MENTAL HEALTH COURTS: THE SILVER BULLET MADE OF RUBBER

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I. INTRODUCTION

Imagine Sam, a man you walk past daily on your way to work. He sits on the sidewalk with all of his belongings next to him, talking to himself, homeless. Unbeknownst to the public, Sam suffers from schizophrenia and has been unable to access necessary treatment. As time passes, people complain to law enforcement about Sam, and he gets arrested for trespassing. Sam returns to his spot after spending a few nights in jail because he does not have any other place to go. People complain about him again, and this time, he gets arrested for loitering.

Many Americans share Sam's reality of untreated mental health issues; those untreated mental health issues are often contributing factors to the commission of a crime, which ultimately leads to incarceration. Many offenders with untreated mental illnesses are trapped in the cycle of commission of a petty crime, arrest, incarceration, release, homelessness, commission of another petty crime, arrest, and re-imprisonment.[1] This is because the lack of treatment and coping skills, combined with criminal records, hinders these people from getting jobs. Thus, they are restricted from getting housing.

Before focusing specifically on offenders with mental health issues, it is important to look at overall incarceration rates to highlight the prison and jail overcrowding problem America faces today. Statistically, at the end of 2016, over 1.5 million people were incarcerated in a state or federal correctional facility.[2] In 2017, just under 800,000 people were incarcerated in American

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[1] LeRoy L. Kondo, *Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 28 AM. J. CRIM. L. 255, 257 (2001).

[2] E. ANN CARSON, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2016 1 (2018), https://www.bjs.gov/content/pub/pdf/p16.pdf [https://perma.cc/7XJ8-PYKB].

jails,[3] and just under 1.5 million people were incarcerated in a U.S. prison.[4] Although overall incarceration rates are slowly declining from peak imprisonment in 2009, fifteen states recorded increased incarceration rates from 2015 to 2016.[5] Additionally, many facilities are experiencing overcrowding problems. At the end of 2016, fourteen states and the Federal Bureau of Prisons (BOP) met or exceeded the maximum measure of capacity at prison facilities.[6] Likewise, twenty-seven states and the BOP reached or exceeded the maximum number of beds.[7]

High incarceration rates put pressure on the community and economy to financially support the inmates. In Fiscal Year 2017, the average annual cost to support one federal inmate was $36,299.25, or $99.45 per day.[8] Moreover, states must also absorb costs to house inmates. In Kansas, for example, the overall average annual cost to house an inmate in a state facility for Fiscal Year 2017 was $25,841.[9] Other states, such as New York, must absorb much higher costs the average cost to house an inmate for Fiscal Year 2015 in New York was an astonishing $69,355.[10]

A significant percentage of these inmates struggle with mental health problems, just like Sam. The Kessler 6 nonspecific psychological distress scale was used to determine the number of inmates struggling with serious psychological distress while incarcerated from 2011-2012.[11] Although these

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[3] ZHEN ZENG, BUREAU OF JUSTICE STATISTICS, JAIL INMATES IN 2017 1 (2019), https://www.bjs.gov/content/pub/pdf/ji17.pdf [https://perma.cc/4EKR-VP7L].

[4] JENNIFER BRONSON & E. ANN CARSON, BUREAU OF JUSTICE STATISTICS 1 (2019), https://www.bjs.gov/content/pub/pdf/p17.pdf [https://perma.cc/F3CV-2H2T].

[5] CARSON, *supra* note 2, at 4. The three states with the highest increases were South Dakota, Kentucky, and Maine. Each had incarceration rate increases of 7.5 percent, 6.1 percent, and 5.5 percent, respectively.

[6] *Id.* at 14; *Terms and Definitions: Corrections*, OFF. JUST. PROGRAMS, https://www.bjs.gov/index.cfm?ty=tdtp&tid=1 [https://perma.cc/7FQ3-K7LH]. Capacity is measured in three different ways: rated, operation, and design. *Terms and Definitions: Corrections*, *supra*. Rated capacity is the number of beds assigned by a rating official. *Id.* Operation capacity refers to how many inmates a facility can hold based on staff, existing programs, and services offered. *Id.* Design capacity refers to the number of inmates the facility designers intended the facility to hold at its construction. *Id.*

[7] CARSON, *supra* note 2, at 14. This article includes federal recidivism rates because the included data on mental health courts does not uniformly focus on one state. Because of this, it would not be helpful to include different states' recidivism rates.

[8] Annual Determination of Average Cost of Incarceration, Bureau of Prisons, 83 Fed. Reg. 18,863, 18,863 (U.S. Dep't of Justice Apr. 30, 2018).

[9] JOE NORWOOD ET AL., KAN. DEP'T OF CORR., ANNUAL REPORT FISCAL YEAR 2017 36 (2017), https://www.doc.ks.gov/publications/Reports/2017 [https://perma.cc/A78P-8YXC].

[10] *Prison Spending in 2015*, VERA, https://www.vera.org/publications/price-of-prisons-2015-state-spending-trends/price-of-prisons-2015-state-spending-trends/price-of-prisons-2015-state-spending-trends-prison-spending [https://perma.cc/76BV-BZG2].

[11] JENNIFER BRONSON & MARCUS BERZOFSKY, BUREAU OF JUSTICE STATISTICS, INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011-12 2 (2017), https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf [https://perma.cc/9ST8-HQHV]; R.C.

numbers are reflective of data from 2011-2012, this study was recently published in 2017.[12] This survey asked participating inmates how often they felt nervous, hopeless, restless or fidgety, so depressed that nothing could cheer them up, that everything was an effort, and worthless.[13] Participants answered based on a scale from zero to four: zero signifying none of the time, four signifying all of the time.[14] The answers were then scored on a scale of zero to twenty-four.[15] Scores thirteen and greater indicated serious psychological distress.[16] Based on this survey, about fourteen percent of state and federal prisoners, and about twenty-six percent of jail inmates suffered from serious psychological distress.[17] Among inmates held from 2011-2012, just under thirty-seven percent of state and federal inmates had been previously diagnosed with a mental disorder.[18] Additionally, about forty-four percent of jail inmates reported having been previously diagnosed with a mental disorder.[19] Though the Kessler 6 is a survey for inmates, answered by inmates, it indicates the prevalence of mental health problems among inmates.

In response to this prevalent problem, states throughout the nation have implemented mental health courts.[20] Ultimately, the goal of mental health courts is to reduce overall recidivism rates while breaking the dangerous repeat offender cycle discussed above.[21] These courts were created in hopes of linking offenders with mental illnesses with the treatment they need to improve their lives while diverting them from the criminal justice system.[22] Thus, the main question becomes whether these courts are positively impacting mentally ill offenders and the community as many believed they would.

From the creation of mental health courts, critics, field professionals, and others immediately began analyzing how these courts ran and why they were being created; many of these people ultimately supported the establishment of these courts.[23] As mental health courts became more prevalent, field

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Kessler et al., *K-6 Distress Scale – Self Administered*, MEASURE INSTRUMENT DATABASE SOC. SCI., http://www.midss.org/content/k-6-distress-scale-self-administered [https://perma.cc/U7AK-KMGN] ("The K-6 is a 6-item inventory rated on a 5 point Likert-type scale. It[']s a truncated version of the K-10 and its purpose is also to function as a global measure of distress drawing from depressive and anxiety related symptomology. It measures distress over a period of four weeks prior to administration of the test. The K-6 contains several additional questions; however, these are supplementary and are not required for scoring the K-6.").

[12] *See* BRONSON & BERZOFSKY, *supra* note 11, at 1.

[13] *Kessler Psychological Distress Scale (K6+)*, SCI. BEHAV. CHANGE, https://scienceofbehaviorchange.org/measures/kessler-psychological-distress-scale-k6/ [https://perma.cc/L6TN-6BXR].

[14] *Id.*

[15] BRONSON & BERZOFSKY, *supra* note 11, at 2.

[16] *Id.*

[17] *Id.* at 1.

[18] *Id.*

[19] *Id.*

[20] BUREAU OF JUSTICE ASSISTANCE, MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS 2 (2008).

[21] *Id.* at 8.

[22] *Id.*

[23] *See, e.g.*, Kondo, *supra* note 1.

professionals began reviewing how specific courts were functioning.[24] Most recently, professionals and advocates of mental health courts have attempted to measure the courts' effectiveness by evaluating their strengths and weaknesses, particularly by focusing on recidivism rates as one of the main benchmarks of success.[25]

This article will synthesize previously published data to analyze whether mental health courts are having a positive impact on offenders struggling with mental illnesses. Section II will describe the background of mental health courts. It will explain their creation, address how mental health courts work, and include typical elements of mental health courts. Beginning with a discussion on recidivism, Section III will synthesize available data on mental health courts' success rates and discuss whether they are lowering overall recidivism rates—a critical measure of mental health court success.[26] Section IV will then offer potential solutions to improve mental health courts since they have not had a significant impact on recidivism and rehabilitating offenders with mental illnesses. These suggestions will focus on improving the court process and reducing recidivism rates, while encouraging continuous rehabilitation for these offenders after exiting the mental health courts.

II. CONTEXT OF MENTAL HEALTH COURTS

To contextualize mental health courts, this section will discuss in detail why mental health courts were created, how they work, and what elements are important in their administration. Mental health courts were created in response to the societal realization that many inmates struggle with untreated mental illnesses.[27] These underlying, untreated mental illnesses contribute to individuals cycling through the criminal justice system unnecessarily.[28] Therefore, the purpose of mental health courts is to address problems associated with mental illnesses sometimes overlooked by the traditional justice system, while improving outcomes for those charged with crimes, the victims, and the community.[29]

In 1997, only four mental health courts existed nationwide.[30] Now, over

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[24] *See, e.g.*, Kirk Kimber, *Mental Health Courts—Idaho's Best Kept Secret*, 45 IDAHO L. REV. 249 (2008); John Petrila et al., *Preliminary Observations from an Evaluation of the Broward County Mental Health Court*, 37 CT. REV. 14 (2001).

[25] *See, e.g.*, Nancy Wolff & Wendy Pogorzelski, *Measuring the Effective of Mental Health Courts: Challenges and Recommendations*, 11 PSYCH. PUB. POL'Y & L. 539, 551 (2005); E. Lea Johnston & Conor P. Flynn, *Mental Health Courts and Sentencing Disparities*, 62 VILL. L. REV. 685, 686 (2017).

[26] *See* Bradley Ray, *Long-term Recidivism of Mental Health Court Defendants*, 37 INT'L J.L. & PSYCHIATRY 448 (2014); *see* Evan M. Lowder et al., *Effectiveness of Mental Health Courts in Reducing Recidivism: A Meta-Analysis*, 69 PSYCHIATRIC SERV. 15 (2018).

[27] MAIA PELLEG, THE EVOLUTION OF MENTAL HEALTH COURTS AND A PROSPECTIVE STUDY OF AGGREGATE: RECIDIVISM RATES FOR MENTALLY ILL CRIMINAL OFFENDERS 1 (2013).

[28] *Id.*

[29] BUREAU OF JUSTICE ASSISTANCE, *supra* note 20, at 3.

[30] *Mental Health Courts*, JUST. CTR., https://csgjusticecenter.org/mental-health-court-project/ [https://perma.cc/AQF7-EFJ8].

twenty years later, more than 300 mental health courts have been established throughout the country.[31] In addition to functioning as a response to the societal realization of the prevalence of mental illnesses among inmates, the establishment of these courts also served as a judicial response to public concerns about whether the judicial system was harming criminals struggling with mental illnesses.[32] Advocates for these offenders felt that this harmful treatment amounted to "criminalization of the mentally ill."[33] "Criminalization" refers to situations in which individuals dealing with mental illnesses, without a desire to break the law, are arrested for minor crimes or ordinance violations.[34] State legislatures have also responded to this fear by passing legislation governing the creation and implementation of mental health courts.[35]

A. *How Mental Health Courts Work*

Mental health courts utilize "specialized court dockets and employ a problem-solving, collaborative model of court processing for eligible mentally ill offenders."[36] This rehabilitative approach is aimed at treating the origin of the problem, the mental illness, rather than merely punishing the offender for the criminal conduct.[37] As problem-solving courts, mental health courts "divert mentally ill offenders away from jail and into long-term community mental health treatment."[38] Mental health courts are also intended to promote recovery and reduce recidivism rates.[39]

More generally than just mental health courts, typical problem-solving courts[40] share a few overarching characteristics that differentiate them from traditional courts:

> (1) a separate docket for specified defendants; (2) ongoing status hearings with a dedicated judge presiding over both the initial and subsequent status hearing; (3) a collaborative approach to decision-making with input from the judge, counsel, and relevant professionals;

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[31] LAUREN RUBENSTEIN, PRIOR MENTAL HEALTH TREATMENT AND MENTAL HEALTH COURT PROGRAM OUTCOMES 4 (2018).
[32] Ginger Lerner Wren, *Mental Health Courts: Serving Justice and Promoting Recovery*, 19 ANNALS HEALTH L. 577, 586 (2010).
[33] *Id.*
[34] Justin L. Joffe, *Don't Call Me Crazy: A Survey of America's Mental Health System*, 91 CHI.-KENT L. REV. 1145, 1157 (2016).
[35] *See, e.g.*, OKLA. STAT. ANN. tit. 22, § 472 (West 2014); S.C. CODE ANN. § 14-31-10 (2015); 730 ILL. COMP. STAT. ANN. 168-10 (West 2012). Oklahoma, South Carolina, and Illinois are three states that have passed legislation governing implementation of mental health courts.
[36] PELLEG, *supra* note 27, at 1.
[37] Gregory L. Acquaviva, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 985 (2006).
[38] *Id.*
[39] Wren, *supra* note 32, at 587.
[40] *See* PELLEG, *supra* note 27, at 29. "Problem-solving courts" refers generally to courts that use alternative methods other than traditional criminal prosecution. *Id.* at 27. This could include mental health courts, drug courts, veterans' courts, etc. *Id.* Instead of simply prosecuting offenders, these courts look for ways to help the offender by treating underlying problems. *Id.* at 29.

> (4) voluntary defendant participation; (5) intensive judicial supervision of participants; and (6) the possibility of reduced charges, sentences, or dismissal for successful program completion.[41]

Mental health courts function no differently than other typical problem-solving courts.

Though the purpose of all mental health courts is the same, the structure of each court can differ because each court can be strongly influenced by available funding, resources, and partners.[42] Additionally, because there is no accepted uniform approach to the detailed structure of mental health courts, more inconsistencies arise. In response to the inconsistencies, in 2008, the Bureau of Justice Assistance and Council of State Governments Justice Centers released a list of ten essential elements of a mental health court.[43] The ten elements were derived from existing courts (as opposed to separate research), and will change as mental health courts evolve.[44] Practically, the ten elements function more as recommendations than requirements.[45] The elements are as follows:

> **(1) Planning and Administration**. The planning and administration should be collaboratively run by those representing the criminal justice, mental health, substance abuse treatment, and related systems.
>
> **(2) Target Population**. Eligibility criteria should be well-defined, consider a community's treatment capacity, and consider the relationship between the mental illness and the offense.
>
> **(3) Timely Participant Identification and Linkage to Services**. Participants should be selected and begin the treatment program as quickly as possible.
>
> **(4) Terms of Participation**. These need to be clear, promote public safety, facilitate engagement in treatment, be individualized, and provide for positive legal outcomes for those who complete the program.
>
> **(5) Informed Choice**. Offenders need to fully understand the program requirements before entering a program, and are provided legal counsel to ensure this.
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> **(6) Treatment Supports and Services**. These should anticipate the

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[41] *Id.* at 28–29.
[42] John H. Guthmann, *Ramsey County Mental Health Court: Working with Community Partners to Improve the Lives of Mentally Ill Defendants, Reduce Recidivism, and Enhance Public Safety*, 41 WM. MITCHELL L. REV. 948, 963 (2015).
[43] *Id.* at 961.
[44] MICHAEL THOMPSON ET AL., BUREAU OF JUSTICE ASSISTANCE, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT viii (2007).
[45] *Id.*

needs of participants and work with providers to ensure availability of services.

(7) Confidentiality. Information pertaining to treatment and medical records should be kept confidential, and discussion of clinical information in open court should be avoided.

(8) Court Team. Criminal justice and mental health staff should receive ongoing training.

(9) Monitoring Adherence to Court Requirements. Courts should offer individualized sanctions or incentives to participants and modify treatment as necessary to adhere to requirements.

(10) Sustainability. Periodic data collection should be used to help increase sustainability in the future.[46]

B. *Eligibility Criteria for Participation in Mental Health Courts*

Once established, mental health courts may begin to accept participants. To participate in a mental health court, courts may require a referral from a variety of sources.[47] Examples of potential referral sources include criminal defense attorneys, judicial officers, and mental health professionals.[48] Moreover, an offender must satisfy both legal eligibility requirements (based on the type of crime committed) and clinical eligibility requirements (based on the mental health status of the individual).[49]

Legal eligibility refers to the level of crime committed by the mentally ill offender. However, there is no uniform standard governing legal eligibility; it may depend on the severity of the committed offense (whether it was a misdemeanor or a felony), or it might depend on whether the committed crime fit into a specific category of crime, depending on court-specific rules.[50] Originally, most mental health courts only accepted misdemeanor offenders.[51] The original limitation to misdemeanor offenders may have originated from public safety concerns.[52] Likely, people may have feared that felony offenders, even though offending because of their mental illness, were a danger to the public, and thus should not be able to participate in a non-traditional court system.[53] This fear has seemingly subsided as mental health courts have begun

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[46] *Id.* at 1–10.
[47] *See, e.g.*, Guthmann, *supra* note 42, at 967–68.
[48] *Id.*
[49] Eligibility criteria varies amongst mental health courts; therefore, it is important to look to specific requirements held by each court separately.
[50] PELLEG, *supra* note 27, at 42. Of surveyed mental health courts, half accepted both misdemeanor and felony offenders. *Id.*
[51] *Id.* at 43.
[52] *See, e.g.*, *id.*
[53] *Id.*

to take on more felony offenders than ever before.[54]

Additionally, as more research is completed, treatment providers and court professionals have begun to recognize that treatment needs and the severity of the committed offense may not be as related as people once thought.[55] A 2005 study showed that about two-thirds of federally funded mental health courts rendered clients with violent offenses automatically ineligible.[56]

However, misdemeanor offenses carry shorter sentences, so these offenders may be less motivated to elect mental health treatment due to the increased time and effort required as compared to serving a prison or jail sentence.[57] By focusing on felony offenders with lengthier sentences, treatment and continued care may be more meaningful than it would be for misdemeanor offenders.[58] This research has led to a shift in allowing more felony offenders to opt into a mental health court.[59]

Clinical eligibility focuses on the level of an offender's clinical mental illness.[60] As with legal eligibility, there is no uniform standard to determine if a defendant is clinically eligible.[61] Varying definitions exist regarding what constitutes a mental illness and its respective severity.[62] For instance, one definition of severe mental illness according to the Substance Abuse and Mental Health Services Administration[63] is "a diagnosable mental, behavioral, or emotional disorder . . . that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities."[64] Illnesses with episodic, recurrent, or persistent features—such as schizophrenia, bipolar disorder, and major depressive disorder—may be included in this category.[65] This definition is also followed by the U.S. Department of Health and Human Services, the National Institute of Health, and many state and local actors.[66]

Mental illness is defined in the same way but without a focus on the level of functional impairment.[67] Anxiety and personality disorders may be categorized as mental illnesses.[68] However, not every mental health court will

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[54] *Id.*
[55] *Id.* at 43–44.
[56] PELLEG, *supra* note 27, at 42–43.
[57] *Id.* at 42.
[58] *Id.* at 42–43.
[59] *See, e.g.*, THIRTEENTH JUDICIAL CIRCUIT COURT, ADULT MENTAL HEALTH COURT PROGRAMS POLICY AND PROCEDURE MANUAL 44 (2003); DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES (2018) [hereinafter DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES].
[60] THIRTEENTH JUDICIAL CIRCUIT COURT, *supra* note 59.
[61] PELLEG, *supra* note 27, at 44.
[62] *Id.* at 5–9.
[63] See *SAMSHA*, U.S. DEP'T HEALTH AND HUMAN SERVS., https://www.samhsa.gov/ [https://perma.cc/CYH8-CACZ], for more information on this administration.
[64] PELLEG, *supra* note 27, at 5.
[65] *Id.* at 5–6.
[66] *Id.* at 5.
[67] *Id.* at 7–8.
[68] *Id.* at 8.

follow these definitions in applying eligibility criteria. Even if they adopt these uniform definitions, the courts have discretion to deem, for example, only offenders with a severe mental illness eligible, or alternatively, they may deem them ineligible. The varying definitions and non-uniform standard of clinical eligibility is an example of the many inconsistencies present among mental health courts.

The Behavioral Health Court in Douglas County, Kansas (the BHC) illustrates one court's eligibility criteria. To be clinically eligible for the BHC, a defendant must have a severe mental illness, as determined through "State-approved criteria," which is never defined.[69] To be legally eligible, defendants must be charged with misdemeanor, nonviolent charges, although felony offenders or violent offenders may be eligible on a case-by-case review basis.[70] However, individuals who committed murder or sex crimes are ineligible.[71]

Additionally, the defendant must be a resident of Douglas County and agree to remain in the program for at least twelve months.[72] The last requirement regarding eligibility is that the participant must be willing to engage in community treatment services and sign a release of information about the treatment for the purpose of planning and supervision.[73] Once deemed eligible, Douglas County requires a recommendation for the offender.[74] These recommendations may come from prosecutors or defense attorneys, jail staff and treatment providers, police and probation officers, and Municipal and District Court judges.[75] The District Attorney must approve the participant, but ultimately, the BHC's judge makes the final decision.[76] Different mental health courts will require varying degrees of clinical and legal eligibility. These differences may appear in the requisite level of mental health problems (clinical eligibility) or in the level of offense (legal eligibility). The BHC is just one example of how one mental health court determines offender eligibility.

C. *Treatment Plans Utilized by Mental Health Courts*

In addition to varying eligibility requirements, treatment plans offered by courts also vary, depending on applicable court procedures and available resources, such as housing options, medication, and rehabilitation options.[77] To illustrate one treatment plan, again, the BHC will be utilized as an example.[78]

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[69] DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES, *supra* note 59. This brochure does not include the State-approved criteria. Defendants with co-occurring substance abuse disorders may also be eligible.
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES, *supra* note 59.
[76] *Id.*
[77] PELLEG, *supra* note 27, at 46.
[78] DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES, *supra* note 59.

The BHC personalizes treatment plans and takes into account the offender's "baseline functioning, capabilities, strengths and holistic needs including physical, mental, and spiritual interests."[79] These treatment plans are regularly updated based on a participant's progress.[80] The BHC requires participation in mental health treatment at Bert Nash Community Mental Health Center (Bert Nash).[81] Bert Nash provides outpatient and community based mental health services.[82] If participants engage in negative behavior related to substance use or a co-occurring disorder, they must also participate in substance abuse treatment services.[83]

Throughout the entire treatment plan, all participants must remain drug and alcohol free and are subject to random drug or alcohol testing.[84] Supervising officers from the BHC work closely with both the Mental Health Clinical Coordinator and the participant's Case Manager from Bert Nash to ensure compliance with the treatment plan.[85] Supervising officers work closely with participants under community supervision and update the rest of the team on the participant's compliance.[86] The Mental Health Clinical Coordinator provides mental health assessments, clinical oversight, and care coordination for participants.[87] Moreover, the Clinical Coordinator also develops the treatment plan, which includes referrals about how to directly address the mental health symptoms that led to the criminal charge.[88] The Case Manager connects the offender to community-based services the treatment plan deems necessary.[89] Regular status hearings are held during which the Court hears reports from the Clinical Coordinator and the Supervision Officer.[90]

Additionally, the participant interacts directly with the judge regularly during status and review hearings.[91] Status hearings happen regularly where the judge reviews the participant's progress and receives additional status reports from the Supervising Officers and the Clinical Coordinators.[92] Review hearings occur when a participant is ready to move to the next phase of treatment (the

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[79] *Id.*
[80] *Id.*
[81] *Id.* Participants may be permitted to receive mental health services from a different provider, but Bert Nash will still monitor compliance and progress. *Id.* If a participant uses a different provider, the individual must sign an information release allowing the BHC to communicate with the provider and receive updates. *Id.*
[82] *Id.*
[83] *Id.*
[84] DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES, *supra* note 59.
[85] *Id.*
[86] *Id.* (stating that this person "focuses on community involvement, . . . interacting with treatment and supportive services providers . . .").
[87] *Id.*
[88] *Id.*
[89] *Id.*
[90] DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES, *supra* note 59.
[91] *Id.*
[92] *Id.*

phases are discussed below).[93]

The BHC has a four-phase treatment program focused on Stability, Maintenance, Wellness, and Healthy Choices/Lifestyle.[94] The emphasis of Phase One (Stability) is "helping participants obtain/sustain housing, create routines to assist in daily activities and begin mental health treatment."[95] The emphasis in Phase Two (Maintenance) is "continuance in mental health and substance abuse treatment, maintenance of stable housing, progress towards employment or education, continuing compliance with probation requirements and no new arrests."[96] Phase Three (Wellness) focuses on "defining goals and solidifying wellness practices" for the participants and suggesting "service project" ideas for Phase Four.[97] Additionally, participants must develop a plan for restitution of payments for court fees or completion of community service.[98] Lastly, Phase Four (Healthy Choices/Lifestyle) focuses on how participants can give back to the community.[99] In this phase, participants complete a service project of their choice.[100] This service project serves as a way for participants to contribute to the community by using their talents and skills.[101]

D. *Geographic Availability of Community Treatment Programs*

As discussed above, no mental health court is administered in the same way as another when it comes to aspects such as eligibility requirements and treatment plans. However, arguably another problematic inconsistency exists: availability of community treatment programs. A basic premise of mental health courts is to connect offenders to *community* treatment programs. The level of available treatment varies depending on the location of the court. For example, imagine two communities, Community *A* and Community *B*, which are identical in every way: identical populations, tax rates, budgets, political leanings, and demographics, to name a few. Both communities have also implemented mental health courts. Community *A* has recently built a state-of-the-art rehabilitation center that offers those with mental health problems access to psychologists and counselors, prescription medication, substance abuse treatment, and stability. Community *B*, conversely, has a rehabilitation center, but it essentially functions merely as a place for someone to stay the night. Community *B*'s mental health court may have less success than Community *A*'s mental health court because access to adequate treatment is much more difficult to access in Community *B*.

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[93] *Id.*
[94] DOUGLAS CTY. BEHAVIORAL HEALTH COURT, DOUGLAS COUNTY BHC – PHASES (2018) [hereinafter DOUGLAS CTY. BEHAVIORAL HEALTH COURT, DOUGLAS COUNTY BHC – PHASES].
[95] *Id.* Phase one is also where substance abuse treatment begins.
[96] *Id.*
[97] *Id.*
[98] *Id.*
[99] *Id.*
[100] DOUGLAS CTY. BEHAVIORAL HEALTH COURT, DOUGLAS COUNTY BHC – PHASES, *supra* note 94.
[101] *Id.* Inclusion of how the BHC in Douglas County operates is not intended to serve as a suggestion of how other similar courts should operate.

Arguably, if mental health courts have little geographic access to substance abuse treatment, mental health treatment, or any other kind of treatment included in the participant's treatment plan, the participant may not be as successful as those participating in a program with significantly more access to these resources. This availability problem may ultimately be rooted in a lack of governmental support for mental health treatment. However, this article will not delve into governmental support for mental health treatment. Instead, the focus is that the differing availability of treatment resources creates another inconsistency among mental health courts. These inconsistencies in eligibility, treatment plans, and access to community treatment programs directly impact the ability to obtain cohesive research determining the overall successfulness of mental health courts.

III. COMPILATION OF AVAILABLE DATA ON MENTAL HEALTH COURTS' SUCCESSES

At the outset of this section, it is imperative to recognize that there is limited research available that determines whether mental health courts are achieving their goals of helping offenders struggling with mental illnesses while reducing recidivism rates.[102] "The rapid proliferation of mental health courts across the United States has outpaced research, indicating a need for further analysis of these specialized problem-solving courts."[103] Moreover, "[b]ecause there is no current standardized model of [mental health courts] it is difficult to generalize [statistical] findings to all courts across the United States."[104] Comparing national recidivism rates to mental health court recidivism rates reveals that mental health courts have a positive impact on recidivism, but not to the extent many had hoped for.

A. *Overall Recidivism Rates*

Recidivism "refers to a person's relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime."[105] It can be measured by re-arrest, reconviction, or return to prison with a new sentence following a prisoner's initial release.[106] Essentially, recidivism rates focus on how many offenders re-offend following their release from incarceration. Return to prison is probably the most common unit of measurement, but arguably, it is best to include all of these measurements to determine the most accurate recidivism rate.[107] Providing the national

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[102] Laura N. Honegger, *Does the Evidence Support the Case for Mental Health Courts? A Review of the Literature*, 39 LAW & HUM. BEHAV. 478, 486 (2015).
[103] *Id.*
[104] Christine M. Sarteschi et al., *Assessing the Effectiveness of Mental Health Courts: A Quantitative Review*, 39 J. CRIM. JUST. 12, 19 (2011).
[105] *Recidivism*, NAT'L INST. JUST., https://www.nij.gov/topics/corrections/recidivism/Pages/welcome.aspx [https://perma.cc/PU6R-TN6D].
[106] *Id.*
[107] RYAN KING & BRIAN ELDERBROOM, URBAN INSTITUTE, IMPROVING RECIDIVISM AS A PERFORMANCE MEASURE 2–3 (2014).

recidivism rate not only illuminates the current recidivism problem but also contextualizes how effective mental health courts have been in reducing this rate.

The latest study of recidivism rates published by the Bureau of Justice Statistics in 2018 followed released prisoners from 2005-2014.[108] This study refers to all released inmates, not just those with mental health issues. This study tracked patterns of about 400,000 persons released from state prisons in thirty states.[109] However, it did not specify whether the re-arrested offenders were then charged and sentenced, or only re-arrested. In 2018, the U.S. Department of Justice revisited the 400,000 prisoners released in 2005.[110] The department found that eighty-three percent of the studied state prisoners released in 2005 were arrested at least once between 2005 and 2014.[111]

B. *Research Compiled in 2014 Shows a Minor Positive Impact on Recidivism Rates*

As of 2014, few studies had looked at the long-term outcomes of mental health courts on criminal recidivism.[112] Indiana University – Purdue University Indianapolis (IUPUI) Professor Bradley Ray aimed to change that. Professor Ray published a study that monitored 449 mental health court participants from North Carolina's original mental health court during its first six years of operation (from 2000-2006).[113] These participants were monitored for a minimum of five years after their final disposition from this mental health court to determine recidivism rates.[114] This study focused particularly on whether successful completion of the mental health court program led to lower recidivism rates when compared with those who did not complete the program.[115]

Regarding eligibility requirements, this mental health court allowed both misdemeanor and felony offenders to participate, as well as violent and nonviolent offenders.[116] When examining the crimes committed among the 449

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[108] *Recidivism*, BUREAU JUST. STAT. (May 2018), https://www.bjs.gov/index.cfm?ty=tp&tid=17 [https://perma.cc/4YWE-YYXD].

[109] *Id.* These thirty states made up seventy-seven percent of all released state prisoners and were selected based on their ability to provide records.

[110] MARIEL ALPER ET AL., BUREAU OF JUSTICE STATISTICS, 2018 UPDATED ON PRISONER RECIDIVISM: A 9-YEAR FOLLOW-UP PERIOD (2005-2014) 1 (2018).

[111] *Id.* About sixty-eight percent of released prisoners were re-arrested within three years of release. About seventy-nine percent were re-arrested within six years of release. Finally, by year nine, eighty-three percent of offenders were re-arrested.

[112] *See* Ray, *supra* note 26. Bradley Ray is an associate professor at Indiana University-Purdue University Indianapolis in the School of Public & Environmental Affairs. *Brad Ray*, IUPUI SCH. PUB. & ENVTL. AFF., https://spea.iupui.edu/contact/people-directory/ray-brad.html [https://perma.cc/T3RW-7QE7]. His focus is on mental health and substance use, particularly where these connect with treatment in the criminal justice system. *Id.*

[113] Ray, *supra* note 26, at 449–50.

[114] *Id.* at 449.

[115] *Id.* at 448.

[116] *Id.* at 449.

participants, 87.5 percent of them committed misdemeanor offenses.[117] To complete this specific court's program and ultimately have charges disposed of positively, the participant must have complied with the mental health court for a minimum of six consecutive months.[118] Of the 449 participants who entered the court between 2000-2006, fifty-nine percent of them successfully completed the program.[119]

According to Professor Ray's data, 53.9 percent of the 449 participants recidivated.[120] Of those who recidivated, 84.3 percent recidivated by committing misdemeanor offenses, while 15.7 percent were charged with felonies.[121] However, there was a stark difference in recidivism rates between those who completed the program and those who did not complete the program. Only 39.6 percent of those who completed the program recidivated, while 74.5 percent of those who did not complete the program recidivated.[122]

C. *Research Compiled in 2015 Shows a Minor Positive Impact on Recidivism Rates*

In 2015, Laura Honegger, an assistant professor of social work at the University of St. Francis in the College of Business & Health Administration, published a review of available research and data conducted over many years evaluating the effects of mental health courts.[123] Professor Honegger studied twenty articles from peer-reviewed journals to evaluate the empirical successfulness of mental health courts.[124] She focused on the effects of mental health courts on improvement of psychiatric symptoms, connecting individuals to behavioral health services, improvement of overall quality of life, and reduction of recidivism rates.[125] This article will focus only on Professor Honegger's data surrounding reduction of recidivism rates.[126] Importantly, Professor Honegger's study does not indicate eligibility criteria for any courts she studied, how those courts selected eligible participants, or the resources available to participants.

One study Professor Honegger reviewed compiled data from fifteen

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[117] *Id.* at 450.
[118] *Id.*
[119] Ray, *supra* note 26, at 450.
[120] *Id.*
[121] *Id.* Within the full sample, 33.4 percent of offenders recidivated within the first year of release. *Id.* By the end of year three, 50.3 percent had recidivated, but only 1.6 percent recidivated beyond five years. *Id.*
[122] *Id.*
[123] *See* Honegger, *supra* note 102. Honegger did not complete any studies herself, rather she looked to studies published by others, similar to Ray's study, and compiled the data. *Laura Honegger*, ST. FRANCIS C. BUS. & HEALTH ADMIN., https://www.stfrancis.edu/laura-honegger/ [https://perma.cc/8HF7-VEM6]. Honegger's research includes a focus on the intersection of the criminal justice and mental health systems. *Id.*
[124] Honegger, *supra* note 102, at 478.
[125] *Id.*
[126] *Id.*

separate studies on mental health courts (the Sarteschi study).[127] The Sarteschi study concluded that studied mental health courts reduced recidivism rates by an overall effect size of -.54.[128] This means that the mean recidivism rate for mental health courts, according to this study, is about one half of a standard deviation below the national recidivism rate mean.[129] Sarteschi relied on Cohen's effect size guidelines[130] to determine that this effect size means these mental health courts only moderately reduced recidivism.[131] Another study Professor Honegger included followed four mental health courts located in Minnesota, Indiana, and California, over eighteen months (the Steadman study).[132] To compare recidivism rates amongst individuals, Steadman compared 447 mental health court participants to 600 individuals receiving treatment as usual through the traditional court system.[133] The mental health court participants were statistically less likely to be re-arrested during the eighteen months after release.[134] Forty-nine percent of mental health court participants were re-arrested in the eighteen months following release, compared to the fifty-eight percent re-arrest rate of those who went through the traditional court system.[135]

D. *Research Compiled in 2018 Shows a Minor Positive Impact on Recidivism Rates*

In 2018, Evan Lowder, Candalyn Rade, and Sarah Desmarais (Lowder et al.) published a compilation of available studies similar in form to Professor Honegger's article from 2015.[136] Lowder et al. reviewed seventeen studies that focused on the effectiveness of mental health courts published between 2004-2015.[137] In fact, many of the studies Lowder et al. included overlap with those included in Professor Honegger's article.[138] As with Professor Honegger's article, Lowder et al. do not include any eligibility criteria of the assessed mental health courts.

Overall, Lowder et al. found that recidivism rates for mental health court participants were reduced by an effect size of -.20 compared to the traditional justice system regardless of whether the participant completed the program or

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[127] *Id.* at 483–84.
[128] *Id.* at 484.
[129] *See, e.g.*, ROBERT COE, IT'S THE EFFECT SIZE, STUPID: WHAT EFFECT SIZE IS AND WHY IT IS IMPORTANT (2002), https://www.leeds.ac.uk/educol/documents/00002182.htm [https://perma.cc/7T6R-UH7M] ("For example, an effect size of 0.8 means that the score of the average person in the experimental group is 0.8 standard deviations above the average person in the control group. . . .").
[130] *Hedges' g: Definition, Formula*, STAT. HOW TO (Oct. 16, 2016), https://www.statisticshowto.datasciencecentral.com/hedges-g/ [https://perma.cc/KB62-X4AZ].
[131] Sarteschi et al., *supra* note 104, at 18.
[132] Honegger, *supra* note 102, at 484.
[133] *Id.*
[134] *Id.*
[135] *Id.* Additionally, mental health court participants had fewer average days of incarceration (eighty-two days) compared to those who went through the traditional system (152 days) in the eighteen-month follow-up period.
[136] *See* Lowder et al., *supra* note 26.
[137] *Id.* at 15.
[138] *See* Honegger, *supra* note 102; Lowder et al., *supra* note 26.

not.[139] This indicates a modest impact on overall recidivism rates.[140] They agreed with Professor Ray that graduation from a mental health court was associated with better outcomes (as opposed to those who do not graduate from the program).[141] However, Lowder et al. only mentioned their agreement and then returned to the main focus of their study: the overall effectiveness of mental health courts as a "judicial strategy to reduce the number of adults with mental illnesses who are returning to the criminal justice system," as opposed to differing outcomes based upon completion.[142]

It is crucial to understand the many variables present in the studies included by Lowder et al. For example, different studies had different criteria regarding what constituted recidivism.[143] Most studies focused on new arrests as the main type of recidivism, but some studies only included new jail convictions in determining whether a participant recidivated, and yet others focused on new charges to determine if a participant recidivated.[144] Whether a study defined recidivism as new arrests, jail convictions, or new charges would potentially affect recidivism numbers because the same event involving the arrest of a previously incarcerated person would constitute recidivism in one study, but not in another.

Additionally, the length of time the participants were tracked (follow-up periods) varied among studies.[145] Most studies followed mental health court participants for a twelve-month period, while others followed them for longer periods of time.[146] Interestingly, general recidivism research has suggested that most recidivation occurs within the first three years post-release.[147] Moreover, by years six to ten post-release, a previously incarcerated person is as likely to reoffend as someone without a criminal record.[148] Some studies' follow-up periods began right after a participant enrolled in the mental health court, while others did not begin their follow-up periods until after the participant exited from the mental health court, whether by completion or dropping out.[149] Regarding variables on lengths of studies, in Professor Ray's study, just over eighty-two percent of mental health court participants who recidivated did so within the first two years post-release.[150] Thus, had the study lasted only two years instead of five, the re-arrest rate would have been just over forty-four percent instead of 53.9 percent.[151] This is just one example of how much of an impact the length

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[139] Lowder et al., *supra* note 26, at 19.
[140] *Id.* An effect size of .20 usually indicates a small overall impact. *Hedges' g: Definition, Formula*, *supra* note 130.
[141] Lowder et al., *supra* note 26, at 19.
[142] *Id.* at 19.
[143] *Id.* at 17.
[144] *Id.*
[145] *Id.*
[146] *Id.*
[147] Ray, *supra* note 26, at 452.
[148] *Id.*
[149] Lowder et al., *supra* note 26, at 17.
[150] Ray, *supra* note 26, at 451.
[151] *Id.*

of the follow-up period can have on overall recidivism rates.

E. *Data Review*

As a review of the above statistics, all three articles conclude that research is very difficult to conduct because of the many variables associated with the mental health courts and methods of research. These variables make it difficult to determine with any accuracy the impact all mental health courts have on recidivism nationwide.

The overall federal recidivism rate is an astonishing eighty-three percent.[152] Professor Ray's study from 2014 concluded that the overall recidivism rate among participants from one North Carolina mental health court was 53.9 percent.[153] Moreover, Professor Ray also found that only 39.6 percent of those who completed the mental health court program recidivated, while 74.5 percent of those who did not complete the program recidivated.[154] In 2015, Professor Honegger's study concluded mental health courts have a modest effect on overall recidivism rates.[155] Lastly, in 2018, Lowder et al. concluded there was a modest reduction in recidivism rates among mental health court participants compared to those in the traditional justice system.[156]

Overall, all three of the articles indicate that mental health courts do have a positive impact on recidivism rates, especially if a participant graduates from the program. Some courts showed very minimal effects on recidivism rates, while others showed major impacts. As evidenced by these studies, the inconsistencies present among mental health courts is a problem that is likely hindering how impactful mental health courts could be.

IV. IMPROVING MENTAL HEALTH COURTS' OVERALL IMPACT

Ultimately, mental health courts can, and do, have a positive impact on recidivism rates. However, arguably, these courts are operated so inconsistently that they are likely not operating to their fullest potential.[157] To allow mental health courts to function more efficiently than they currently do, they need to have more uniform implementation. Additionally, to exponentially increase their benefits on recidivism, participants need to have access to long-term treatment plans and benefits after completion or exit from the program. But even more important than improving consistency and offering access to long-term treatment, the judicial system needs to step back and allow mental health professionals to have a larger role in guiding these courts.

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[152] ALPER ET AL., *supra* note 110, at 1.
[153] Ray, *supra* note 26, at 450.
[154] *Id.*
[155] Honegger, *supra* note 102, at 484; *see supra* Section III.C.
[156] Lowder et al., *supra* note 26, at 19; *see supra* Section III.D.
[157] *See, e.g.*, Honegger, *supra* note 102, at 486; Lowder et al., *supra* note 26, at 20–21.

A. *Mental Health Courts Need Professional Guidance*

Mental health courts need guidance from mental health professionals. Usually, case managers, who are mental health professionals, connect participants to community treatment programs.[158] These programs may include substance abuse programs, vocational or educational training, or outpatient care.[159] The court then uses incentives and sanctions to encourage participation in the treatment program.[160] The mental health system focuses on treating illnesses, harm reduction, and public health.[161] Conversely, the main purposes of the criminal justice system are to "ensure public safety, promote justice, and punish and prevent criminal behavior."[162] Judges and lawyers attend law school to become experts in the law; mental health professionals attend extensive schooling to become experts in that field. Just as mental health professionals have no expertise in the law, judges and lawyers have no expertise in the field of mental health. Because of this, judges and lawyers are not the best group of professionals to directly administer these mental health courts.

Lawyers and judges obviously need to be involved in mental health courts to ensure sentences are carried out. However, the structure of these courts and the treatment plans, for example, need to be governed by mental health professionals with expertise in these areas. Rather than giving the judicial system a majority control in running these programs, at the least, mental health professionals need to have equal authority. By working as equals, the successfulness of mental health courts can improve extensively. Not only will offenders with mental illnesses still be diverted from the traditional criminal justice system, they will also be more likely to receive more meaningful treatment. More meaningful treatment will ultimately result in a positive impact on recidivism rates.

Experts from each applicable field must collaborate together to allow mental health courts to function most efficiently. Lawyers alone do not possess all the requisite knowledge and expertise to successfully create effective laws geared toward bettering the lives of those offenders dealing with mental illnesses. Additionally, the criminal justice system almost solely focuses on punitive responses to crime. Collaborating with other professionals will allow for a more well-rounded, rehabilitative approach which would improve the lives of offenders who struggle with mental illnesses.

B. *Consistency is Key*

Regulation is another way to increase consistency among mental health courts. One way to accomplish this is through statutory regulations. Legislators need to work with the mental health, substance abuse treatment, social work, and

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[158] LAUREN ALMQUIST & ELIZABETH DODD, COUNCIL OF STATE GOV'TS JUSTICE CENTER, MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 16 (2009).
[159] *Id.*
[160] *Id.* at 17.
[161] *Id.* at 5.
[162] *Id.*

psychology communities to pass the most effective laws and regulations. A more collaborative approach would help mental health courts increase efficiency and success. Additionally, regulations could provide for financial structuring and support, as well. This could ultimately help improve the overall operation of these non-traditional courts by budgeting certain amounts toward the creation and implementation of mental health courts and community treatment programs. By adding these as line-items in the fiscal budget, states would be front-loading costs to ultimately reduce the total amount spent to incarcerate inmates every year.

However, there are potential detractors to regulation. Arguably, critics of a more regulated mental health court system may worry that there could be negative side effects to public safety. Increased participation in mental health courts could mean these offenders are not incarcerated; thus, the public is less safe. However, this argument can be countered with the simple fact that the offenders participating in mental health courts would still eventually get out of prison, but treatment likely gives them a better chance of success post-release.[163] Without long-term tools and resources to cope with mental illness, participants may continue to get stuck in the cycle of commission of a petty crime, incarceration, release, homelessness, commission of another petty crime, and re-imprisonment. This not only worsens the lives of these people but also increases the cost to the taxpayers of having to incarcerate these people multiple times.[164] Thus, the public will ultimately be safer and better off with a more regulated, cohesive approach to mental health courts.

C. *Access to Long-Term, Outpatient Treatment is Necessary*

One main focus of mental health courts is to create a treatment plan to help offenders struggling with mental illnesses cope with their mental health issues.[165] Mental health courts allow participants access to necessary medication, sometimes for the first time in the person's life. Before graduation, the Behavioral Health Court requires participants to have an "aftercare plan" with Bert Nash.[166] Once the participant graduates, the graduate's case will be

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[163] *See, e.g.*, Honegger, *supra* note 102; Lowder et al., *supra* note 26; Ray, *supra* note 26. As discussed above, these studies indicate that those who participate in mental health courts are less likely to recidivate. Thus, one can conclude that the treatment offered through these programs decreases the likelihood these participants will re-offend, and thus increases their chances of success post-release.

[164] The higher recidivism rates mean offenders are likely to serve multiple stints incarcerated (either in jail or prison). Thus, taxpayers must pay to incarcerate the same person multiple times. If funds are front-loaded—meaning taxpayer money is used to create these courts and community treatment programs from the start—this will likely reduce the number of times these people serve time incarcerated, thus ultimately saving taxpayers money.

[165] It is important to note that the author is not a mental health professional. This section offers an overarching suggestion to improve mental health courts without attempting to suggest any specific form of mental health treatment.

[166] *See, e.g.*, DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES, *supra* note 59.

dismissed.[167] By implementing a long-term treatment plan at graduation and increasing overall accessibility to mental health treatment, participants who follow the plan would likely have more long-term success than those who do not implement and follow a long-term plan. This is because long-term treatment helps people with mental health issues avoid "chronic disability and premature death" while offering support that gives those people a "healthier and richer" life "lived with dignity."[168] However, in some courts, this treatment plan finishes when the participant graduates from the program.[169] After graduation, not only does the participant lose the treatment plan, but sometimes the participant loses access to medications, as well, because the cost of this treatment is now on the participant.[170] Not having access to long-term treatment options hinders these participants from continuing to successfully navigate through life. This would also require some changes surrounding nation-wide financial support for mental health care generally, but that is for another article.

Admittedly, collaboration, consistency, or regulation may be difficult to implement throughout the country. Additionally, as discussed above, access to treatment varies based on geographical location, and funding for these courts may be lacking.[171] Long-term treatment plans also pose their own problems. The public cannot force those struggling with a mental health issue to go to treatment or to take their medications, just as the public cannot force an alcoholic to go to rehabilitation. However, these "problems" are fixable if the public places enough importance on this undertaking by expanding access to treatment and removing the negative stigma surrounding mental health issues.

V. CONCLUSION

Mental illness affects more people than just those who struggle with it. As society realizes this, there have been more calls to action to remove the negative stigma surrounding mental illnesses. This article serves as one more call to action to improve alternative approaches to punishment for those who commit crimes because of their mental illnesses. If mental health courts do not become more consistent, or if the participants are not assisted in creating and implementing long-term treatment plans, these people are only receiving a

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[167] *Id.*

[168] WORLD HEALTH ORG., DEP'T OF MENTAL HEALTH & SUBSTANCE DEPENDENCE, INVESTING IN MENTAL HEALTH 3 (2003).

[169] *See, e.g.*, THIRTEENTH JUDICIAL CIRCUIT COURT, BOONE COUNTY MENTAL HEALTH COURT (ASCII): PARTICIPANT MANUAL 16, 18–21 (2017). Prior to graduation from this mental health court, participants must describe their relapse prevention program (e.g., what they struggled with, what they learned, and how to apply what they learned). After graduating, participants are given contact information of aftercare services, but seemingly are not required to make plans to attend or get help from any of these services.

[170] *See, e.g.*, *id.* at 4. Most fees in the Boone County Mental Health Court are covered while in the program. There is no discussion of financial support after graduation from the program. *See also* DOUGLAS CTY. BEHAVIORAL HEALTH COURT, BEHAVIORAL HEALTH COURT PARTICIPANT HANDBOOK 10 (2018). The only discussion of costs in the Douglas County BHC regards paying any ordered restitution fees prior to graduation. *Id.*

[171] *See supra* Section II.D.

portion of the help that could be available to them. With help creating long-term plans and rehabilitative approaches to punishment, these offenders, struggling with mental illnesses, can most importantly better their lives long-term, while increasing overall public safety.

Mental health courts already have a minor positive impact on recidivism rates, which also likely means they are positively impacting the participants' lives, as well. Studying the effectiveness of mental health courts is difficult based on their current state. But, by increasing collaboration between professionals in multiple fields, improving consistency among courts, and offering long-term outpatient care to participants, these mental health courts could be significantly more effective than they are, even now.