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Mental health courts: a workable proposition?

In the UK the notion of diverting people suffering from mental disorders from the criminal justice system to treatment within the health service is not new (Home Office, 1990), nor is the concept of a court-based psychiatric assessment and liaison service (Joseph & Potter, 1990; James & Hamilton, 1991; Joseph, 1992). Similarly, the concept of 'specialist' courts is not a novelty in the USA (Bean, 1998; Schwartz & Schwartz, 1998). We report on the first specialist mental health court in the USA and propose a modification of the current provision of psychiatric services to courts in England and Wales by combining elements of the mental health court with current court diversion practice.

Broward County Mental Health Court

This was established in 1997 in Broward County, Florida, as a result of an idea of the Chief Assistant Public Defender and the subsequent recommendations of a task force headed by a circuit judge. This task force brought together the relevant legal and mental health personnel, and it laid down the terms and structure of the court. It is funded by the state of Florida, and its goals include: providing the least restrictive, most appropriate and most workable disposal of cases before it; diverting defendants suffering from mental illness with minor criminal charges to community-based mental health services; and, most crucially, monitoring the delivery and receipt of mental health services and treatment.

In addition to the usual legal personnel, the court includes among its officers a forensic social worker (provided by the public defender's office), a court worker (provided by a local community mental health centre), a case manager (funded by community mental health providers) and a mental health court liaison officer.

The court accepts defendants charged with non-violent misdemeanours only. These include crimes such as petty theft, disorderly conduct, trespassing, drunkenness and uniquely, 'reclining in the park'. Crimes of violence and felonies are excluded from the court. Cases are referred from the magistrates' court, from other court clinics, from the public defender's office and from the Broward County Jail. The local community mental health centre also reviews jail booking logs daily to identify active mental

health cases. An estimated 41 new cases are identified per month in this way.

Defendants are mostly male, comprising 77% of the mental health court case-load. The majority (51%) of the defendants are aged between 28–40 years, 10% are over 55 years and 20% are aged between 18–27 years. A significant proportion (30%) are homeless. Ninety-two per cent of all participants suffer from a serious and persistent mental illness, the largest group suffer from schizophrenia (28%), with 70% having one or more previous admissions to a psychiatric hospital. Twenty-six per cent have a dual diagnosis of substance misuse and major mental illness.

Once referred to the court, the case is reviewed in the presence of the defendant by the district attorney and the defence attorney to determine whether the defendant qualifies for the court. If the case meets the criteria for the court, namely that the defendant is suffering from a mental illness or has a previous psychiatric history and has committed a non-violent misdemeanour, the defendant is asked whether he or she wants the case transferred to the court. Once the defendant agrees to opt in, he or she is assigned a public defender and the court mandates judicially monitored mental health treatment. This may include admission to the state psychiatric hospital for psychiatric treatment or substance misuse detoxification, or treatment by the appropriate division of the local community mental health team. In the event that a defendant declines to have his or her case referred to the mental health court, the case is simply transferred back to the regular misdemeanour court for disposal.

A consensus is reached between defendant, public defender and the court's mental health staff as to the most appropriate agency to which to refer the patient for treatment. That agency then decides on the most appropriate clinical treatment. This process is not without controversy, on occasion degenerating into what one staff member described as a "psychotic three-ring circus". In the case of an acutely ill defendant appearing before the court, an admission to the local state psychiatric hospital for evaluation and treatment occurs, after which the defendant is returned to court and again offered the opportunity to opt in with the programme of the court. An assessment of competence to stand trial may be



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ordered by the judge in any individual case where a defendant's fitness to stand trial is in question.

A useful resource of the court is direct access to, and complete control over, a residential unit of 24 beds provided by the state, after the court had been in existence for a year. These are situated in the grounds of the South Florida State Hospital. The unit, known as Pembroke Pines, or more affectionately as the 'cottages in the pines', consists of four newly renovated pastel-coloured houses. Each cottage houses up to six people with a counsellor on duty at all times. A psychiatrist visits twice a week and residents receive regular assessment and medication from him or her. Residents are also offered the opportunity to secure employment and assisted by the provision of free travel passes, and, in some cases, bicycles. The average length of stay for a resident is 4–6 months. It is hoped that Pembroke Pines will offer a valuable opportunity to help break the cycle of 'street–crime–jail–street' for homeless offenders suffering from mental illness and allow further close monitoring over a lengthy period of time by residential staff and mental health services.

Rather than completely hand the case over to another agency, such as probation or mental health services, the court retains its own direct personal involvement, retaining control over the case for a period of up to 1 year. Ultimately, however, the defendant's willingness to adhere to the programme is the determinant of what happens next. If the defendant fails to follow through the programme there is the possibility of immediate incarceration and referral of the case to the misdemeanour court for prosecution. Most defendants are given a second chance.

The defendants who are not in current contact with mental health services are required to report to the judge in court regularly, usually monthly, to enable the judge to monitor their progress and act accordingly. For those in current contact the court will seek a report, and if it is satisfied that the pre-existing treatment plan is the most appropriate and should continue, it will dispose of the case immediately, with no further judicial monitoring. Defendants have the opportunity to speak about their situation and usually appear with a mental health provider or carer who provides the court with a progress report. For patients who successfully engage with the court programme for 1 year, charges may be either dismissed or adjudication withheld (the equivalent in English law is the matter being left to lie on file). There is no conviction recorded in these cases.

Discussion

The mental health court is a new concept, barely 2 years old, and although experience gained over the next few years of its operation will most likely result in changes being made, the system as it currently exists offers a number of advantages. It provides a humane approach to dealing with individuals suffering from mental disorders who have committed no more than petty non-violent offences, for which the pursuit of a prosecution is not

always in the public interest. It also attempts to safeguard the legal rights of the defendant suffering from a mental disorder. It further provides for a regular process of judicial review, restricted not only to the criminal matters but to matters of mental health. A defendant's obligation to take responsibility either for his/her mental health or his/her criminal behaviour, when competent to do so, may be considered to be of some psychological good to the patient. The provision of transitional residential accommodation for use only by the court, with access to therapeutic, vocational and educational activities on site, is an enormous asset.

Among its limitations is its restriction to cases of non-violent misdemeanours. Felonies and crimes of violence are excluded from the court, even if the defendant suffers from a mental disorder. This was largely in an attempt to minimise the risk of a defendant charged with a serious violent offence being seen to receive a 'lenient' mental health court disposal, which was deemed to be politically sensitive in the court's early days. It may be that as the court becomes more established and accepted, it may expand to accept more serious offenders.

The defendant is required either to opt in with the treatment programme of the mental health court or accept the heavy hand of the regular court. It might reasonably be said that there are some elements of subtle coercion involved in this. On the other hand, it could also be said that the existence of the court creates another option for the defendant to choose from, which would not otherwise be available. The involvement of the court for up to 1 year after the first appearance may lead to a lack of continuity of care after this time.

We propose that the disadvantages might be overcome by a considered amalgamation of the best features of the mental health court and many court diversion schemes as operated in the UK. We suggest the establishment of a pilot mental health court that should be adequately resourced with its own full multi-disciplinary clinical team. This clinical team would be recognised as providing a service to the court, but should remain employees of the health service and should have a liaison role between the court and the health service. Residential placements provided and regulated by the court would contribute to its success, in addition to the presence of a presiding magistrate/judge with experience in mental health law. Staff committed to providing and encouraging engagement with mental health services, while also considering the rights of society to protection from harm, would be invaluable. We also propose that the court should have direct access to secure beds in psychiatric and forensic (low security) intensive care units in order that the remit of the court be extended beyond non-violent misdemeanours.

We realise that our proposals have resource implications in a world of growing rationing. We suggest however that expenditure on these proposals would be a sensible investment that would produce savings in the health service and the criminal justice system expenditure in the long term.

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