs under a MHC framework.<sup>190</sup> As such, by the end of the court's second year, researchers reported "both average mental health services and jail costs [were] reduced, suggesting that the MHC program may help to decrease total taxpayer costs."<sup>191</sup> Thus, the saved costs could be diverted away from TCMs and instead redirected as additional funding for the more effective MHC model to further reduce both recidivism and cost to the average taxpayer on a national scale.

A recent report titled "Solving Problems, Saving Lives" published by the Michigan Supreme Court details the contemporary successes of Michigan's various problem-solving courts, including MHCs, DTCs, and Veterans Treatment Courts.<sup>192</sup> Michigan hails itself as a shining example of how successful treatment diversion programs can be when effectively implemented and managed.<sup>193</sup> For the fiscal year of 2020, researchers found that graduates of MHCs were two to three times less likely to reoffend in the two years after graduation when compared to those who navigate TCMs.<sup>194</sup> Moreover, the same report indicated that among Michigan MHC graduates from the same fiscal year, unemployment rates were cut by more than half;<sup>195</sup> over 95% of both district and circuit participants who

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<sup>188</sup> RIDGELY ET AL., *supra* note 160, at 19.

<sup>189</sup> *Id.*

<sup>190</sup> *Id.* at 20.

<sup>191</sup> *Id.*

<sup>192</sup> MICH. SUP. CT., *supra* note 52.

<sup>193</sup> *Id.* at 3–4.

<sup>194</sup> *Id.* at 5, 38.

<sup>195</sup> *Id.* at 34–35.

completed the program reported improved mental health;<sup>196</sup> and over 93% of the same MHC graduates reported overall improved quality of life.<sup>197</sup> This report emphasizes that to improve a MHC participant's quality of life, the court must take a multi-systems, interdisciplinary approach, therein utilizing available community resources for treatment, housing, medical attention, and other necessary services.<sup>198</sup> As such, "through supervision, care, and treatment," Michigan MHCs aim to "help participants gain independent functioning, improve social and family relationships, and achieve mental stability, thereby reducing crisis interventions."<sup>199</sup> As suggested by the recency of this report, MHCs are a modern, progressive solution to assist those with mental illness who are repeatedly cycling in and out of incarceration.

The above findings mirror results reported by the Council of State Governments Justice Center in 2008 which showed MHC participants were less likely to be rearrested when compared to other defendants with mental illness who did not engage in the MHC program.<sup>200</sup> Additionally, when compared to TCM defendants, MHC participants had increased access to treatment services; greater development of effective, healthy coping skills for both mental illness and substance use disorders; fewer days spent behind bars; "and more favorable interactions with the judge and perception of being treated with greater fairness and respect than in traditional court."<sup>201</sup> The above benefits of MHC participation simply cannot be achieved under the more adversarial TCM framework, as the latter approach fails to address the root cause of the individuals' criminal behavior, reinforcing the cyclical effect of traditional incarceration for those with mental illness. Moreover, the benefits to the individual participant are much greater under a MHC framework.<sup>202</sup> Accordingly, MHC participants over the last decade and across jurisdictions have consistently reported a more dignified experience in which they are able to address the foundational causes of their behavior in an effort to better their life and avoid additional contact with the criminal justice system.<sup>203</sup> Although the two above-referenced publications were published over a decade apart, the reported success of MHCs over TCMs

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<sup>196</sup> *Id.* at 36.

<sup>197</sup> *Id.* at 37.

<sup>198</sup> *Id.* at 37, 42.

<sup>199</sup> *Id.* at 37.

<sup>200</sup> MENTAL HEALTH COURTS PRIMER, *supra* note 3, at 14.

<sup>201</sup> *Id.*

<sup>202</sup> *See supra* section II.D.

<sup>203</sup> *See infra* notes 243–63.

for defendants experiencing mental illness is strikingly similar.<sup>204</sup> The fact that the data on this issue is remarkably comparable, despite being evaluated over ten years later, demonstrates the timeliness and importance of this issue, as well as how successful a more unified approach would be for countless participants.

Several additional studies repeatedly indicate that rates of recidivism are reduced for defendants who participate in MHCs when compared to TCMs.<sup>205</sup> Although at least one recent meta-analysis indicated that some studies suggest MHCs make little or no impact on recidivism,<sup>206</sup> the enduring, positive success rate of MHCs in reducing recidivism in a majority of studies is well documented.<sup>207</sup> For example, a 2014 study indicated that MHCs reduce the number of new arrests for individuals who participate, finding that those who at least participated in MHCs had a rearrest rate half that of those who engaged in TCMs.<sup>208</sup> Moreover, this study reported, “[e]vidence is mounting that [MHCs] are effective in achieving their main goal of reducing criminal recidivism, especially when participants complete their individual plans of treatment and services, and graduate.”<sup>209</sup> Both a 2006 study<sup>210</sup> and 2013 study<sup>211</sup> indicate that a “full dose of mental health court, rather than a partial dose,” makes a huge

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<sup>204</sup> MICH. SUP. CT., *supra* note 52; MENTAL HEALTH COURTS PRIMER, *supra* note 3.

<sup>205</sup> See Dale E. McNiel & Renée L. Binder, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 AM. J. PSYCHIATRY 1395, 1395–1403 (Sept. 1, 2007), <https://doi.org/10.1176/appi.ajp.2007.06101664> [<https://perma.cc/56VN-9RKN>] (stating: “Based on an intent-to-treat sample (i.e., all of those who enrolled in mental health court, regardless of whether they successfully completed the program), mental health court participants showed a longer time without any new charges or new charges for violent crimes compared with similar individuals who did not participate in the program. Survival analysis showed that the reductions in the likelihood of new charges were more substantial with follow-up of more than 1 year after enrollment in mental health court; for example, at 18 months, the likelihood of mental health court participants being charged with any new crimes was about 26% lower than that of comparable individuals who received treatment as usual, and the likelihood of mental health court participants being charged with new violent crimes was 55% lower than that of individuals who received treatment as usual. Additional analyses showed that persons who graduated from the mental health court program maintained reduced recidivism after they were no longer under supervision of the court, in contrast to comparable persons who received treatment as usual.”); see also Goodale et al., *supra* note 2; Han & Redlich, *supra* note 2.

<sup>206</sup> See generally Jason Matejkowski et al., *Voluntariness of Treatment, Mental Health Services Utilization, and Quality of Life Among Mental Health Court Participants*, 26 PSYCH. PUB. POL’Y & L. 185 (Mar. 2, 2020).

<sup>207</sup> See, e.g., Goodale et al., *supra* note 2; Han & Redlich, *supra* note 2; OSHER ET AL., *supra* note 4; McNiel & Binder, *supra* note 207.

<sup>208</sup> Hiday, *supra* note 71, at 192.

<sup>209</sup> *Id.* at 196.

<sup>210</sup> See generally Marlee E. Moore & Virginia Aldigé Hiday, *Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants*, 30 L. & HUM. BEHAV. 659 (2006).

<sup>211</sup> Canada et al., *supra* note 85, at 86.

difference in regard to the observed drop in recidivism.<sup>212</sup> In other words, sticking with the program until graduation and consistently engaging with the enhanced services provided significantly lowers a participant's likelihood of rearrest, while failing to complete the program does little to reduce recidivism rates.<sup>213</sup> As such, the same study reported that those who completed the MHC program had an even lower rearrest rate at approximately one-fourth that of TCM participants.<sup>214</sup>

However, a concern exists that—due to the fact that MHC participants are intensely monitored for extended periods of time—“small violations of their terms of participation and conditioned release are more likely to be noted,”<sup>215</sup> which may invite further observation and scrutiny of the individual's behavior or even land them behind bars if court orders are repeatedly ignored.<sup>216</sup> However, the forgiveness, flexibility, and compassion of the MHC approach rooted in therapeutic jurisprudence often allows for second chances and reports indicate judges are extremely hesitant to send participants to jail or eject them from the program entirely since these are seen as measures of last resort.<sup>217</sup> Due to the success associated with the MHC framework, the researchers emphasize that “a significant proportion of participants overcame the risk factors of their past and changed their behavior from prior behavior patterns (multiple prior arrests and drug use) with the structure and supports of MHC.”<sup>218</sup>

Moreover, prolonged incarceration of mentally ill individuals typically does not alter their behavior and it can often make their symptoms much worse, especially if forced into isolation.<sup>219</sup> Recent research suggests “incarceration can exacerbate symptoms of serious mental illness, disrupt treatment regimens, and contribute to victimization and suicide.”<sup>220</sup> Further, a 2020 report indicates those with serious mental illness “are also more likely to be detained longer than sentencing maximums, denied probation or

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<sup>212</sup> Moore & Hiday, *supra* note 212.

<sup>213</sup> *Id.*; see also McNiel & Binder, *supra* note 207.

<sup>214</sup> Moore & Hiday, *supra* note 212; see also McNiel & Binder, *supra* note 207.

<sup>215</sup> ALMQUIST & DODD, *supra* note 20, at 24.

<sup>216</sup> *Id.*

<sup>217</sup> *Id.* at 18.

<sup>218</sup> Hiday, *supra* note 71, at 196.

<sup>219</sup> See Kyleigh Clark, *The Effect of Mental Illness on Segregation Following Institutional Misconduct*, 45 CRIM. JUST. & BEHAV. 1363, 1364 (Sep. 2018) <http://safealternativestosegregation.vera.org/wp-content/uploads/2018/10/The-Effect-of-Mental-Illness-on-Segregation-Following-Institutional-Misconduct.pdf> [<https://perma.cc/96GL-WDBY>]; see also Tullis, *supra* note 5.

<sup>220</sup> Jo Ciavaglia, *Mental Health Court Would Benefit Bucks County, Mentally Ill Defendants, Report Says*, BUCKS CNTY. COURIER TIMES (Sep. 4, 2020, 3:31 PM), <https://www.buckscountycouriertimes.com/story/news/2020/09/04/bucks-county-mental-health-court-could-save-lives/5693595002/> [<https://perma.cc/PW4X-XWBJ>].

parole, and placed in isolation.”<sup>221</sup> Accordingly, a 2018 study found inmates with a mental illness were 1.36 times more likely to be placed in isolation when compared to their peers without mental illness, providing “evidence that these inmates are being segregated for their mental illness alone, rather than their misconduct record.”<sup>222</sup> Even suicide attempts can result in the person being placed in isolation, as the person may be viewed as a danger to themselves or others which may warrant the use of solitary confinement as a disciplinary tactic.<sup>223</sup> As such, this 2018 study concluded that “the analysis presented . . . generated empirical evidence that mental illness is a unique predictor of assignment of disciplinary segregation.”<sup>224</sup>

In 2017, the Office of the Inspector General suggested that—due to many jails and prisons lacking adequate resources, staff, and space—isolating inmates experiencing mental illness may be seen as the only viable option to protect their safety and the safety of others.<sup>225</sup> Long periods of isolation, generally without access to mental health treatment, are often forced upon inmates with mental illnesses awaiting competency hearings to determine whether they are fit to stand trial.<sup>226</sup> A 2017 poll revealed the national average wait time for such a hearing was more than thirty-five days.<sup>227</sup> In 2015, the typical wait time in California was longer than seventy-five days, yet that was just an average, and one defendant reported waiting 258 days with no access to mental health care.<sup>228</sup> Unfortunately, as they await competency hearings or transfers following a determination

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<sup>221</sup> *Id.*; see also Carpenter, *supra* note 61 (stating: “Data on Douglas County[, Kansas] inmates booked in April, July and October 2014 and in January 2015 showed 18 percent had a mental, behavior or emotional disorder resulting in functional impairment of major life activities. These mentally ill inmates stayed in jail an average of four days longer than those without a diagnosed disorder: 13.9 days versus 9.7 days.”).

<sup>222</sup> Clark, *supra* note 221, at 1376.

<sup>223</sup> *Id.* at 1376–77.

<sup>224</sup> *Id.* at 1378.

<sup>225</sup> See generally OFF. INSPECTOR GEN., DEP’T JUST., REVIEW OF THE FEDERAL BUREAU OF PRISONS’ USE OF RESTRICTIVE HOUSING FOR INMATES WITH MENTAL ILLNESS (July 2017), <https://www.oversight.gov/sites/default/files/oig-reports/e1705.pdf> [<https://perma.cc/NFX2-W7AW>]; see also Tullis, *supra* note 5.

<sup>226</sup> See Tullis, *supra* note 5.

<sup>227</sup> See *id.* (stating: “No organization or government agency tracks the number of people nationwide who are waiting beyond the legal limit in their state to be evaluated for competency or transferred to a state hospital once declared incompetent to stand trial. But the National Association of State Mental Health Program Directors, which polled states, found in 2017 that eight of the 37 states with relevant data reported having average wait times of longer than 35 days just to be evaluated for competency, during which detainees with mental illness were held in jails. When it came to transferring people from jails after they are found incompetent to stand trial, 11 states reported average wait times exceeding 28 days. In a 2014 survey, the organization reported that 31 of 40 states said they couldn’t clear up space for new detainees because the demand for inpatient services was increasing.”).

<sup>228</sup> See *id.*



defendants with mental illnesses are often behind bars longer than if they had been convicted for the maximum sentence associated with their relevant crime(s), which also results in millions being paid from taxpayer dollars for significant delays in transfers.<sup>229</sup> Moreover, progressive worsening and intensification of symptoms of mental illness due to extended periods in isolation can make successful reentry to society upon release almost impossible, leaving inmates with mental illnesses in a constant cycle of hopelessness.<sup>230</sup> This approach is a clear failure of the TCM framework in rehabilitating offenders experiencing mental illness, yet some echo the Inspector General's opinion that there are few other options.<sup>231</sup> However, upon analysis, this is an obvious area in which the structure, function, and purpose of MHCs is perfectly poised to alleviate the disproportionate treatment that inmates with mental illnesses receive while incarcerated by providing enhanced access to treatment, community services, and additional resources to provide them the best chance for success upon release.

As a central reason for the success of these problem-solving courts, MHCs provide enhanced access to out-of-court services and resources for mentally ill defendants when compared to more traditional, adversarial adjudication models.<sup>232</sup> Additional services and resources that MHCs should ideally be able to offer participants are access to medication and therapy; medical treatment; rehabilitation; employment and educational programming; family support; and crisis services.<sup>233</sup> As previously noted, treatment plans for each participant are personalized so the specific services each person is connected to will be dependent on their individualized goals and needs, as well as the available community resources.<sup>234</sup> Although the MHC does not directly operate or fund these community resources, it is essential that court staff and mental health professionals maintain an

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<sup>229</sup> *Id.* (“In some cases, states have paid fines and fees for failing to comply with court orders requiring them to move incompetent defendants within a set time period. Washington, one of the worst offenders, has paid more than \$80 million.” Additionally, in the few months between June and December of 2019, “Colorado has paid \$6.7 million in fines for failing to adhere to time limits for transferring detainees.”).

<sup>230</sup> Clark, *supra* note 221, at 1378.

<sup>231</sup> See Tullis, *supra* note 5; see also Jason Auslander, *Pitkin County Jail Inmate Died by Suicide Sunday Night, Sheriff Says*, ASPEN TIMES (Nov. 4, 2019) <https://www.aspentimes.com/news/pitkin-county-jail-inmate-dies-sunday-night-investigation-underway/> [<https://perma.cc/S8YG-FEKA>] (When interviewed about the suicide of Jillian White, who died in custody after waiting over sixty days following a determination of incompetency to stand trial, Sheriff Joe DiSalvo remarked, “Right now, society is dealing with severely mentally ill people by placing them in jail. That’s not the place for them . . . but we keep using it because [there is] no alternative.”).

<sup>232</sup> OSHER & LEVINE, *supra* note 69, at 23.

<sup>233</sup> *Id.*

<sup>234</sup> ALMQUIST & DODD, *supra* note 20, at 16.

effective cross-system, interdisciplinary approach to ensure participants receive the best possible care in order to avoid reentry into the criminal justice system.<sup>235</sup> Such access to enhanced services allows MHC participants to actively work to better themselves by providing opportunities to interact with others and stimulate their minds with healthy coping strategies.<sup>236</sup> This involvement also allows participants to develop roots in the community through building relationships with others who have similar experiences, thereby supplying the participant with a support system to rely on upon graduation.<sup>237</sup> The heightened accessibility to these resources is paramount to MHC participants' success, as many individuals in contact with the criminal justice system are unable to seek and/or finance treatment, housing, education, and/or employment without additional support, care, and motivation.<sup>238</sup> Thus, the aforementioned augmented resources and services available to MHC participants serve to reduce recidivism in this population, as they have consistent support and encouragement throughout the duration of the program and learn the skills to be able to cope once released.<sup>239</sup>

One study indicated that, even when TCM participants were “under supervision of the same pretrial mental health services unit with the same case management, mental health treatment linkage, and drug testing/treatments,” the MHC participants were found to have lower rates of recidivism when compared to those navigating TCMs.<sup>240</sup> Thus, there must be an independently motivating component for participants that exists in MHCs beyond extended resources and services to explain the difference in success rates observed here. This is likely due to the exercise of therapeutic jurisprudence in these treatment diversion programs, which offers participants accountability, incentives, and a personal sense of achievement. Because there is an emphasis on compassion, forgiveness, and rehabilitation, it is also likely that participants form important relationships with court staff and other participants.<sup>241</sup> Beyond this, likely the biggest

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<sup>235</sup> *Id.*

<sup>236</sup> See Lauren Keene, *Mental Health Court Puts Defendants Back on Track*, DAVIS ENTER. (Jan. 5, 2016, 1:27 PM), <https://www.davisenterprise.com/news/local/crime-fire-courts/yolos-mental-health-court-sets-defendants-back-on-track/> [<https://perma.cc/KZ6A-8V37>] (“Twice a week, [Dennis] Cortopassi visits the Wellness Center, a drop-in service operated by the Yolo County Health and Human Service Agency that offers clients a place to socialize, play games, take skill-building classes or share a meal. While not required to go, Cortopassi does ‘because it’s better than just being isolated.’”).

<sup>237</sup> *See id.*

<sup>238</sup> See DOBSON ET AL., *supra* note 50, at 8–9.

<sup>239</sup> *See id.* at 9.

<sup>240</sup> See Hiday, *supra* note 71, at 192.

<sup>241</sup> See, e.g., Bob Gross, *Mental Health Court Celebrates the Success of Graduates*, TIMES HERALD

attraction of MHCs for most participants, outside of access to treatment and support, is the chance to have their charges reduced or even dropped upon completion of the program. Individual programs vary on how they handle a MHC participant's charges; some agree to dismiss or reduce charges, while other programs simply eliminate jail time, but all are contingent upon successful graduation of the program.<sup>242</sup> Either route can drastically change a person's life, as a criminal record can be devastating to employment, education, and housing prospects, and jail time can result in several years of one's life lost.<sup>243</sup>

For some MHC graduates, completion of the program provided far more than reduced or dropped charges and jail time, as it instead led them to a passion and a reason to live. For example, Sandra Holmes, an Idaho mother of two children, had already served seven and a half years behind bars before graduating from a MHC program in 2015.<sup>244</sup> Her time as a participant in the MHC program allowed her to completely reevaluate her priorities, which permitted her to shift her focus to raising her family and serving her community.<sup>245</sup> As part of her court-mandated community service, this mother chose to help a family whose house recently burned down, creating a grassroots effort to give this family some semblance of normalcy after losing all of their worldly possessions.<sup>246</sup> This act of kindness turned into a passion for fundraising to help others in need, which in turn created positive and enduring change in her local community.<sup>247</sup> Similarly, Maria Teri Hazel graduated from a Charleston, South Carolina MHC in 2011, after which she remained sober, coped with her bipolar disorder in healthier ways, and became an advocate for others in her situation.<sup>248</sup> She asserts the program was a "glimmer of hope" after such a dark period in her life, and that it "saved [her] life."<sup>249</sup> Participation in the program provided her with a lifeline to services and support that she never

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(Apr. 18, 2018, 5:30 AM), <https://www.thetimesherald.com/story/news/local/2018/04/18/mental-health-court-celebrates-success-graduates/525376002/> [<https://perma.cc/W8KP-HLMB>] (Travis Armstrong, a 2018 graduate of a MHC in St. Clair County, Michigan, emphasized his appreciation for and important relationship with the court staff in saying, "I have the utmost respect for the law and the judges and the probation officers. They taught me to be a good citizen and what a human being represents.").

<sup>242</sup> Wolff et al., *supra* note 43, at 10.

<sup>243</sup> See *infra* notes 243–62.

<sup>244</sup> John Funk, *Mental Health Court Success Story*, IDAHO PRESS (Jan. 24, 2015), [https://www.idahopress.com/members/mental-health-court-success-story/article\\_de434c06-a384-11e4-ad87-7bad10dc741f.html](https://www.idahopress.com/members/mental-health-court-success-story/article_de434c06-a384-11e4-ad87-7bad10dc741f.html) [<https://perma.cc/RHH8-LQ58>].

<sup>245</sup> *Id.*

<sup>246</sup> *Id.*

<sup>247</sup> *Id.*

<sup>248</sup> Maria Teri Hazel: *A Story of Hope, Healing, and Recovery*, CHARLESTON DORCHESTER MENTAL HEALTH CTR., <https://www.charlestondorchestermhc.org/success-stories/> [<https://perma.cc/P35H-5L8F>].

<sup>249</sup> *Id.*

had the opportunity with which to engage.<sup>250</sup> This experience increased her self-confidence tremendously and ignited her passion to help others who experience mental illness and substance use.<sup>251</sup> She later became a motivational speaker, encouraging people to seek help early on, while also challenging the stigma associated with mental illness.<sup>252</sup> Additionally, Steve Wilmer, a 2011 MHC graduate from Salt Lake City, Utah, described himself as being “near death” when he was battling severe drug addiction and schizophrenia, bouncing around different court rooms for decades before receiving the care and support he needed.<sup>253</sup> The presiding MHC judge in Wilmer’s case reported finally seeing a “remarkable change” in him upon completion of the program,<sup>254</sup> demonstrating the success of MHCs in breaking the cyclical effect of incarceration.

Furthermore, MHC graduates are typically filled with pride and joy when reflecting on their accomplishments, and several graduates hope their stories of personal determination and success will encourage others to participate in similar programs. Dennis Cortopassi, the first graduate of the Yolo County MHC in California, is a great example of this attitude.<sup>255</sup> For Cortopassi, graduating from the MHC was a “personal goal” to get his life back on track after being charged with battery, evading police, and ultimately crashing his car into a gas station while believing himself to be Jesus Christ at the time.<sup>256</sup> However, in 2017, just two years after graduating from the program, Cortopassi was able to get his felony charges reduced to misdemeanor charges, making them eligible for expungement.<sup>257</sup> He described his felony charges as “an anchor on his back,”<sup>258</sup> which is the same weight that many felons carry with them when searching for housing and employment upon release. Despite these setbacks, Cortopassi now counsels others who suffer from mental illness and substance use disorders.<sup>259</sup> He also worked with local officials to secure a \$6,000,000 grant to “provide mental-health services, substance-abuse treatment and

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<sup>250</sup> *Id.*

<sup>251</sup> *Id.*

<sup>252</sup> *Id.*

<sup>253</sup> Jennifer Stagg, *Success Stories from Mental Health Court*, KLS BROAD. (Nov. 8, 2011, 10:11PM), <https://www.ksl.com/article/18010051/success-stories-from-mental-health-court> [https://perma.cc/8WT3-CX8N].

<sup>254</sup> *Id.*

<sup>255</sup> Lauren Keene, *Case Dismissed: Mental Health Court Success Story Gets Fresh Start*, DAVIS ENTER. (July 5, 2017, 7:05 PM), <https://www.davisenterprise.com/news/local/case-dismissed-mental-health-court-success-story-gets-fresh-start/> [https://perma.cc/P282-SQ7Z].

<sup>256</sup> *Id.*

<sup>257</sup> *Id.*

<sup>258</sup> *Id.*

<sup>259</sup> *Id.*

diversion programs for people in the criminal justice system.”<sup>260</sup> Cortopassi hopes his story “will inspire other people in mental health court to stick with it,” and he serves as a great example of how successful MHC graduates, especially those with felony charges, can be if given the opportunity.<sup>261</sup> Additionally, Cortopassi continues to engage with the program by mentoring other participants in the Yolo County program.<sup>262</sup> One of his mentees, Jesse Fiero, was able to find healthy coping mechanisms to effectively manage his mental illness and substance use to remain sober, find employment after completing additional education, and locate stable housing through his participation in the program.<sup>263</sup> All five MHC graduates described above are shining examples of how participation in a MHC program, rather than navigating a TCM framework, can reduce recidivism, increase public safety generally, and significantly improve the lives of participants and their communities.

### III. PROPOSED UNIFORM OR MODEL ACT

To address the existing limitations of MIOTCRA and the current MHC framework noted above, this section advocates for Congress to create a Uniform or Model Act that would mandate or recommend, respectively, the existence and operation of MHCs in every state; increase funding to aid in this process; and issue an updated, cohesive set of guidelines for states to consider when establishing and maintaining MHC programs at the local level. These new guidelines should also allow states to submit proposals that are outside what is pre-determined yearly by the BJA to be appropriate for federal funding, thereby increasing the participant pool and creativity in the process. The model guidelines would additionally act as a reference point for existing or proposed state MHCs to consider when implementing eligibility screenings, graduated sanctions, and rewards upon completion of the program, among other aspects of MHC creation and maintenance. As noted in Part II, the existing resources available to those attempting to create or operate a MHC are disjointed and ineffective. The Council for State Governments provides extensive educational programming and literature on its website to aid those considering establishing a MHC in their local community, yet most of these resources are over a decade old or

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<sup>260</sup> *Id.*

<sup>261</sup> *Id.*

<sup>262</sup> Keene, *supra* note 238.

<sup>263</sup> *Id.*

contain broken website links,<sup>264</sup> thereby making the existing educational materials outdated and largely unhelpful. To avoid similar situations in the future and ensure the continued success of MHCs, the model guidelines should require a mechanism of review to ensure regular and systematic updates to the guidelines themselves as MHCs evolve. Ultimately, MHCs have expanded considerably in the last decade, and it is past time to issue updated, uniform federal guidance on the matter.

*A. Using the Uniform Law Commission to Develop a Uniform/Model Act*

The best way to ensure all states have operational, successful MHCs is to urge the Uniform Law Commission (hereinafter “ULC”) to develop either a Uniform or Model Act to be adopted by the states that will mandate or recommend, respectively, the existence and maintenance of state MHCs, among several other provisions discussed below. A “Uniform” Act, if enacted, statutorily obligates all fifty states to adopt all provisions of the Act, as its purpose is to create uniformity among disputing jurisdictions.<sup>265</sup> A “Model” Act, if enacted, instead simply promotes unity, as the drafters believe the purposes of such an Act can still be accomplished even if some states chose not to adopt all provisions of the Act.<sup>266</sup> The designation of a proposed Act as Uniform or Model is recommended by the drafters of the Act to the Executive Committee (hereinafter “EC”) after an extensive period of consideration and study, and the EC makes the final determination.<sup>267</sup> Proposals created by “state bars, state government entities, private groups, uniform law commissioners, and private individuals” can be submitted twice a year to the ULC Committee on Scope and Program, which sifts through the various proposals to assign Study Committees and ultimately recommend to the EC which topics the ULC should undertake in the upcoming session.<sup>268</sup>

If a recommendation is approved by the EC, a Drafting Committee is formed and an expert in that field of law, or a “Reporter,” is hired to

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<sup>264</sup> *Mental Health Courts Resource Guide*, *supra* note 35.

<sup>265</sup> *What is a Uniform Act?*, UNIF. L. COMM’N, <https://www.uniformlaws.org/acts/overview/uniformacts> [<https://perma.cc/UG5J-NMFS>].

<sup>266</sup> *What is a Model Act?*, UNIF. L. COMM’N, <https://www.uniformlaws.org/acts/overview/uniformacts> [<https://perma.cc/L8NP-HJXG>].

<sup>267</sup> *New Project Criteria: Statement of Policy Establishing Criteria and Procedures for Designation and Consideration of Uniform and Model Acts*, UNIF. L. COMM’N, <https://www.uniformlaws.org/projects/overview/newprojectcriteria> [<https://perma.cc/43C5-53QR>].

<sup>268</sup> *FAQ*, UNIF. L. COMM’N, <https://www.uniformlaws.org/aboutulc/faq> [<https://perma.cc/9BTW-Z7Y3>] [hereinafter ULC FAQ].

consult.<sup>269</sup> The drafting process is very transparent and interested parties are invited to contribute to the process, which the ULC makes easier by posting each draft on their website.<sup>270</sup> Each proposed Act receives at minimum at least two years study and contemplation before moving to the final stage, at which time drafted acts are submitted for preliminary debate before the entire ULC at their annual meeting.<sup>271</sup> Moreover, the ULC as a whole, each state having one representative, must consider each provision of the proposed Act at no less than two annual meetings.<sup>272</sup> If approved by the entirety of the ULC at an annual meeting, the last step is a vote by all states, with each representative casting a singular vote.<sup>273</sup> A majority of state representatives present, but no fewer than twenty, must vote to officially approve the proposed Act before it can be sent to state legislatures to adopt in totality or partially.<sup>274</sup>

Although this is an incredibly time-intensive goal to undertake, mandating or recommending the existence and maintenance of state MHCs by a Uniform or Model Act is the best way to ensure all eligible individuals are afforded the same opportunity to participate in these effective treatment diversion plans, which will in turn reduce recidivism rates and increase public safety. Further, this entire process will take at least five years to complete, and, as noted, it is already past time to supply local MHCs with up-to-date resources to handle issues as they arise—as well as provide more recent resources to aid in the establishment of new MHCs. As stated, the leading sources providing this outdated information are the National Center for State Courts<sup>275</sup> and the Council of State Governments.<sup>276</sup> The organizations' websites provide guides and seminars on how to establish and maintain a successful MHC, yet all of the available resources are over a decade old.<sup>277</sup> Moreover, several pages on their sites claiming to contain helpful resources instead contain broken links and little direction.<sup>278</sup> The current resources are disjointed and ineffective, which is a problem that could be fixed by a Uniform or Model Act that includes national guidelines on how to apply for, establish, and maintain successful local MHCs.

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<sup>269</sup> *Id.*

<sup>270</sup> *Id.*

<sup>271</sup> *Id.*

<sup>272</sup> *Id.*

<sup>273</sup> *Id.*

<sup>274</sup> *Id.*

<sup>275</sup> See generally NAT'L CTR. FOR STATE CTS, *supra* note 33.

<sup>276</sup> See generally COUNCIL STATE GOV'TS, *supra* note 34.

<sup>277</sup> See, e.g., THOMPSON ET AL., *supra* note 28.

<sup>278</sup> See *Mental Health Courts Resource Guide*, *supra* note 35.

*B. Using the Model Veterans Treatment Court Act as a Model*

The ULC's goal is to simplify peoples' lives by providing consistent rules and procedures from state to state.<sup>279</sup> If the proposed Uniform or Model Act contains cohesive rules and guidelines to aid in the creation and regulation of local MHCs, jurisdictional differences in this area of law would be rectified. As mentioned earlier, research indicates that there are two states that do not have MHCs at all, and there are four states that have treatment diversion programs that provide similar services under a different title.<sup>280</sup> This lack of uniformity across jurisdictions makes it more challenging for potential participants to learn of the diversion services provided in their area, thus making it harder for those individuals to access and engage with such services.<sup>281</sup> While this task is undoubtedly daunting, there is an example that this proposed Act could follow: The Model Veterans Treatment Court Act and Model Veterans Treatment Court Rules (hereinafter, collectively "MVTCA/R").<sup>282</sup> Both MHCs and Veterans Treatment Courts (hereinafter "VTCs") exist to aid a specific part of the population that needs additional assistance and care to avoid incarceration. This allows the MVTCA/R to serve as an effective example of how to structure a similar Uniform or Model Act for MHCs to engage in a similar type of therapeutic jurisprudence.

In response to the growing numbers of incarcerated veterans throughout the United States, the ULC enacted the MVTCA/R to provide the states with explicit guidelines and direction when creating and maintaining state VTCs.<sup>283</sup> The designation of this Act as "Model" allows individual states to decide whether they want to adopt the included provisions by statute or by court rules.<sup>284</sup> This is likely the approach the ULC would take for MHCs given their similarities as problem-solving courts. The designation of the proposed Act as Model would allow individual states more flexibility than a Uniform Act, while still requiring the states to adopt the Act in some form.

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<sup>279</sup> ULC FAQ, *supra* note 270.

<sup>280</sup> *Adult Mental Health Treatment Court Locator*, *supra* note 29.

<sup>281</sup> *Id.*

<sup>282</sup> *Model Veterans Treatment Court Act and Model Veterans Treatment Court Rules*, UNIF. L. COMM'N (July 2017), <https://www.uniformlaws.org/viewdocument/final-act-no-comments-78?CommunityKey=3c91a212-1d3d-4768-9adf-ce809a43f66b&tab=librarydocuments> [<https://perma.cc/MJR5-R2NQ>].

<sup>283</sup> UNIF. L. COMM'N, NAT'L CONF. COMM'RS ON UNIF. STATE LS., MODEL VETERANS TREATMENT COURT ACT AND MODEL VETERANS TREATMENT COURT RULES 1 (Oct. 2018), <https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=6b4d3a34-688f-4ea0-89e1-59825411f0af&forceDialog=0> [<https://perma.cc/58DG-XF84>].

<sup>284</sup> *Id.*



Initially, VTCs were developed on an “ad hoc” basis in which several states created VTCs by rule or practice, partially due to the success of DTCs and MHCs, thereby creating “wide variation within states and at the national level regarding which veterans are qualified to participate in these courts and how the veterans’ participation is managed.”<sup>285</sup> These are the same problems currently facing hopeful MHC participants, and, just as the ULC developed the MVTCA/R to combat this growing issue,<sup>286</sup> the ULC could provide a model MHC statute and rules to cohesively address the existing jurisdictional disputes.

The MVTCA/R provides the Ten Key Components of VTCs,<sup>287</sup> which were drafted under the heavy influence of the widely recognized Ten Key Components of Drug Courts, created by the Bureau of Justice Assistance and National Association of Drug Court Professionals.<sup>288</sup> This borrowed intersystem approach allows VTCs to form partnerships with substance abuse treatment programs, as well as community-based treatment programs, by outlining available supplemental policies and procedures for courts to consider.<sup>289</sup> The MVTCA/R provides uniformity in VTCs by defining eligibility requirements, modification methods, termination procedures, and the expectation of completing the program for the participant.<sup>290</sup> Additionally, the Act requires that all participation be voluntary and confirmed in writing,<sup>291</sup> just as is required for MHC participation.<sup>292</sup> The remarkable similarities between the goals, purposes, and success rates of these treatment diversion courts allows the MVTCA/R to serve as an example of how effective utilization of the ULC can be used to create systematic change surrounding the relationship between mental health and incarceration.

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<sup>285</sup> *Id.*

<sup>286</sup> *Id.*

<sup>287</sup> *Model Veterans Treatment Court Act and Model Veterans Treatment Court Rules*, *supra* note 284, at 3–4.

<sup>288</sup> BUREAU OF JUST. ASSISTANCE, OFF. OF JUST. PROGRAMS, U.S. DEP’T OF JUST., DEFINING DRUG COURTS: THE KEY COMPONENTS, (Jan. 1997), <https://www.ojp.gov/pdffiles1/bja/205621.pdf> [<https://perma.cc/4Q2V-A2WR>].

<sup>289</sup> *Model Veterans Treatment Court Act and Model Veterans Treatment Court Rules*, *supra* note 284, at 4

<sup>290</sup> *Id.* at 5.

<sup>291</sup> *Id.* at 6.

<sup>292</sup> ALMQUIST & DODD, *supra* note 20, at 7–8.

## CONCLUSION

Mental health awareness and advocacy is becoming increasingly important, including in the world of criminal justice. Although MHCs can be costly, funding toward these courts should be viewed as an investment in reducing recidivism through treatment and supervision, which will ultimately lower taxpayer costs incurred due to of the high prices of incarceration. Although funding at the state and federal levels must increase to provide the most benefit to the maximum number of eligible MHC participants, the money saved from reduced recidivism would largely offset the increased cost over time. Further, because MHC programs provide participants with enhanced access to community services and resources, increased public safety will also be achieved with this investment in MHCs. Without learning effective coping skills to manage their mental illness or substance use disorder under a TCM approach, inmates experiencing mental illness are more likely to pose a threat to public safety upon release, thereby undermining two core goals of the American incarceration system: deterrence and rehabilitation. Through the examination of the intersectionality of the comorbid factors of mental illness, substance use, homelessness, and incarceration, it is evident that the structure, function, and purpose of MHCs are perfectly poised to address this unique combination of factors that contribute to mass incarceration and its costs.

While it is impossible to turn back the clock and provide helpful resources, services, and support to eligible MHC participants before they encountered the criminal justice system, providing eligible participants with such resources, services, and support through MHC programs allows participants a much greater chance at successful reintegration to society after completion of the program. When one is facing personal battles and public legal charges, the associated stress and shame can be extremely challenging to overcome. Being treated with kindness and respect as a participant in a MHC program offers a more dignified, impactful, and beneficial experience with the criminal justice system when compared to TCMs, which can truly change the participants' lives and communities in amazing ways. To ensure the continued success of MHCs, a cohesive, uniform set of guidelines should be developed by the ULC to alleviate jurisdictional discrepancies that limit potential participants' access to MHC programs. A streamlined approach, similar to the MVTCA/R, is necessary to provide effective treatment and care to all current and potential MHC participants. Rather than the TCM framework, MHCs offer the opportunity to punish, deter, and rehabilitate qualifying inmates with serious diagnosable mental illnesses in a way that simultaneously reduces

recidivism and increases public safety. Through a more thoughtful, effective employment of federal and state funding, hopefully as many eligible participants as possible will be able to engage with the significant opportunity for personal change and growth that is provided by a MHC program.

