

Creating A Mental Health Court in Delaware

White Paper I:

Issues, Goals and Objectives to be Considered

**Report to the
Delaware Criminal Justice Council
Mental Health Sub Committee
Larry Sullivan, Chair**

By

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Executive Statement / Recommendations

The Delaware Criminal Justice Council has established a Mental Health subcommittee to address the issues of the mentally ill coming into contact with the Delaware criminal courts. The subcommittee is charged with reviewing all of the issues involved with the mentally ill and their contact with the criminal justice system, make recommendations for the creation of a mental health court in Delaware, and prepare an application for federal funds to support the implementation of a mental health court in Delaware.

The goal of this working paper is to review some the issues and concepts behind the mental health courts, what objectives and goals should be considered in the design and implementation of a mental health court, and the drafting of an application to the U.S. Department of Justice in line with the "America's Law Enforcement and Mental Health Project" Act.

Recommendations:

- 1. Quantitative research must be conducted to establish the need for a mental health court.**
- 2. Conduct an assessment of the criminal justice system and how coordinated mental health programs could aid in reducing the incarceration of the mentally ill and the improvement of community based programs for the mentally ill.**
- 3. Conduct a cost analysis of a program specifically designed for dealing with the mentally ill defendant.**
- 4. Determine of the judicial jurisdiction of a mental health court.**
- 5. Determine of population to be served by the mental health court.**
- 6. Draft a mission statement for the mental health court.**
- 7. Draft a mental health court plan that has the full and complete cooperation of various agencies and departments.**

Introduction

On November 13, 2000 President Clinton signed the "America's Law Enforcement and Mental Health Project" Act¹ (see appendix one for copy of legislation). The act seeks to address the following findings of Congress:

1. 16% of inmates in State prisons and local jails suffer from mental illness;
2. Each year, between 600,000 and 700,000 mentally ill persons are arrested and placed in jail;
3. 25% to 40% of America's mentally ill come into contact with the criminal justice system; and
4. 75% of mentally ill inmates have been sentenced to time in prison or jail or probation at least once prior to their current sentence.

The act authorizes the U.S. Attorney General to award up to 100 grants to States, local courts and local governments that have programs that provide judicial supervision of "preliminary qualified offenders with mental illness, mental retardation or co-occurring mental illness and substance abuse disorders who are charged with misdemeanors or non violent offenses" through coordinated delivery of services. The act defines programs that have coordinated delivery to include:

1. Specialized training for law enforcement to identify and address the needs of the mentally ill or mentally retarded offender;
2. Voluntary outpatient or inpatient mental health treatment with the possibility of dismissal of charges or reduced sentencing upon successful completion of treatment;
3. Centralized case management involving the consolidation of all cases involving the mentally ill or mentally retarded and treatment services; and
4. Continued supervision of treatment plans and compliance with treatment.

¹ 42 USC 3798.

The act defines *mental illness* as a diagnosable mental behavior, or emotional disorder (1) of sufficient duration to meet diagnostic criteria within the most recent edition of the APA Diagnostic and Statistical Manual of Mental Disorders and (2) that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. The act defines "*preliminary qualified offenders with mental illness, mental retardation or co-occurring mental illness and substance abuse disorders*" as a person who

1. Previously or currently has been diagnosed by a qualified mental health professional as having a mental illness, mental retardation, or co-occurring mental illness and substance abuse disorders; or
2. Manifests obvious signs of mental illness, mental retardation, or co-occurring mental illness and substance abuse disorders during arrest or confinement or before any court; and
3. Is deemed eligible by designated judges.

The act requires that any application to the Justice Department for grant awards must include the following:

1. A long term strategy and a detailed implementation plan;
2. Inability to fund program without federal assistance;
3. Certification federal funds will support and not supplant state funds that would be otherwise available;
4. Identification of related governmental or community initiatives which complement or will be coordinated with the proposal;
5. Certification of consultation with all affected agencies and that there will be appropriate coordination with all affected agencies in the implementation of the program, including the state mental health authority;
6. Certification that participating offenders will be supervised by one or more designated judges with responsibility for the mental health court program;

7. Plans to secure the necessary support for the program after federal assistance ends;
8. Description of methodology and outcome measures that will be used to evaluate the program; and
9. Certification that participating first time offenders without a history of mental illness will receive a mental health evaluation.

The Act allows for federal funds to support 75% of the total cost of the proposed program. The Attorney General is authorized to waive the requirement of matching funds. Federal funds can only be used support new expenses necessitated by the proposed program, including the development of treatment services and the hiring and training of personnel. In kind contributions may constitute a portion of the non – federal share of the grant.

Review of available information on Mental Health Courts

Mental Health Courts are one of many therapeutic courts in which courts “seek to address the problems (“root causes”) that contribute to criminal involvement of persons in the criminal justice population.”² Four events over the past two decades have led to the need for the development of mental health courts: (1) deinstitutionalization of the mentally ill during the 1960s and 1970s, (2) the drug epidemic in the 1980s and 1990s, (3) the increase in the homeless population and (4) overcrowding in state jails and prisons.³ Mental health courts seek to deal with the over crowding of jails and prisons and the collateral results of the policies of the 1980s and 1990s that cracked down on drug offenders; and the increased contact between those with mental illnesses and the criminal justice system.

In an effort to reduce the amount of contact mentally ill people have with the criminal justice system, mental health courts have been instituted to remove mentally ill people from the criminal justice system, enforce continued therapy, or order mental health therapy for offenders who come into contact with the criminal justice system as a result of behavior linked to their mental illness. The theory supporting mental health courts is that such courts are sensitive to the issues of mental health and mental illness and they will be able to address the root causes of mentally ill offenders coming into contact with the criminal justice system.

Four mental health courts have served as models for how a mental health court can be constructed and implemented. The success of these four courts were partially the impetus for the

² Goldkamp, J. and Irons-Guynn, C. (2000). EMERGING JUDICIAL STRATEGIES FOR THE MENTALLY ILL IN CRIMINAL CASELOAD: MENTAL HEALTH COURTS IN FORT LAUDERDALE, SEATTLE, SAN BERNADINO, AND ANCHORAGE. Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice: Washington, D.C. NCJ182504 at vii.

³ Id.

passage of the America's Law Enforcement and Mental Health Project Act. These four mental health courts, located in Broward County Ft. Lauderdale, FL; Seattle, Washington; San Bernardino, California; and Anchorage, Alaska all have some common characteristics. All four have voluntary participation by the defendant and only accept defendants who have "demonstrable mental illness likely to have contributed to their involvement in the criminal justice system."⁴ The objective of the court is to prevent the jailing of the mentally ill and the "predominant focus [is] on misdemeanor and other low-level offenders [with] careful screening or complete exclusion of offenders with histories of violence."⁵ Mental health courts seek to "expedite early intervention" of mentally ill patients by screening and making referrals to treatment agencies in a coordinated effort within a very short period of time after arrest.⁶ The goal of mental health courts is to create and maintain an increased coordination and cooperation between various agencies that can offer treatment and management of the mentally ill. *The purpose of the mental health court is to prevent mentally ill defendants from being placed in jails or prisons when other less restrictive options are available.* The judge in the mental health court is the center of the treatment and supervision process and provides the incentive for cooperation and completion of treatment.⁷

I. Issues raised by the implementation of mental health courts

Like drug courts, one of the first issues is the *identification of the target population* to be served by the special courts. "To be effective, mental health courts. . . need to identify mentally

⁴ Id. at viii

⁵ Id.

⁶ Id.

⁷ Id.

ill or disabled candidates at the earliest possible stages of processing to avoid the damaging experience of arrest and confinement, to intervene medically to stabilize offenders and then to situate them in an appropriate placement process.”⁸ Additionally mental health courts need to address three issues when attempting to *create and implement appropriate and effective screening procedures* – (1) the timeliness of the evaluation (swiftness between contact with the system and the evaluation); (2) the accuracy of the evaluation and (3) the confidentiality of the results of the evaluation.

In addition to the issues of appropriateness and effectiveness of the evaluation, mental health courts have to contend with certain inherent conflicts and limitations on its operations due to the safeguards with the criminal justice system itself. Like other problem solving courts, mental health courts require the defendants’ *voluntary participation*. Voluntary participation, when dealing with mental health courts, presents two different problems to the operation and the effectiveness of the program. First, as a voluntary program the court will not have access to all the defendants who would benefit from the program. The program participants will be self-selected. Secondly, the “mental health courts . . . must confront questions about a person’s mental capacity and ability to comprehend the proceedings and the options being provided. [Q]uestions may be raised about the ability of persons to really understand the choices being presented and the consequences of those choices If a requirement for voluntary participation in the [mental health] courts is not only competency as legally defined, but also an ability to understand and make reasonable decisions, then achieving voluntariness among mentally ill or disabled treatment candidates is a challenging proposition.”⁹ The concern with the issue of

⁸ Id. at x

⁹ Id. at xi

voluntariness is that “defense counsel and/or the court may make decisions in the candidate’s best interest when in fact the candidate, though competent, is thoroughly confused and afraid.”¹⁰

Another area of concern that a mental health court design must address is the *conflicts that arise between social service agencies and between social service agencies and the criminal justice system*. For example, substance abuse treatment professionals tend to have higher toleration for relapse or multiple relapse in drug treatment than a judge or a probation officer. While the criminal process has an interest in the swiftness of its process to adjudication and case finality, mental health professionals require greater amounts of time and deliberation to make a diagnosis of a mental health defendant. Issues of privacy, client confidentiality and differences in purpose for securing information about a clients mental state can interfere with the functioning of a mental health court.

The complexity of mental illness or co-occurring substance abuse and mental illness can make *specific formulation of success* difficult. “Mental health court participants may suffer from a variety of symptoms and illnesses and, thus, lack a common starting point. The steps necessary to stabilize participants . . . are likely to differ considerably from individual to individual.”¹¹ More practically, mental illness takes much longer to “cure” than a drug addiction. Since a court can’t say “be cured within 12 months”¹² a mental health court has a challenge in defining what it wants to accomplish, how it will be accomplished and the measurement of stated goals and objectives.

The assumption underlying the operation of a mental health court is that the court has the *resources for referral to mental health services* that can be used when a mentally ill defendant is

¹⁰ Id at xii

¹¹ Id. at xii – xiii

¹² Id. at xiii

before the court. In other words, the key to the success of a mental health court is the resources that it has at its disposal. One of the problems that may occur with a functioning mental health court is that resources (both private and governmental) that deal with the needs of the mentally ill will receive an increased load, a load it may not be willing or able to accept. Put simply, the court would funnel more cases onto the mental health service system that they may not be able to support regardless of court instructions.

Each of the mental health courts described in this report have identified potentially large populations of mentally ill and disabled defendants who are in need of mental health and related supportive services. Each has also found that treatment resources and funding are insufficient for the populations they are serving and plan to serve in the near future. When resources exist, they do not adequately provide the type or range of services the mentally ill and disabled persons in the criminal justice population require.¹³

The problem of inadequate community treatment resources to deal with mentally ill people before they come into contact with the criminal justice system is not changed by the fact that the criminal justice system orders treatment for them. The lack of services remains a factor to be addressed independently of the creation of mental health court.

The mentally ill come to the attention of the criminal justice system through quality of life violations (violation of nuisance statutes, loitering, urinating in public, laude behavior, ect.). But they can also come to the attention to the criminal justice system through more serious misdemeanors, drug offenses and sometimes through violent acts against themselves or others. "In many instances, the mentally ill or disabled find themselves in the criminal justice system

¹³ Id. at xiv

primarily because of their mental illness and their inability to connect with or stay in supportive community-based treatment services.”¹⁴

II. Summary of issues for the planning and implementation of a mental health court

Mental health courts must address the following to implement functional programs:

1. Development of strategies for identification of mentally ill defendants;
2. Implementation of early screening processes;
3. Efficient, timely and accurate identification of mentally ill defendants;
4. Establishment of cooperation and coordination of private and government mental health service providers and agencies;
5. Establishment of due process safeguards for defendants;
6. Procedures to determine voluntariness, competency, and client understanding of the process beyond the legal definition of competency;
7. Procedures to address and settle conflicts between social service agencies and between social service agencies and the criminal justice system;
8. Identification of measures of success with the understanding of the special nature of mental illness and its inability to be “cured” in the short term.
9. Securing the needed resources in order to give a mental health court judge options beyond those that already exists and are available to any judge. The increase in and creation of new resources to deal with mental health patients is key to the success of mental health court.
10. Training for police and court personnel in how to deal with mentally ill defendants and how to recognize criminal behavior that is the result of a mental illness.

“At the core of the mental health court approach is a newly established working relationship between the supervising court and community mental health treatment and related

¹⁴ Id. xv

services.”¹⁵ The goal is to remove the mentally ill from the custody of the criminal justice system and return them to community mental health services and “prevent mentally ill and disabled individuals from entering the justice system in the first place.”¹⁶

III. Summary of the four Mental Health Courts that are used as models by the U.S. Department of Justice

A. The Broward County Mental Health Court

The Broward County Mental Health court started operations on June 6, 1997 through an administrative order by the Chief Judge of the Florida 17th Judicial Circuit.¹⁷ The mental health court was formed out of work conducted by the Mental Health Task Force that was started in 1994 by the Honorable Mark A. Speiser a 17th Judicial Circuit Judge due to concern about the level of care and placement of mentally ill defendants.¹⁸

The nation’s second Mental Health Court¹⁹ has the following mission and purpose statements:

The mission of the mental health court is to address the unique needs of the mentally ill in our criminal justice system.

¹⁵ Id at xvi

¹⁶ Id.

¹⁷ 17th Judicial Circuit Mental Health Task Force, Fiscal and Data Subcommittee (1998). THE NATION’S FIRST MENTAL HEALTH COURT PROGRESS REPORT. 17TH Judicial Circuit Court: Ft. Lauderdale, Florida

¹⁸ Id.

¹⁹ Although the BJA report, supra note 2 at 9 claims that the Broward County Mental Health Court was the nation’s first mental health court; my research has found that the first mental health court was in Indianapolis, Indiana. The mental health court was located within a county mental health hospital. The program allowed for mentally ill patients to be brought and held in the same mental health center that housed the mental health court. The program procedures and operations were similar in fashion to the four reviewed in this white paper and began operation in January 1980. See Sipes, G., et al (1986). *A Hospital-Based Mental Health Court*. COMMUNITY MENTAL HEALTH JOURNAL 22(3): 229 – 237. The article is attached in appendix three.

The purpose of the Mental Health Court is to expedite the mentally ill defendant through the criminal justice system by balancing the needs of both the defendant and the community.²⁰

The stated *guiding principles* for the mental health court include the *involvement of the family members*, ensuring that *those with mental illness are provided access* to appropriate and flexible mental health services, with the acknowledgement that the *mentally ill inmate in jail is a concern of the community* as a whole, that the *creative uses of existing resources* can produce needed changes without the infusion of new funds, that *targeting the coexisting disorders* of mental illness and substance abuse is a priority and *cross training* of court and law enforcement personnel is crucial.²¹

The Broward County Mental Health Court only handles misdemeanor cases involving mentally ill defendants.²² The selection of misdemeanor defendants was made to focus on defendants who “without treatment and supportive services, could become involved in more serious matters at a later time when appropriate treatment would be more difficult to arrange.”²³ The court seeks to handle defendants whose mental illness is the cause of the behavior that brought them into contact with the criminal justice system in the first place. To be eligible for the court, a defendant must have a diagnosis of a mental illness on Axis I of DSM IV, have an organic brain injury or head trauma, or be developmentally disabled.

The Broward County Mental Health Court serves as a pre – adjudication court in an effort to handle cases as early in the judicial process as possible in order to locate and provide

²⁰ Supra note 17.

²¹ Id.

²² Supra note 2 at 10.

²³ Id.

services to defendants who are mentally ill. Many candidates “are identified at the misdemeanor bail stage within 24 hours of their arrest.”²⁴ Advanced doctoral students from Nova Southeastern University screen clients who are in custody for signs of mental illness prior to formal court hearings. Any defendant in custody found to have signs of mental illness or who admits to having past contact with mental health services is housed in a special mental health section of the jail and is given a full assessment by a psychiatrist from Emergency Medical Services Associated (EMSA) which is contracted with the Broward County jail to provide mental health and other medical services for the jail.

Defendants are referred to the Mental Health Court if mental illness is found to exist – but the defendant does not pose a threat to him/herself or others. Referrals to the court can come from police, other judges, defense counsel, the defendant’s family or other mental health providers. The court has the resources to provide temporary housing and temporary in-patient mental health care²⁵ for defendants who have acute episodes of mental illness and are unstable. If a defendant is found competent, the court holds a probable cause hearing to inform the defendant of the charge and to inform the defendant of the Mental Health Court options. The defendant is given the option of entering treatment under the jurisdiction of the court. During the time the defendant is under mental health court supervision, periodic case reviews occur at 2 – 4

²⁴ Id. at 11. “At the initial stages, once a referral is made, the court monitor [provided by the Henderson Mental Health Center, funded by Broward County] interviews the defendant [and] checks to see if the defendant is already in mental health treatment and, if so, consults with [the] caseworker If the defendant is not already in treatment, he is referred to the Henderson clinic or the Nova University Community Mental Health Center to determine whether he meets the mental health eligibility requirements.” Id. at 18.

²⁵ Henson Mental Health Center and Nova University Community Mental Health Center provide short term and long-term residential treatment, including supportive housing, substance abuse treatment, and assertive community treatment. The court also has at its disposal the presence of its own transitional housing program called the “cottages in the Pines” which provides 24 beds to provide up to 5 months of housing. The cottages are located on the grounds of the Henderson Mental Health Center. The cottages provide primary health care, substance abuse treatment, daily medication dispensing and vocational training. The court also has at its disposal the “Options” program which is an out-patient program run by Nova Southeastern University that provides gender assistance to women suffering mental illness due to sexual and physical abuse.

week intervals. The court maintains jurisdiction over the cases for one year. If the client remains in treatment the charges are either dropped or not adjudicated by the court.

The whole process of the Broward County Mental Health Court reflects a philosophy of being a “supportive, instructive, problem – solving and understanding” court in which a “respectful and helpful manner towards participants” is shown, demonstrated by the “careful use of language that is sensitive to the issues related to mental illness” when addressing defendants with mental illness.²⁶ The reason for the increased sensitivity to language and tone of the court towards the defendants is the result of the belief that how the defendant is addressed and dealt with can aggravate or alleviate the mental illness of the defendant. To meet this philosophy, court staff are not assigned on a short term basis, but rather they are assigned long term and become specialists in handling defendants with mental health issues. The court acts as a problem solver in that issues are not postponed, “the judge seeks to have answers and problems solved before sending a participant out of the courtroom or back to jail to await another hearing. *With each of the appropriate agencies and functions represented in the courtroom, the judge is able to craft and implement a response and to request necessary action and follow up on the spot.*”²⁷

Some basic stats:²⁸

1.	Cases heard Between July 1997 - June 2000	1, 534
2.	Cases heard Between July 1999 – June 2000	652

²⁶ Supra note 2 at 17. “In the Broward Mental Health Court, understanding and communication are viewed as part of the problem-solving process. In some cases, the judge speaks very slowly and waits patiently for participants to understand and respond. The patience and tolerance for the problems of comprehension and communication that defendants may have create an impression that speedy disposition of a large number of cases is not necessarily high priority.” Id at 18.

²⁷ Id. (Emphasis added)

²⁸ 17th Judicial Circuit Mental Health Task Force, Fiscal and Data Subcommittee (2000). THIRD ANNUAL MENTAL HEALTH COURT PROGRESS REPORT. 17TH Judicial Circuit Court: Ft. Lauderdale, Florida.

3. Average number of cases heard per month 54
4. Average number of cases active at the end of each month 124
5. The number of new cases referred between July 1999 – June 2000 was 39% over the same period last year.
6. The average number of active cases at the end of each month between July 1999 – June 2000 was 48% over the same period last year.
7. Average number of status hearings each month 73 cases
8. Average number of status hearings per client 2 hearings
9. Males comprised 69% of the caseload
10. Percentage of clients 41 – 54 years old 39%
11. Average age of clients 39.9 years old
12. Minimum age of clients 18.4
13. Maximum age of clients 77.8
14. 55% White, 33% Black, 5% Hispanic, 6% unknown
15. 26% of clients homeless
16. 54% of total clients have serious and persistent mental illness
 - a. 54% mental illness only
 - b. 16% mental illness & substance abuse
 - c. 2% substance abuse or dependence
 - d. 2% developmentally disabled
 - e. 26% undetermined
17. Of the 98 defendants who were homeless at first court appearance between January 1, 2000 and June 30, 2000
 - a. 39% schizophrenia
 - b. 27% major depression
 - c. 21 bipolar disorder
 - d. 75% males
 - e. Average age was 42
 - f. 51% white and 35% Black
 - g. 59% had no mental health benefits
 - h. 23% had Medicaid or S.S. Income

18. Of the 101 defendants who had an appearance between January 1, 2000 and June 30, 2000
 - a. 27% were diagnosed with schizophrenia
 - b. 25% major depression
 - c. 24% bipolar disorder
 - d. Average age 39 years old
 - e. 57% White, 5% Hispanic and 3% Black
 - f. 43% no mental health benefits
 - g. 34% had Medicaid and S.S. Income

B. The King County District Court Mental Health Court

The King County District Court Mental Health Court began operations on February 17, 1999 as a result of recommendations made by the Mental Health Court Task Force in August 1998.²⁹ The task force was formed by the King County District Court Presiding Judge in response to recommendations made by the King County Mentally Ill Offender Task Force to develop a pilot Mental Health Court and a site visit to the Mental Health Court in Broward County, Florida.

The task force sought to create a mental health court to address the problem of case processing at the misdemeanor level that “fails to address the needs of mentally ill offenders [which] requires [mentally ill] defendants to appear before a number of judges on the same case [which] creates barriers that prevent the Court from identifying and addressing the unique needs of the mentally ill offender.”³⁰ The task force observed that the current system did not allow the court to take a detailed interest and understanding of mentally ill defendants and what causes their repeated entrance into the criminal justice system. The task force took note of research that showed that mentally ill defendants in the King County Jail who were placed in the Psychiatric Unit of the jail and were charged with misdemeanors had an average of six prior arrests and

²⁹ King County Mental Health Court Task Force (1998). RECOMMENDATIONS FOR THE KING COUNTY MENTAL HEALTH COURT. King County Mental Health Task Force: Seattle, Washington.

³⁰ Id. at i

placements in the jail in the three years prior to their current offense. Inmates with mental illness, on average, stayed in jail three times as long as the average inmate.

The task force made eleven recommendations which included the formation of a mental health court in which a *judge, prosecutor and public defender be exclusively dedicated to the Mental Health Court*. Additionally, they recommended that *a monitor and probation officers be trained and exclusively assigned to the Mental Health Court* to prepare and monitor treatment plans for mentally ill defendants. The Mental Health Court would be a fully functional court in that it would maintain daily first appearance and case status review calendars. In other words the *Mental Health Court would exclusively handle mental health cases on a daily basis*.

The King County Mental Health Court is modeled on the Broward County (Ft. Lauderdale) Florida Mental Health Court. The King County Mental Health Court has the following mission statement:³¹

The Mental Health Court will strive to increase public safety and humanely deal with individuals with mental disorders who enter the criminal justice system. This court is committed to focusing resources, training, and expertise on the unique needs of these individuals.

The goals of the court³² are similar to those in Florida in that the King County Mental Health Court will seek to:

1. Reduce the number of times mentally ill offenders come into contact with the criminal justice system in the future;
2. Reduce the inappropriate use of institutionalization for people with mental illness;
3. Improve the mental health and well-being of the defendants who come in contact with [the] Mental Health Court;

³¹ Id.

³² Id at 7 – 8.

4. Expedite case processing;
5. Develop greater linkages between the criminal justice system and the mental health system;
6. Protect public safety; and
7. Establish linkages with other County agencies and programs that target the mentally ill population in order to maximize the delivery of services.

The District Court Mental Health Court has jurisdiction over defendants who are charged misdemeanors who also have or are believed to have a mental illness. The “Mental Health Court *candidates include individuals whose crimes or charges appear related to mental illness, who have been referred for competency evaluations, whose medical histories include a diagnosis of a major mental illness or an organic brain impairment, or who are determined by court clinicians to need mental health treatment.*”³³ The court has *jurisdiction over those who have prior convictions, both felonious and misdemeanor, if the prior act is believed to be a “causal factor” of the prior act or “the current offense” before the court.*³⁴ The Mental Health Court believes that it can supervise offenders, even those with prior dangerous offenses, properly. Originally, the program was designed not to function as a straight diversion program – defendants were required to agree that the case will not proceed to trial and accept court treatment as a plea agreement or in return for suspension of prosecution. The program has since adjusted and defendants can “enter the court through a statutory petition for deferred prosecution or an agreement with the prosecution for a deferred sentence. With successful participation in

³³ Supra note 2 at 23.

³⁴ Id.

the Mental Health Court, these defendants are much more likely to have charges withdrawn and not reflected on their records.”³⁵

Most of the defendants enter the Mental Health Court process with misdemeanor arrests and informal assessment at the Kent County Detention Center. Although defendants can be referred to the Mental Health Court through other court judges, police, probation officers, family members or other social service agencies, the majority of program participants are in custody misdemeanor arrestees. When a detainee is suspected of having a mental illness or serious mental problems the defendant is informed of the Mental Health Court program and the jail staff seeks the defendant’s consent to “share the information in the assessment with the Mental Health Court.”³⁶ If the defendant appears to the jail staff to be incompetent, the Mental Health Court is contacted with the name and charges of the defendant only. If the defendant gives consent all of the information is sent to the Court. Upon receipt of information from the jail, the Mental Health Court team is notified by e-mail in order to provide time for the team members to prepare for the defendant’s hearing – “usually the following afternoon.”³⁷

Before the first court appearance, the Court Monitor interviews the defendant and takes time “getting to know the defendant” and secures consent to review the defendant’s treatment history.³⁸ The goal of the Court Monitor is to get as much information as possible in order to draft a report on the defendant “containing information about the defendants history, including any current medications, history of compliance with treatment, behavior at home and/or in the

³⁵ Id.

³⁶ Id. at 24.

³⁷ Id. at 24, 26.

³⁸ Id. at 26.

jail, as well as information about housing and family support, if any.”³⁹ The Monitor also prepares a treatment plan that would be effective if the defendant agrees to participate in the program and is released. The goal is to have this treatment plan completed before the defendant goes before the court, which would inform the court of the defendant’s living arrangements and provisions for treatment and supervision.

The defendant appears before the court in order to have a hearing to determine probable cause sufficiency. This occurs if the Mental Health Court is the first court to review the cases after arrest. Upon a finding of probable cause, the Mental Health Court proceeds to address the competency of the defendant and his release or further detention. Once the court finds that the defendant is competent, the judge determines if the defendant is an appropriate candidate for the program and whether the defendant wants to participate in the program.⁴⁰ If the judge finds that the defendant is competent but unstable, the judge determines what levels of treatment and services are needed to make sure the defendant can make an informed decision about entering the program. If the defendant agrees to participate, the judge reviews the service plan and approves it; the defendant is released as soon as a probation officer and case manager can organize proper supervision. If the defendant does not have a stable residence, the defendant is held until a shelter bed or some other arrangement can be made. The defendant remains in custody, under supervision of the Mental Health Court and Court Monitor, until release can be organized utilizing the court approved plan.⁴¹

³⁹ Id.

⁴⁰ Id at 28.

⁴¹ Id.

Defendants who agree to the program must have their charges addressed either by “entering a plea of guilty or no contest to the misdemeanor charges, petitioning for a deferred prosecution, or entering an agreement with the prosecutor for a deferred sentence.”⁴² In a deferred prosecution no finding of guilt is entered and upon successful completion of the program the charges can be dismissed by agreement by the prosecutor or by court order.⁴³ The deferred sentence allows the defendant to plead guilty but if the defendant successfully completes the program the defendant can have the charges dismissed by agreement with the prosecutor or by court order.⁴⁴ “In most cases, the defendant will be placed on probation in the mental Health Court for up to 2 years or will receive a suspended sentence of up to 1 year while participating in the program.”⁴⁵ Once a defendant agrees to participate in the Mental Health Court program a probation officer coordinates the implementation of the plan with the caseworker and the court case manager. The defendant is required to appear before the Mental Health Court for case reviews and determination of compliance with the treatment plan. Any problems with compliance are addressed with the use of incarceration being the very last resort – “jail is what the Mental Health Court is seeking to avoid.”⁴⁶

About 15% of the defendants who appear before the court at first appearance are suspected of being incompetent and they are referred to the Western State Hospital for competency evaluation by court order.⁴⁷ Those defendants who are found to be competent are

⁴² Id at 29.

⁴³ Id.

⁴⁴ Id.

⁴⁵ Id.

⁴⁶ Id. at 31

⁴⁷ Id at 27

returned to the Mental Health Court. Under state law, a defendant can be held up to 14 days to determine competency. Defendants who are charged with a felony and (1) have a history of violence, or a history of insanity, or charged with a violent felony, or (2) have been previously acquitted by reason of insanity or been previously found incompetent involving a charge of actual, threatened or attempted physical harm to another person, or (3) not found to be competent after 14 days may be held for an additional 14 days in an attempt to restore competency. If after 28 days the defendant is not restored to competency, the charges are dismissed and the defendant is detained consideration of civil confinement. Defendants who do not meet these criteria cannot be held the additional 14 days but can be held for consideration of civil confinement.

Some relevant stats:

Between February 19, 1999 and December 31, 1999, 199 defendants were referred:

- a. 76% were male;
- b. 61% were between 31 and 50;
- c. 74% were White;
- d. 51% were referred by jail;
- e. 43% were referred by other judges;
- f. 3% were referred by defense counsel;
- g. 3% were referred by family members and probation officers;
- h. 71% were in custody at the time of referral;
- i. 55% of the referred defendants were not in mental health treatment at time of referral;
- j. 25% of the referrals were homeless; and
- k. 22% were able to live independently.⁴⁸
- l. 27% (54 defendants) refused to participate; and
- m. Of the remaining 145 defendants;
 - a. 69 defendants (48%) chose to participate
 - b. 33 defendants (23%) were undecided as of Dec. 31, 1999
 - c. 6 cases were closed
 - d. 17 cases were dismissed
 - e. 13 cases found not to be appropriate for the court
 - f. 7 cases in which the prosecution did not file charges

⁴⁸ Id. at 24

- n. Of the 69 defendants who chose to participate
 - a. 35 plead guilty
 - b. 8 received stipulated orders of continuance
 - c. 6 were granted deferred prosecution
 - d. 20 were referred from other courts, either already being on probation or having been sentenced and having sentences transferred to the mental health court
 - e. As of December 31, 1999 – 63 participants were on active probation.⁴⁹

C. The Anchorage Mental Health Court

The Anchorage “Mental Health Court” is actually the combination of two initiatives. On July 6, 1998 as a result of findings by the Alaska Criminal Justice Assessment Commission and its Decriminalizing the Mentally Ill subcommittee, the Jail Alternative Services Pilot Program (JAS) was instituted.⁵⁰ The JAS program was instituted as a “special jail-based program to provide placement in community mental health treatment programs for inmates” with the additional aid of reducing jail overcrowding by removing mentally ill inmates who were incarcerated on misdemeanor charges.⁵¹ On April 14, 1999 the Presiding Judge of the Third Judicial District (Anchorage) signed an administrative order that officially established the Court Coordinated Resources Project (CCRP). While the JAS program dealt with providing community mental health services for inmates, the CCRP was established as a court-centered approach to identify and treat “mentally ill persons in the criminal caseload in the Anchorage District Court.”⁵² The CCRP program was “designed to provide an alternative to jail and routine adjudication of misdemeanor cases for persons with mental disabilities by instituting special

⁴⁹ Id. at 30

⁵⁰ Id. at 35

⁵¹ Id. at 35 – 36.

⁵² Id. at 35

procedures that allow trained judges to address and treat mental illness and create more effective linkages and coordination between the courts, other justice agencies and mental health resources.”⁵³ Unlike other mental health courts, the CCRP program does not call itself a mental health court “to avoid the stigma that might be associated with participation in a court designed to respond to the mentally ill.”⁵⁴

The two-pronged program, JAS and CCRP, have five broad purposes:

1. To preserve public safety;
2. To reduce inappropriate incarceration of mentally disabled offenders and promote their well-being;
3. To relieve the burden on the Department of Corrections presented by inmates with mental disabilities;
4. To reduce repeated criminal activity among mentally disabled offenders (legal recidivism); and
5. To reduce psychiatric hospitalization of mentally disabled offenders (clinical recidivism).⁵⁵

The administrative order creating the CCRP program noted that the “failure to provide appropriate services [for mentally ill] offenders has [led] to a revolving door of clinical and legal recidivism among the mentally disabled and has increased the risks to public safety.”⁵⁶ The order noted that there were three additional needs that the CCPR program would address.

⁵³ Id. at 36. The CCRP program “aims at a broader population [than the JAS program]. It accepts mentally ill persons in the misdemeanor population whether or not they are confined. Although CCRP places some defendants in the JAS Program, it draws upon a large array of community mental health and other supportive services. [The aim is] to link mentally ill defendants with community-based mental health services.” Id.

⁵⁴ Id.

⁵⁵ Alaska Mental Health Court Project Summary (1998). <http://akmhcweb.org/mhcourt/mhcourt.htm>

⁵⁶ Id.

These needs are as follows:

1. The need for a more humane approach to divert defendants, with mental disabilities from overcrowded jails and into community treatment;
2. The enormous financial and administrative burden on the Department of Corrections as the largest provider of institutional mental health services in the state; and
3. The need for specialized, trained mental health court judges and for centralized coordination of court, agency, and mental health resources.⁵⁷

The JAS (Jail alternative Services) program is a restrictive program; only a defendant who is in custody on misdemeanor charges with a history of diagnosis for major mental illness with a history of psychosis or organic brain injury is eligible. The program is limited to 40 participants of which 5 must be defendants suffering from organic brain impairments. The Court Coordinated Research Project (CCRP) program is not as restrictive as the JAS program. To be eligible for the CCRP program the defendant must be charged with a misdemeanor offense (in or out of custody) and either have a history or show signs of mental illness, developmental disability, or organic brain syndrome. Unlike the JAS program, a defendant does not need a history of psychosis and the CCRP program does not have a limitation on the number of participants. Candidates for the CCRP program are referred from the Department of Correction jail staff, defense attorneys, other judges, family members or other sources.

The Court Coordinated Resources Project (CCRP) has full jurisdiction over state and municipal misdemeanor offenses. A defendant who is arrested goes before an arraignment judge within 24 hours after arrest. The jail staff make initial determinations of whether a detained defendant is eligible for the CCRP or JAS program. If jail staff believe a defendant is eligible for either program, the JAS Coordinator is contacted who in turn notifies the CCRP court. The JAS Coordinator meets with the defendant and if he/she is interested in the JAS program, the

⁵⁷ Id.

JAS Coordinator makes a determination of eligibility. If the defendant is JAS eligible, the JAS Coordinator drafts a report with a brief history of the defendant's mental illness and a treatment plan. The report is sent to the court, the prosecutor and defense counsel. If the defendant does not meet JAS requirements but wants to participate in the CCRP program, the jail staff makes the referral to the CCRP court.

At the first CCRP court hearing, the Judge makes a final determination as to JAS or CCRP program eligibility. The court also makes certain that the defendant understands what is going on and has voluntarily decided to enter the JAS or CCRP program. To enter the program the defendant must plead guilty or no contest to the charge in exchange for a plea agreement that the sentence will not include jail. Once the plea is entered and accepted, the defendant is sentenced. "Typically, the adjudicated defendant receives a probationary term with a suspended sentence, with treatment through CCRP as a condition of probation. [T]he probationary sentence in mental health court is usually between 3 and 5 years . . . defendants are not eligible to have their charges dismissed upon successful program completion."⁵⁸ The sentence will include, in JAS cases, a treatment plan that will be ready to be implemented upon the release of the defendant. The defendant will not be released until the treatment plan is set up. CCRP clients tend to wait in custody for longer periods of time than JAS clients because CCRP cases do not have a caseworker to prepare the program before release. Defense counsel and state mental health services are expected to make the proper arraignments for the treatment plan.

Under the JAS program, a defendant who meets the criteria the JAS Coordinator, who also is the JAS Caseworker, is assigned to link the defendant to community treatment, oversees the treatment process and reports to the CCRP court progress and potential violations. The JAS Coordinator holds regular meetings with the defendant and schedules review hearings before the

⁵⁸ Supra note 2 at 40.

CCRP court. Participants who have difficulty with compliance with the treatment plan have adjustments made to the plan to meet desired goals. Defendants who have continued treatment non-compliance are brought before the CCRP court, the court has options ranging from further adjustments in the treatment plan and increased case review to the last resort of revocation of probation and sentencing on the original charge which could lead to incarceration.

Under the CCRP program, eligible defendants will be released on probation to follow the court approved treatment plan as a condition for release. Due to a lack of funding the defendant is left to coordinate needed services on his own or with the assistance of his attorney. Monitoring of compliance occurs through reports from the treatment program the defendant is referred to, the prosecutor and by the CCRP court itself. CCRP defendants who do not comply with treatment plans can receive sanctions ranging from counseling with the court to revocation of probation and receiving full imposition of incarceration.

Some stats:

1. The CCRP program in fiscal year 1999 had a total of 129 participants; and
2. From July 6, 1998 to June 30, 1999 the JAS program had 138 participants.
3. Of the 138 JAS participants 26% agreed to participate in the program;
4. As of February 2000, the program had 49 active clients
 1. 71% were male;
 2. Average age 31 years old;
 3. 39% native Alaskans;
 4. 39% Caucasian;
 5. 20% African American;
 6. Majority have co-occurring substance abuse;
 7. Had an average of 7 prior convictions;
 8. Almost all had history of psychiatric hospitalization – average 10 prior admissions; and
 9. 17 were rearrested with the first years after sentence.⁵⁹

⁵⁹ Id. at 46 – 47

D. The San Bernardino (California) Mental Health Court

The movement to deinstitutionalize the mentally ill and the lack of services for the mentally ill in the community has contributed “to more mentally ill persons being found among the homeless, drug-addicted and criminal justice populations” in California.⁶⁰ The mentally ill have been estimated to make up 12% of the San Bernardino jail population.⁶¹ To address the problem of the presence of the mentally ill in jails in San Bernardino a task force was created and the result of their work was the formation of the Mental Health Comprehensive Offender Umbrella for Release and Treatment (MH COURT) program. The MH COURT program began in January 1999 in the San Bernardino Superior Court with the Supervised Treatment After Release (STAR) program being the key component.

The MH COURT program differs from other mental health court in that it will accept defendants of non-violent felony charges as well as misdemeanor charges. The program will also accept defendants with violent felony charges on a case-by-case basis if the facts of the case show that the incident was really non-violent and was related to the presence of a mental illness regardless of the violent felony charge. Because the MH COURT program is designed to address jail inmates or those who are bound for jail, only defendants who are in custody are eligible for referral to the MH COURT program. Additionally, only those who have a previously diagnosed and persistent mental illness and a history of recidivism are eligible. Additional requirements include residency in San Bernardino and either gainful employment or eligibility for SSI benefits.

After a defendant is arrested and arraigned the staff at the West Valley Detention Center identifies potential candidates for the MH COURT program. Three staff members (two Ph.D.s

⁶⁰ Id. at 49

⁶¹ Id.

in psychology and one licensed clinical social worker) conduct interviews with potential participants and secure consent to receive medical and criminal records to determine if the potential participant meets the program criteria for admission. If a defendant makes a request to be admitted into the program, the screening is passed on to the MH COURT team (the judge, the prosecutor, the public defender, the probation officer, the mental health case worker, the day treatment provider and sometimes the housing service manager) for review for admissibility.⁶² If any of the members object, the defendant is not accepted into the program. Processing and review of the defendant and his file is about 2 to 3 weeks from referral. This time is used for all the team members to prepare for the first MH COURT hearing and for the formation of plea agreements and treatment plan development. The 2 to 3 weeks is also used to stabilize the defendant before appearance in the MH COURT.

MH COURT hearings are held once a week and the team meets prior to court hearings to iron out any issues before the hearing. The first issue to be addressed at the hearing is competency. If the defendant is found competent, the plea is explained to the defendant. To enter the program the defendant must plead guilty to the charge and accept the terms of the plea, which include the treatment plan developed by the MH COURT team. Probation usually lasts for 2 years in misdemeanor cases and 3 years in felony cases. Upon successful completion the plea may be withdrawn, the charges may be dismissed and the defendant has the right to request that the charges be expunged.⁶³ If the defendant is found not to be competent the court orders a competency evaluation and a competency hearing is scheduled. Clients found to be incompetent,

⁶² Id. at 52, 54

⁶³ Id. at 53

are placed in a hospital until competency is restored.⁶⁴ Defendants, charged with felonies, can remain in the hospital up to 3 years or the maximum time for the crime charged – which ever is less.⁶⁵ Defendants charged with misdemeanors will more likely be placed in public or private treatment facilities to restore competency.

Once the defendant agrees to the plea and the plea is entered, the defendant is released into one of four augmented board-and-care residential treatment facilities (the program has an allotment of 24 beds)⁶⁶ and the caseworker assigned to the case visits the defendant to determine compliance with the treatment plan.⁶⁷ Status hearings are held about every 3 to 4 weeks to track compliance and address any problems. Non-compliance can result in sanctions ranging from reprimands from the judge to weekend incarceration. “Serious and willful” violation can lead to program termination.⁶⁸ New minor offenses do not require termination but new more serious offenses will result in program termination.⁶⁹

After a plea is entered and the MH COURT orders the defendant released, the defendant is transported by the case manager to one of four augmented board-and-care residential treatment centers operated by a licensed clinician who is authorized to dispense medication and provide counseling treatment (both individual and group). These augmented facilities provide 24 hour supervision with medical and counseling therapy as well as transportation to day treatment programs as ordered by the court. Clients move from these augmented facilities to regular

⁶⁴ Id. at 52

⁶⁵ Id. at 53

⁶⁶ Id. at 53 – 54

⁶⁷ Id. at 53

⁶⁸ Id. at 53 - 54

⁶⁹ Id. at 54

board-and-care facilities and then to basic room and board facilities. Each step is approved by the court and occurs upon successful treatment completion by the defendant. A private company, Mental Health Systems, Inc, provides the day treatment program (Pegasus). Defendants are in the day treatment program from 8:30 a.m. to 1pm five days a week. The Pegasus program provides various programming including counseling, pre vocational training, anger management and drug dependency counseling. The Pegasus program lasts for the first year of the defendant's participation in the MH COURT program.

The MH COURT has two new programs to address the needs of mentally ill patients who do not meet the requirements of the more intense program (STAR). The STAR LITE program provides intermediate programming similar to the more intense program but with less intense treatment.⁷⁰ The SPAN (San Bernardino Partners for Alternative Networking) program is designed "to provide case management and augmented services to in-custody defendants who had not been previously diagnosed, but rather were diagnosed with an Axis I illness in jail, and who are not chronic offenders. Lower level services are offered these defendants, and only regular board-and-care referrals are available for homeless participants."⁷¹

Between January 1999 and November 16, 1999:

1. 181 referrals were made to the MH COURT program (STAR)
 - a. 106 were evaluated;
 - b. 25 participants were accepted;
 - c. 81 rejected (majority of rejections due to the District Attorney);
 - d. 60% of participants were remanded to jail at least once;
 - e. 40% remanded to jail more than once;
 - f. 6 participants were terminated; and
 - g. 19 were active as of November 19, 1999.⁷²

⁷⁰ Id. at 55.

⁷¹ Id. at 56.

⁷² Id.

IV. **Summary and recommendations for planning to implement a Mental Health Program in Delaware**

The establishment of a mental health court will be a work intensive task. In the models cited, each location established a task force with memberships from the judiciary, mental health community, the District Attorney, the Public defender and funding sources to design the mental health court programs.

After review of reports from two of the programs and the federal report describing the four first mental health courts the following are recommended to the Delaware Criminal Justice Council Mental Health Sub committee:

1. **Quantitative research must be conducted to establish the need for a mental health court.**
 - a. A study on the **need for the mental health court.**
 - b. A study on the **types of charges mentally ill defendants receive after arrest.**
 - c. A study on the **types of mental illnesses** that mentally ill defendants have.
 - d. A study on the **state of community based mental health care available** to the mentally ill.
 - e. The **impact on the detention population** of having mentally ill defendants.

2. **Conduct an assessment of the criminal justice system and how coordinated mental health programs could aid in reducing the incarceration of the mentally ill and the improvement of community based programs for the mentally ill.**

Although it is presumed that the current system does not meet the needs of the mentally ill and that additional services are required to decrease the number of mentally ill in the Delaware Criminal Justice System – empirical research is needed to quantify this fact. Research and study is needed to map out what services exist and don't exist for mentally ill defendants. Specifically, a plan needs to be developed that, *on paper and in fact*, takes a defendant from arrest, provides services and special attention through the criminal justice process and provides services necessary to treatment completion. One of the key concepts of a mental health court program is that every possible problem with a mentally ill defendant is anticipated and answered. For example, a defendant is not competent – the court has resources to place the defendant in an inpatient facility in order to

restore competence. A defendant is homeless; the court has resources to find the defendant a bed before the defendant leaves the courtroom, and has the ability to physically get him there.

3. Conduct a cost analysis of a program specifically designed for dealing with the mentally ill defendant.

All four program summaries noted that they did not have enough resources; but each had enough resources to make the program functional. All four had enough funding, usually through the state, to provide in-patient treatment, accommodations for homeless defendants, day treatment counseling, drug addiction treatment, transportation, dedicated staff to perform needed reports and recommendations and intensive follow-up to make sure treatment plans were complied with. In other words, staff were specifically dedicated and trained for the implementation of the mental health court. The costs of these types of programs must be realistically assessed. The funds and resources need to be secured before the implementation of a mental health court. Lastly, the federal law authorizing funding for mental health courts requires statements of financial support for the mental health court after federal funds end.

4. Determine the judicial jurisdiction of a mental health court

All four programs had one specific court to handle the mental health cases. Delaware would need to do the same. Mental health courts generally take jurisdiction of misdemeanor cases but they can be designed to handle non-violent felony cases as well. Agreements will have to be made between the Attorney General, the Public defender and the Court on how defendants would be handled, assessed for eligibility for participation in the program and how plea agreements would be made. Agreements will have to include how charges will be handled upon successful completion. Additionally, questions such as does the defendant have to plead guilty to be allowed to participate will have to be discussed and decided upon.

5. Determine the population to be served by the mental health court

In addition to determining who will be served by the program (misdemeanor defendants, felony defendant or both) the mental health court design will need to determine if repeat offenders will be allowed and how the targeted population will be handled from point of arrest and/or detention. What procedures will allow for the immediate identification and referral of defendants to the mental health court?

6. Draft a mission statement for the mental health court

Two of the mental health courts have stated mission statements, goal statements and guiding principles that govern the operations of the program. A mental health court in Delaware will need to develop a set of similar principles. More

importantly, THE PROGRAM WILL NEED PERMENANT STAFF ON ALL LEVELS WHO TRULY BELIVE IN THOSE PRINCIPLES. The better models are those that have a court with dedicated staff who are trained to handle mentally ill defendants. In other words, those assigned to the court should be permanent not rotated.

7. Draft a mental health court plan that has the full and complete cooperation of various agencies and departments.

Partnerships and agreements need to be established with the Attorney General, the Public Defender, the private defense bar, the Department of Corrections, Department of Probation and Parole, the various departments that provide mental health services, private mental health service providers, the Delaware Judiciary, the Governors Office, the Delaware General Assembly (for funding at the very least), the Delaware Criminal Justice Council, private and/or public organizations for program evaluations and mental health experts for the planning and implementation of the mental health court.