

Mental Health Court
Final Report (9-03-04)
By Jeffery Fraser

The actual names of criminal offenders with mental illness were not used in this report at the request of the Allegheny County Office of Behavioral Health, Department of Human Services.

Tony graduated in February 2004. He was not a student. He was a criminal offender with a mental illness. Tony is a graduate of the Allegheny County Mental Health Court program - a distinction he earned by honoring a one-year term of probation, staying out of trouble and abiding by a court-ordered plan to treat his bipolar disorder and the drug and alcohol problems that have aggravated his condition most of his adult life. His reward was not a diploma, but an opportunity to avoid debilitating jail time and stabilize his illness and life.

"I just want to get well," Tony told Allegheny County Common Pleas Judge Bob Colville on a bitter cold January morning in 2003, when he agreed to enter the Mental Health Court program that more than a few defendants have found more demanding than a jail sentence.

Tony had been arrested on a bus by Port Authority police in 2002 with five tablets of Vicodin - a narcotic pain reliever and a controlled substance - in his pocket. Police said he had been belligerent. At the time of his arrest, he had been on probation for a previous offense, a simple assault.

Two years earlier, such transgressions and his history of small-time offenses would have earned Tony three to 12 months in prison under Pennsylvania's nonbinding sentencing guidelines. But a diagnosis of bipolar disorder and his willingness to commit to treatment presented Colville with another option.

In 2001, Allegheny County created the first Mental Health Court in Pennsylvania to divert certain nonviolent offenders with mental illness from jails and prisons, which have become America's de facto psychiatric institutions. The new court - supported by public funds and grants from the Jewish Healthcare Foundation, Pittsburgh Foundation and the Staunton Farms Foundation - quickly proved to be a more humane and cost-effective way of dealing with a growing population of mostly petty criminals who, in most cases,

are better off on the outside undergoing treatment than behind bars crowding an already overcrowded prison system.

In Tony's case, he received probation rather than jail in exchange for a guilty plea. Conditions were negotiated by a Mental Health Court team, which included a public defender, the District Attorney's office, and county Office of Behavioral Health. Tony continued to live in the community, but under the watchful eye of the court. He kept regular contact with his probation officer, case manager and doctors. He was required to follow a service plan, which included taking his medication as prescribed. His progress or lack of it was recorded and he returned to court every three months to hear his report card reviewed.

Tony earned passing grades, for the most part. Not that the road to recovery was always smooth. A relapse in his struggle to overcome substance abuse bought him a warning from the judge during a "negative reinforcement" hearing to help him resolve the problem. But it was not deemed serious enough to revoke his probation.

Few Repeat Offenders

For all of Tony's struggles with drugs and alcohol, he remained true to his pledge not to commit another crime. He was not rearrested or jailed while serving his Mental Health Court-sanctioned one-year term of probation.

Tony is not alone. From June 1, 2001 through December 31, 2003 only 13 of the 239 offenders accepted into Mental Health Court – about 5.5 percent – had been rearrested.¹

Allegheny County's Mental Health Court experienced its share of growing pains over its first 30 months. It has accepted far fewer offenders with mental illness than planned. And the average time they spent in jail before their release under supervised service plans was longer than the court's architects envisioned.

But the outcomes of the mentally-ill offenders who took part in the Mental Health Court are encouraging. Recidivism is remarkably low. Fewer than 10 percent of offenders in the program strayed from their treatment plan or otherwise breached their agreement with the court. Only one was terminated from the program for repeatedly violating the terms of her probation.

How well these men and women will do over the long term is unclear, particularly after their probation expires and they are no longer under close supervision. But the courts in Allegheny County now have a process that allows judges to look at nonviolent offenders with mental illness and ask whether it is more prudent to treat than to incarcerate.

"It's an opportunity," says Judge Colville, "for the courts to become problems solvers, not just referees in the match between defense and prosecution."

From Hospitals To Prisons

The imprisoning of the mentally ill is not a new concern in the United States. As early as 1827, an investigation of jail conditions by the Massachusetts legislature reported many "lunatics and persons furiously mad" were being jailed and that "less attention is paid to their cleanliness and comfort than to wild beasts in their cages."²

But the sheer number of inmates with mental illness who are incarcerated today is staggering by any historical comparison. The most complete census of the mentally ill ever done in the U.S. reported that in 1880 only .7 percent of jail and prison inmates were mentally ill. In 1999, more than 267,157 inmates were severely mentally ill – about 16 percent of America's jail and prison population, according to the U.S. Department of Justice.³

The trend gave California the dubious distinction of having the largest single mental institution in the U.S. – the Los Angeles County jail.

Some cases of the incarceration of the mentally ill are incredible. In 1984, a Colorado man with schizophrenia was jailed for the 100th time on a charge of creating a disturbance in the community.⁴ In Memphis, Tenn., a severely mentally ill woman was incarcerated for the 258th time in 1998.⁵ A study in Orange County, Calif., showed that 300 severely mentally ill offenders were rearrested three times and 119 were arrested four times.⁶

"If people with Parkinson's disease or Alzheimer's were incarcerated in these numbers there would be a public revolt," says Susan Ferraro, RN, Administrative Case Manager, Forensic and State Hospital Community Liaison at Western Psychiatric Institute and Clinic, part of the University of Pittsburgh Medical Center.

Few Hospitals, Few Options

Several developments contributed to the flood of the mentally ill into the criminal justice system. None, however, was more influential than the wholesale closing of the nation's psychiatric hospitals in the 1960s and 1970s. From a peak of 559,000 patients in 1955 the population of state mental hospitals had fallen to fewer than 60,000 by 1999.

The diversion of people with serious mental illness was part of the plan. Community-based treatment, it was argued, was a far better alternative to the warehousing of patients in overcrowded and understaffed facilities. What was not

anticipated, however, was that the thorough and effective community-based mental health system envisioned to help these people would never be fully realized.

As a result, the criminal justice system increasingly absorbed people who could not function acceptably in the community on their own.⁷ A huge upswing in the number of homeless in American cities only worsened the problem.

"A lot of times, judges didn't know what to do with them because the state hospitals were closing," says Amy Kroll, Director of Forensic Services, Allegheny County Department of Human Services. "So they put them in jail."

Other factors also contribute to the rising mentally ill population in jails and prisons as well.

Legal reform has made it more difficult to involuntarily commit a severely mentally ill person to a hospital. Many of the mentally ill struggle with drug and alcohol abuse, leaving them vulnerable to arrest, particularly during heightened anti-drug campaigns, such as the "war on drugs" during the 1980s and early 1990s. Stricter enforcement of "quality of life" offenses sweep more of the mentally ill into jails, particularly the homeless.

And, says Allegheny County Public Defender M. Susan Ruffner, some police officers tend to take mentally ill offenders straight to jail because they see it as the most convenient option. That was the case with a mentally ill man her office defended who was jailed for trying to set himself on fire, she says. "The police response was to take him to jail, because it was quicker. Drop off the prisoner, drive away. If they'd taken him to a hospital, they might have had to stick around while he is evaluated.

"They charged him with risking a catastrophe. This happened outside of a residence. No flame threatened the structure. But they charged him, made it a criminal matter. We see this at all levels for people who are nuisances in public places. First responders often treat it as a crime."

The longer the trend of rising incarceration rates continues, the greater the likelihood that being mentally ill in America will mean being arrested at some point.

"Too often," Ruffner says, "the person who is acting out due to mental illness is not viewed in terms of their treatment needs but in terms of what crimes they have committed."

Misunderstood Population

Mental illness is so poorly understood that it is not surprising that the nation's courts, in general, are ill prepared to deal with its complexities.

The majority of Americans hold perceptions of mental illness that in some cases are wildly off the mark. About 71 percent, for example, believe mental illness is caused by mental weakness, according to a survey by the National Mental Health Association. And 65 percent of Americans believe mental illness is the product of poor parenting.

Perhaps most troubling is that 35 percent of Americans believe these disorders are some kind of retribution for sinful or immoral behavior.

Part of the problem is that mental illness is complex. Axis I disorders alone have 13 major classifications of syndromes – from schizophrenia to substance use and abuse – and each has its own subsets.

"This is a population that is being under-served and stigmatized," says Ferraro. "You have to educate political figures, the legislature, and the community at large because their perception of the mentally ill in prison and jails is that they are very dangerous. That certainly is not the truth in most cases."

'Infernal Machine'

One disorder more than any other fuels public fear of the mentally ill offender. Schizophrenia, a disorder from which more than 2.5 million Americans suffer, is a widely misunderstood affliction and one of the most common mental health disorders found among jail and prison inmates.

Voices, delusions, demons – schizophrenia's image is chilling. In the first clearly described case, James Tilly Matthews said in 1810 that he became convinced an "infernal machine" was torturing and controlling him, using methods he described as "lobster-cracking, bomb-bursting, and brain lengthening."

Schizophrenia causes a person to lose core cognitive functioning, particularly in attention and working memory. Dramatic behavior and social decline is not uncommon. Symptoms may include hallucinations and disorganized thought. Emotional effects may include guilt, shame, hopelessness, and anger. In many cases, it is difficult for people with schizophrenia to achieve independence, identity, and intimacy, and such symptoms impair relationships. They often must cope with isolation and conflict. Many Americans with schizophrenia – perhaps as many as 80 percent – are jobless. And those with the disorder are 20 times more likely to become homeless.⁸

What they are not more likely to become are violent criminals. Yet, that is a common fear – one exacerbated by a few high-profile homicides committed by the mentally ill.

When the tormented Andrea Yates drowned her five children in her suburban Texas home in 2002, schizophrenia was associated with her horrible crime, the topic of massive news coverage. When *Newsweek* published a special report on "The Mystery of Schizophrenia" in its March 11, 2002 issue, the cover photograph was that of Yates in her red prison jumpsuit.

Two years earlier, mental illness was linked to two high-profile mass murders in Allegheny County. Ronald Taylor, 39, killed three men and wounded two others during a March 2000 shooting spree that had racial overtones. A defense psychiatrist said Taylor suffered from deep-seated paranoia and schizophrenia that had plagued him much of his life. One month later, Richard S. Baumhammers, 34, killed five people and wounded another in a shooting rampage, also with racial overtones, which covered 20 miles and two counties. The defense argued that he suffered from delusions and heard "voices" ordering him to kill people.

Such extreme crimes, however statistically rare, can influence the way courts handle the cases of the mentally ill, at least in the short term. In the wake of these crimes, all offenders with mental illness can become suspect in the eyes of the court. Approval for service plans and community release become more difficult to win. Jail is more likely, even for nonviolent offenders.

"The Taylors and Baumhammers," says Kroll, "set us back months."

The court's apprehension, however, ignores a few key facts. Studies suggest, for example, that any increase in arrests among people with schizophrenia is due to an increase in misdemeanor charges, such as disorderly conduct, not felonies. In fact, patients with schizophrenia are far more likely to become victims of crime than the general public.⁹

The U.S. Department of Justice reported in 1999 that 13.2 percent of all mentally ill inmates in state prisons were incarcerated on a murder charge and 1.9 percent of the mentally ill in federal prisons were serving time for murder. Studies also suggest that when violent crimes are committed by a person with schizophrenia, the offender is usually in the grip of active paranoia, is not taking any medication, and is abusing drugs or alcohol.¹⁰

Drug convictions are far more common among mentally ill prison inmates than homicide convictions: 12.8 percent of mentally ill inmates in state prisons and 40.4 percent of the mentally ill in federal prisons are incarcerated on drug offenses.¹¹

The County Jail Experience

Men and women, fresh from arrest and headed for the Allegheny County Jail, typically arrive at a secure garage of cement blocks and steel bars just off Second Avenue in downtown Pittsburgh. Their first stop is the sally port, where they are searched for weapons, drugs, and anything else that is prohibited in a facility that allows virtually no private possessions.

Once inside, one of two types of temporary painted-blue concrete cells accommodate them: individual cells for those who are immediately suspected of being psychotic, or group cells, a pen with a few steel benches bolted to the floor.

The first questions regarding an inmate's health are asked in the sally port. This is a very brief assessment: Are you all right? Are you bleeding? Taking any medication? Where do you get medical care on the outside?

Municipal court is next and is held on the premises. A second, more thorough, health assessment usually follows, during which vital signs are recorded, notes are made on the inmate's appearance, medical history, drug and alcohol use, and symptoms of psychiatric conditions. Questions also touch on topics such as sexually transmitted diseases, suicidal behavior, psychiatric history, depression, history of violent behavior. Still another assessment may be ordered if the inmate has a mental health history or shows signs of a serious mental disorder.

On any given day, there are about 225 inmates in the jail with serious mental illnesses who are on psychotropic drugs. They are kept on the jail's fifth floor in an acute mental health unit, a step-down unit, or the general population mental health unit, depending upon the severity of their illness or how stable they are.

The most seriously ill are taken to the acute mental health unit, staffed around the clock by a nurse and correctional officers. Like the other units, the lobby is carpeted and furnished with tables, chairs, a few sofas, a bank of televisions mounted on a pillar, and a kiosk of telephones. What sets this unit apart from the others, at least in appearance, is the single glass-walled cell facing the lobby and security desk. Here, an inmate considered a suicide risk is kept under conditions that deny him even a moment of privacy, but allow for closer surveillance.

Cells in the mental health units and throughout the jail are narrow and claustrophobic - four gray concrete walls, a single slit of a window to the outside, a tiny wall-mounted steel plate that passes for a desk with a stool, a steel sink-toilet unit bolted to the floor, and a steel-frame

cot, also bolted to the floor, covered with a thin mattress and tear-resistant blanket – another precaution taken to deny troubled inmates a means of suicide.

Inmates new to the mental health units are placed in single cells, but, unless they are actively psychotic, often end up sharing a cell with another person.

"Until fairly recently, we never needed to double-cell anyone with a mental health diagnosis," says Dana Phillips, Chief Operating Officer of Allegheny Correctional Health, the nonprofit that provides health services to inmates at the jail under a \$5 million contract with the county. "But, like other jails across the country, we are a lot more crowded than we used to be."

The disorders seen in the jail cover the spectrum of mental illness. The most common include schizophrenia, bipolar disorder, and depression.

These inmates are offered a range of services, including medications, forensic diversion, forensic support, and the services of social workers, psychiatrists, psychiatric nurses, and community caseworkers. Recently, the jail has added classes to help them pass the GED exam.

Despite such help, says Phillips, "jail is not the best place for most people with a mental health problem and we try to get them out as soon as possible."

The Rise Of Mental Health Courts

Dealing with mentally ill offenders has long challenged courts across the nation. Simply understanding the complex issues of mental illness from diagnosis to treatment was difficult enough. But by the early 1990s, the nation's courts, jails, and prisons were overwhelmed with people with mental illness – many, if not most, repeat offenders.

As experiments, a few jurisdictions began to look at devoting a special court to deal with the offender with mental illness. These courts, it was hoped, would develop a degree of expertise in mental illness and keep an open mind to the option of ordering treatment in the community rather than prison time.

It was not an entirely new idea. In the 1960s, the Psychiatric Institute attached to the Municipal Court of Chicago referred thousands of mentally ill offenders each year to treatment programs – including outpatient therapy – as long as their crimes were not serious.

By the late 1980s, the notion of giving the court a problem-solving role more focused on treatment was emerging as a byproduct of the war on drugs. A wave of special drug courts emerged to help ease prison overcrowding that resulted from a deluge of drug arrests. These drug courts

represented a major departure from business as usual. To reduce crime, they sought to address the cause – addiction – and preferred treatment over prison when appropriate.

This specialized, hands-on approach by the court was later seen as a way of dealing with mentally ill offenders, an even more challenging population. The first mental health court was opened in Broward County, Fla., in 1997. Other pioneering jurisdictions included King County (Seattle), Washington; Anchorage, Alaska; and San Bernardino, California.

By 2004, as many as 75 mental health courts had been established in the U.S.

Common Features

Perhaps wary of the public's misunderstanding of the mentally ill, the early mental health courts were particularly sensitive to public safety. A narrow focus on misdemeanor and other minor crimes continues to be a common thread running through most of these courts, which either screen very carefully or exclude mentally ill offenders with histories of violence.

Another common characteristic is that most mental health courts try to quickly introduce the mentally ill offender to early intervention by timely screening and referral.

A dedicated team approach is also built into most mental health courts. Such an approach requires the disparate players in the criminal justice system – judges, prosecutors, public defenders, probation officers, bail agencies, and forensic support staff – to collaborate on helping the mentally ill offender get well. It also tends to improve continuity and judicial oversight of cases involving the mentally ill. And it promotes expertise among judges and attorneys assigned to the court through special training and regular exposure to cases involving mental health issues.

Most mental health courts are voluntary programs that give offenders the choice of whether to try the treatment-oriented approach or take their chances in court, business as usual.

Mental health courts also, as a rule, tend to provide more intensive supervision of mentally ill offenders, monitoring their progress and holding them accountable for complying with their court-ordered service plans.

Different Approaches

From the beginning, mental health courts were tailored to the philosophies embraced by the jurisdictions where they were established. This has led to a few important differences.

Perhaps the most fundamental is whether being accepted into the mental health court program hinges on whether offenders plead guilty to the crimes they are accused of committing.

In Broward County, mentally ill offenders are not required to enter a plea. The court, by design, was diversion oriented and focused on those arrested for misdemeanors. Those eligible for the court are placed in treatment programs before disposition of their charges in the hope that such a non-punitive approach will help them get well and stem recidivism.

Other jurisdictions take a conviction-based approach. Mentally ill offenders generally plead guilty to the crimes they are charged with in order to be eligible for the mental health court program. Over the years, however, this approach has been softened by many courts to allow offenders to opt for a trial and remain eligible for the mental health court program if they are found guilty.

The success of these courts demonstrated in their early years and federal legislation in 2000 appropriating limited funds to explore such ideas encouraged other jurisdictions to become involved in the mental health court experiment. Allegheny County was one of them.

The Allegheny County Mental Health Court

Allegheny County was not spared the dramatic increase in mentally ill inmates the nation was experiencing throughout the 1990s.

By 2001, the Allegheny County Jail had become the third largest mental health facility in western Pennsylvania. On any given day, inmates with a serious and persistent mental illness accounted for 20-25 percent of the jail population.¹²

The Allegheny County Department of Human Services began addressing the problem in the late 1980s with the creation of a Forensic Services program, which among other services, works to divert mentally ill offenders from the county jail to community-based mental health services, provides jail inmates with case management and support, and offers follow-up support after their release. Within five years, the county reported the Forensic Services Program reduced the recidivism rate of those offenders it reached to 15%.

While the Forensic Services Program was an effective step toward helping these low-level offenders, a more holistic approach was needed that involved the court, District Attorney's office, and others.

One idea, a special Mental Health Court, would arise from after-work gatherings of several of those who worked with the mentally ill in the criminal justice system.

Beginnings

"It started out as gripe sessions," Forensic Services Director Kroll says of the series of informal meetings that began in 1996. "It was, 'We need this, we need that.'"

At the table were the people who had regular contact with mentally ill offenders as part of their work – probation officers, county mental health officials, representatives of base service units, such as the University of Pittsburgh's Western Psychiatric Institute and Clinic and Mercy Behavioral Health, and others. The frustrations met on the job led them to compare notes and review cases in the hope of identifying the roots of the problems and some possible solutions.

What they determined was that even with forensic support services in place, the court was ill-equipped to adequately respond to the number of mentally ill offenders entering the system. "We saw the same themes, regardless of the client," says Ferraro. "At that point, we realized system issues were causing the problems."

It was clear, for example, that the outcomes of these offenders were greatly influenced by the depth of understanding of mental illness that the court possessed.

For most offenders with mental illness it was simply the luck of the draw. "You may get somebody who knows a lot because they've done a lot of work in mental health and they might be able to help you even though you can't help yourself," says Mary Jo Dickson, Administrator, Bureau of Mental Health Services, Allegheny County Department of Human Services. "But other times, you might get someone who didn't know a single thing and you will have problems."

"My chief complaint," Kroll says, "was that I had four staff going before 15 common pleas court judges. We had to be in six courtrooms at once. Why couldn't we have just one judge to handle mental health cases?"

It was also determined that mentally ill offenders were typically kept in jail longer than usual before their trial. The reasons for this were numerous and varied. The court often viewed these offenders as high risk. Many were poor. And a number of factors would result in higher bonds: having no address, for example, or making a remark that a police officer or court official deemed disrespectful. Even if their bond was affordable, many mentally ill offenders have few friends or relatives able to help them to post it.

Once in jail, they were often dealt serious setbacks. They stood to lose food stamps, cash assistance, Medicaid, and other benefits critical to their chances of succeeding in the community. They could also lose their housing – a commodity in short supply for the mentally ill in Allegheny County and across the nation.

"They kind of fell through the system," says Ruffner. "No one dealt with the issue. There was no intensive probation. No service plan. No reconnection to community resources. So, a person who had been arrested for refusing to leave McDonald's would, again, go to McDonald's and refuse to leave.

"Of course, by the time they got out of jail, they had no benefits and would probably have lost their housing. So, they would have to start all over again."

It wasn't long before the after-hours gripe sessions matured into working groups and committees. What began as an informal gathering of concerned criminal justice and mental health workers became the Mental Health Court Task Force when, buoyed by the reported success of the Broward County experiment, they decided a special court for the mentally ill offender was the best solution yet for the problems they were experiencing in Allegheny County.

Wide Support

The Mental Health Court Task Force had little trouble recruiting key allies, who provided considerable leverage in raising money to launch the new court. Among the most influential were Gerard M. Bigley, administrative judge of the Allegheny County Common Pleas Court Criminal Division, and Marc Cherna, Director of the Allegheny County Department of Human Services.

Raising the prospects of the new court succeeding was the fact that the grassroots movement that developed it included key players in the criminal justice and mental health systems who wanted to see it reach its potential.

By the time the Allegheny County Mental Health Court took its first case in 2001, it commanded a \$790,000 annual budget funded by public and private monies.

The public contribution was significant and included funds from the county and a \$180,000-a-year grant from the state Department of Public Welfare's Office Of Mental Health And Substance Abuse.

Private Sector Interest

The project also appealed to three western Pennsylvania foundations. The Jewish Healthcare Foundation, Staunton Farms Foundation, and the Pittsburgh Foundation each awarded grants to help the court establish itself.

For its part, the Jewish Healthcare Foundation awarded a \$140,000 grant that spanned the first two years of the Mental Health Court.

These private funds would pay for an assistant district attorney and a public defender to be assigned to the new Mental Health Court as part of a dedicated staff trained and experienced in the mental health issues.

Within the Jewish Healthcare Foundation, the new Mental Health Court appealed to a long-standing interest in community behavioral health issues, according to foundation President, Karen Wolk Feinstein, Ph.D. These issues included insurance parity for people with mental illness, depression, and the availability of services and support for young children with behavioral problems, their families, and their teachers.

In 2001, the Jewish Healthcare Foundation had joined the Staunton Farms Foundation and the University of Pittsburgh Institute of Politics in convening a community forum that examined the county's public and private mental health systems in the wake of the Baumhammers and Taylor shooting sprees of that year. The recommendations that emerged included a call for better coordination of the treatment of mentally ill inmates and alternatives to their incarceration.

The Jewish Healthcare Foundation was also "looking for ways to optimize the performance of our courts," says Dr. Feinstein. Only two years earlier, the foundation had been one of several private sector organizations to contribute to sweeping reform in the Allegheny County Juvenile Court.

The New Court

Allegheny County's Mental Health Court, while being the first of its kind in Pennsylvania, was seen more as a way of building upon the existing infrastructure for the mentally ill than an entirely novel approach.

"As criminal justice systems go, we already had a lot in place," says Western Psychiatric Institute and Clinic's Ferraro, who was chairperson of the first Mental Health Task Force. "What we needed was something to pull all of the resources together into something smoother and more efficient."

The framers of the new Mental Health Court described its mission as an "advocate for increased public safety and reduced recidivism rates of mentally ill offenders." The new, specialized court within the criminal division of the Common Pleas Court would be "fully committed to focusing its staff, resources, and expertise on the unique needs of the mentally ill offender, thereby ensuring just process of

the law, as well as promoting public safety and improved quality of life for offenders by incorporating comprehensive community-based treatment and services as mandatory sentencing requirements.”¹³

Several characteristics of the Mental Health Court set it apart from other criminal courtrooms in Allegheny County.

- Treatment rather than incarceration is recommended for offenders diagnosed with an Axis I mental illness who are accepted into the Mental Health Court program.
- A court-approved service plan, intended to promote recovery, guides treatment and is a mandatory element of the offender’s probation.
- The Mental Health Court is assigned a dedicated staff, which includes a judge, assistant district attorney, public defender, court monitor, and probation liaison. The expected benefits include the ability to carefully monitor the progress of offenders and to develop an expertise in mental illness, treatment, and other issues.
- The progress of the offender is reviewed in hearings held in front of the Mental Health Court judge at least every three months and more frequently, if necessary.
- Participation in Mental Health Court is voluntary.

Another important characteristic of the Allegheny County Mental Health Court is that offenders are not required to plead guilty to be eligible. Those who are accepted into the program may plead not guilty and stand trial. If convicted, they are still, in most cases, eligible for the Mental Health Court program.

A Selective Program

Not every offender with mental illness is eligible for Mental Health Court. Only 30 percent of the 750 criminal offenders referred to the Allegheny County program from June 2001 to the end of 2003 were accepted.

How mentally ill offenders are accepted is an important aspect of mental health courts and one that varies from jurisdiction to jurisdiction. In Allegheny County, offenders must at least meet two basic criteria.

- They must have an Axis I diagnosis, a group of illnesses that includes organic mental disorders, substance use disorders, schizophrenic disorders, paranoid disorders, affective disorders such as bipolar disorder and major depression, and anxiety disorders.
- The crimes they are accused of must fall within a range of offenses that includes mostly low-level, nonviolent transgressions. Offenders are not eligible for Mental

Health Court if they are charged with more serious crimes, such as murder, rape, aggravated assault, arson, kidnapping, involuntary deviant sexual intercourse, drug trafficking, and robbery.

Almost anyone can refer an offender to mental health court, including family and friends, jail personnel, judges, prosecutors, defense attorneys, base service units, and district magistrates. In practice, however, most referrals in Allegheny County are made by the county mental health programs – the Behavior Clinic, Forensic Support, and Forensic Diversion.

Once an offender is referred, has been interviewed by county Forensic Services and has undergone a complete mental health assessment, Mental Health Court officials consider whether or not to grant access to the program. This debate takes place weekly behind closed doors and usually involves the assistant district attorney assigned to the Mental Health Court, the Mental Health Court public defender, Mental Health Court monitor, court liaison, and representatives of county Forensic Services.

At these meetings, the district attorney or public defender may ask that certain conditions be written into the offender's service plan. In some cases, these special provisions have allowed offenders to be admitted who might otherwise be excluded.

In most cases, offenders who are denied access to the Mental Health Court are excluded because of their violent behavior or an unfavorable criminal record.

Another common reason offenders are excluded is drawing a minimum jail sentence of one year or longer – a term that places them under the authority of the state Department of Probation and beyond the reach of the Mental Health Court.

Sentenced To Treatment

But Mental Health Court is not a get-out-of-jail-free card. The service plan negotiated as an alternative to jail is intended to be a road map for recovery – but one that must be followed if offenders wish to avoid the risk having a term of probation become prison time.

These plans are often demanding and not all eligible offenders are interested in the rigorous process. For example, 10 percent of the 162 offenders referred to the program from July 1 through December 31, 2003 turned down the offer to participate.

Most Mental Health Court service plans stipulate where offenders live during their probation. Offenders typically must agree to participate in outpatient treatment, which may include individual therapy, vocational rehabilitation,

drug and alcohol counseling, and other services. They are required to abstain from using drugs and alcohol. They must agree to take their medications as prescribed. And they are required to cooperate with their case managers and meet with forensic specialists, doctors, and probation officers. Other requirements may also be added, such as an order to look for a job or work toward earning a GED.

Once they are released into the community to serve out their probation, Mental Health Court participants are kept on the court's radar by their probation officers and the Mental Health Court Probation Liaison.

"The first time they see me is usually in court," says Clyde Ledbetter, the Allegheny County Mental Health Court Liaison. "After that, they'll see a lot of me."

It is up to Ledbetter to update the court on how Mental Health Court participants are progressing and to help them stay in contact with probation officers, visit their doctors as scheduled, and otherwise comply with their service plans. His reports are critical to the outcomes of enforcement hearings before a Mental Health Court judge, which offenders are obligated to attend during their probation.

During the first two years of the program, the court has had little cause for concern. Ledbetter's reports suggest most did not stray from the course prescribed by the court. In fact, positive reinforcement hearings – those in which the court finds progress being made – outnumber negative reinforcement hearings by more than three-to-one.¹⁴

The reasons prompting negative reinforcement hearings included refusal of treatment, leaving treatment programs, and use of illegal drugs or alcohol.

Staying On Track

The enforcement hearings scheduled before Judge Colville on a winter day in late January 2003 were typical of what the court witnesses. In a little more than one hour, 18 hearings were dispatched – a pace possible only because few of the offenders who appeared that day had not complied with their service plans.

When problems arose, they were often minor. One woman doing well in treatment said she sometimes lacks the motivation to get to her appointments on cold winter mornings. Colville stressed the importance of living up to her commitments, then offered a bit of sympathy: "I have the same problem getting out of bed in this weather."

The most serious case involved a young man who by all accounts is following his service plan, but when Colville asked him how he was faring, he openly confessed to

sneaking a drink or two during moments of weakness. He knows it is wrong, he says, but he can't help himself.

The young man's candor is unusual. His struggle with alcohol is not. Nearly 82 percent of the men and women who pass through Mental Health Court have a substance abuse problem.¹⁵ It exacerbates their illness, complicates efforts to help them, and darkens their prospects of recovery.

"I try everything I can to help them before I have a negative hearing," says Ledbetter. "Relapse happens. It's common. So, we try to get a person directed back into treatment."

Colville reminded the young man of the progress he is making and how he stands to lose that precious momentum toward recovery if he starts drinking again. "It starts you on a downhill slide," he says.

"I'll quit," the young man says, having overheard the judge.

Public Defender's Role

As one of its first contributions to the Mental Health Court in Allegheny County, the public defender's office balked at the notion that mentally ill offenders should plead guilty before being considered for the program intended to be improve their ability to live law-abiding lives outside prison walls.

Their right to counsel during every step of the process was another point raised. "It was important to us that if these people are going to talk about what they have done, it should be covered by attorney-client privilege," says Ruffner. "In all due respect to prosecutors around the country, their care for criminal defendant is less than ours."

The eligibility requirements of the Mental Health Court do not include a mandatory plea of guilty to charges. And the new court calls for a dedicated public defender to be assigned to handle the cases of clients with mental illness who have not retained their own counsel.

Defending a client in Mental Health Court is labor-intensive and requires a firm grasp of issues such as mental illness, mental health assessment, service plans, treatment, community services, and housing. The attorneys are also required to represent these clients in hundreds of court proceedings a year. "You can't do this on the fly. You need to dedicate an attorney to this," Ruffner says.

Such an arrangement also allows the Mental Health Court public defender, to get to know her clients better and develop a deeper understanding of what they need to succeed outside the criminal justice system.

"There is nothing worse than having someone who is a paranoid schizophrenic get three or four different attorneys so that every time he turns around there is a new person he needs to trust," says Michael Nahas, supervisor of pre-trial services in the Office of the Public Defender.

"They all have my cell phone number," says Michele Leigh Bailey, Mental Health Court public defender. "I get calls at 3 a.m., 4 a.m. – anything from, 'I'm hearing voices again, what should I do?' to 'Am I allowed to go to this location or that location?'"

For the offender with mental illness, the decision whether to pursue community-based treatment through Mental Health Court rather than stand trial and risk a possible jail term is not always automatic. In some cases, offenders face the likelihood of an easier sentence – a short jail sentence or less demanding term of probation – if they choose not to go through Mental Health Court.

"We abide by the rules of professional responsibility as lawyers," Ruffner says. "That means telling them the truth, which may be there may be a shorter path here."

Such circumstances arise in only about 10 percent of the cases. And it is not unusual for a client to opt for Mental Health Court, even if it imposes more rigorous demands, Bailey says. "A lot of clients are looking for a way to prevent them from returning. They're tired of going through the system and they've come to understand they need help."

The Prosecution's Perspective

For any mental health court to succeed, prosecutors must buy into the idea of emphasizing treatment over punishment when appropriate. At the same time, their responsibility to ensure public safety is not diminished.

"You can't be absolutely certain whether a person is a threat to society," says Anthony DeLuca, an assistant district attorney who was assigned to Mental Health Court in Allegheny County throughout 2003. "What you try to determine is how much of a threat they are. When guns are involved, for example, I get very nervous.

"Is the person a potential Baumhammers? I'm concerned about that."

When he worked Mental Health Court, DeLuca had a voice in decisions about who is accepted into the program and under what terms. Facts that influence his decisions the most include the crime committed; whether violence, a weapon, or drugs were involved; an offender's prior criminal charges; and the jail or probation time referrals likely face if convicted.

Top priority is given to making sure that offenders accepted into the Mental Health Court program are not a high risk to society.

"I see Mental Health Court as being more appropriate for a person who is going to have probation or a short period of incarceration and is going to be released quickly back into the community," DeLuca says. "Those are the people who we want to catch and make sure they get the treatment they need. Otherwise, they're just sitting on probation committing more offenses and not doing too well."

Many minor nonviolent crimes are usually easy approvals. These include possession of a controlled substance, defiant trespass and retail theft. "I never rejected a retail theft and I don't see a situation in which I would. I don't care what the value of the stolen merchandise is. It is a nonviolent offense that is usually committed by someone with mental health or dependency problems who needs help."

Violent crimes and drug trafficking are almost always automatic rejections. The district attorney's office is also reluctant to accept someone arrested for a purse snatching or other robberies that involve force or a threat of force or violence.

The District Attorney's office also finds itself in the role of liaison between court and the victims of crimes and the police, which often involves explaining what a mental health court is all about.

"We're the people who listen to the victims," DeLuca says. "However, that doesn't mean we're always going to do what the victim wants to do. We take their concerns into account when we make a determination about whether the person is going to be admitted into the program."

"Responses vary, as they do with all cases and victims. Oddly enough, it often doesn't depend on the severity of the case, but the individual you are talking to. Typically, people initially are under the misconception that Mental Health Court is a pretrial disposition program - that if the person completes the program, the charges are dismissed. That is not the case."

In some cases, the District Attorney's office attempts to have the bail of certain nonviolent offenders with mental illness reduced so they can avoid jail while waiting for their day in court and retain their benefits and housing arrangements. "We keep control over the person. In these cases, ROR [released on your own recognizance] is kind of a misnomer," says Assistant District Attorney Eric J. Woltshock. "You are really not on your own recognizance when you are in Mental Health Court. You are being closely

supervised and you have to follow your service plan. They are not just let out. They are monitored.”

Court Process Outcomes

The first two years of the Mental Health Court program in Allegheny County saw measured progress toward short-term goals related to the court process as well as some growing pains.

Referrals made to the program remain an important issue.

- 746 referrals were made to the court during its first 30 months, a number lower than 400-a-year projection set at the start of the program.

Those familiar with the court believe referrals are strongly associated with awareness and understanding of the program across the criminal justice system.

For longer than two years, the county has held trainings for those involved in the treatment of offenders with mental illness, including district magistrates, probation officers, base service unit staff, the district attorneys office and the public defenders office.

In one respect, the training has had an impact. The number of referrals made each year has increased from the 280 made during the first year of the program.

However, only 32 percent of those referred were accepted into the program. Of the total 746 referrals made from June 2001 to December 2003, 239 were accepted into the Mental Health Court program.

“Referrals picked up” says Kroll. “But a lot of them aren’t appropriate. Some can’t even show a documented mental health history.”

In some cases, private attorneys may try to get offenders into the program who clearly are ineligible, as a last-ditch attempt to avoid prison sentences. But a poor understanding of the Mental Health Court requirements is likely to account for a high number of inappropriate referrals. And part of the reason for the poor understanding of the new court is the high turnover rates among professions who deal with offenders with mental illness.

A new round of training is scheduled for 2004.

Another important process measure is how long mentally ill offenders remain in jail before they are released into the community on bail or probation as part of the Mental Health Court program.

- Mental Health Court participants spent an average of 45 days in jail before being released on their service plans.

The average time in jail fell significantly from the first year, when program participants spent an average of 148 days in jail. However, even the improved averages are longer than the 30 days the program set as a goal – an objective many program officials now believe was unrealistic.

The average time offenders spend in jail can be misleading. In the first year, for example, many Mental Health Court participants were referred directly from jail, where they had been for days, weeks, even months before the program began.

Complicating the statistics on average length of time in jail is the fact that many Mental Health Court participants have prior offenses. Any new charge, even nonviolent offenses, can result in offenders being detained in jail until their probation violations are adjudicated.

Well Received

Among the more promising two-year outcomes is how well offenders with mental illness have embraced the offer of intensive community-based treatment as a condition of their probation.

Architects of the Mental Health Court hoped a significant share of those chosen for the voluntary program would accept their mental health service plans and comply with the treatment regimen throughout their probation.

The program is rigorous and not suited for all offenders with mental illness. Nevertheless, the vast majority who are eligible agree to participate. Only about 10 percent of offenders who are referred turn down the program. Many of those who refuse are struggling with substance abuse. "They don't want to do intensive treatment," says Kroll. "Many of them aren't willing to say they are done with drugs and alcohol."

Encouraging Trends

From the beginning, the Mental Health Court set its sights on improving the mental health stability of its participants over the long term. The proposed methods of measuring this outcome include looking at recidivism rates of program participants, the number of times they have been hospitalized for mental illness, and arrest rates.

Two-year outcomes suggest encouraging trends. From June 1 2001 to December 31, 2003:

- Fewer than 5 percent of Mental Health Court participants were hospitalized for inpatient mental health care while they were in the program.

- Only 13 of the 239 offenders accepted into Mental Health Court – about 5.5 percent – were rearrested on new charges while in the program.
- 47 offenders with mental illness – 20 percent of Mental Health Court participants – successfully graduated from the program by the end of 2003.
- No offender in the Mental Health Court program received a term of probation greater than five years.
- The average Mental Health Court term of probation was 18 months.

Such outcomes have not gone unnoticed. Interest in the Allegheny County Mental Health Court model is growing with inquiries coming from county governments as well as state and national criminal justice organizations, including the Pennsylvania Commission on Sentencing and the Council for State Governments.

In June 2003, the Mental Health Court program was awarded \$298,188 in additional funding from the U.S. Department of Justice. The two-year grant will provide more training to improve the quality of referrals made to the Mental Health Court, expand the number of experienced service providers and will allow the program to add a Community Treatment Team focused on improving the outcomes of mentally-ill offenders with complex histories and multiple needs.

The low recidivism rate is particularly impressive among criminal justice programs. "We do a few things other courts don't do," says Kroll. "Our forensic liaison follows them all the way through their probation. He is always there. He is talking to the treatment provider, talking to probation officer, talking to the client. That has a major impact on these individual's lives."

A More Enlightened Approach

Anecdotal evidence suggests the new court has also led to a more consistent, even-handed, enlightened approach to dealing with offenders with mental illness who enter the criminal justice system in Allegheny County.

"These are mentally ill people who need treatment," says Ruffner, the county public defender. "Now, we're giving them treatment and guess what – they generally conform to the law; they don't do the things anymore that cause them to be arrested; they're non-assaultive; not suicidal. They're back in touch with their life, whatever their life is."

Even veterans of criminal justice report being awakened to the conditions of the mentally ill.

"One thing that struck me is that these people, for the most part, are nice people," says Judge Colville, a former

district attorney and police officer. "The meds are important for them and they need to get treatment, but they are really happy not to have to fight the demons all of the time. Given half a chance, they justify the court taking the risk to keep them out of jail.

"As I talk to them, I find myself getting to like them and I can say they really are trying to change their lives. I've been in the business of arresting thieves and conmen and most are BS-ers and it's not hard to figure them out when you talk to them. But these people who come to Mental Health Court are trying to do the best for themselves under what are not easy conditions. It's been an enlightenment."

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References

- ¹ Kroll, A. *Allegheny County Mental Health Court: Semi-Annual Report. August 31, 2004.* Pittsburgh, PA: Allegheny County Department of Human Services, Office of Behavioral Health.
- ² Grob, G.N. (1966). *The State of the Mentally Ill.* Chapel Hill, NC: University of North Carolina Press, pp. 22.
- ³ Ditton, P.M. (1999). *Mental Health and Treatment of Inmates and Probationers.* Bureau of Justice Statistics Special Report, Office of Justice Programs, U.S. Department of Justice, Washington, D.C.
- ⁴ Torrey, E.F. (1997). *Out of the Shadows: Confronting America's Mental Illness Crisis.* New York: John Wiley and Sons.
- ⁵ Downing, S. (1998). Social ills get dumped in jail says Lawhead. Memphis, TN: *Commercial Appeal*, Nov. 6.
- ⁶ Saavedra, T. (1999). Mentally ill winding up in jails, *Orange County Register*, March 7.
- ⁷ Goldkamp, J.S., & Irons-Guynn, C. (2000). *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage.* Washington, D.C.: Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice.
- ⁸ Mobray, C.T. (1985). Homelessness in America: Myths and realities. *American Journal of Orthopsychiatry*, 55, pp. 4-5.
- ⁹ Maxmen, J.S., & Ward, N.G. (1995). *Essential Psychopathology And Its Treatment*, 2nd ed. New York: W.W. Norton.
- ¹⁰ Steadman, H.J., Mulvey, E.P., Monahan, J., et al. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, 55, pp. 393-401.
- ¹¹ Ditton, op. cit.
- ¹² Letter written by Gerard M. Bigley, Administrative Judge, Criminal Division, Court of Common Pleas of Allegheny County to members of the Pennsylvania General Assembly and Senate. January 2, 2001.
- ¹³ *Allegheny County Mental Health Court Project, October 31, 2000, Executive Summary*, pp. 3. Allegheny County Department of Human Services, Office of Behavior Health.
- ¹⁴ Kroll, A. op. cit.
- ¹⁵ Ibid.