

**THE COST OF CRAZY: HOW THERAPEUTIC
JURISPRUDENCE AND MENTAL HEALTH
COURTS LOWER INCARCERATION COSTS,
REDUCE RECIDIVISM, AND IMPROVE PUBLIC
SAFETY**

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I. INTRODUCTION

The American criminal justice system is beginning to reflect the changing ideas of incarceration; indeed, the proverbial pendulum that once swung toward the retributive theory of justice is beginning to swing back toward rehabilitation.¹ The traditional method of “lock them up and throw away the key” has proven to be ineffective at reducing crime, yet very effective at taxing the public with enormous costs—more than one in every one hundred adults in America are in jail or in prison for the first time in history.²

Within the past twenty years, legal practitioners and legal scholars have devised and implemented legal theories that have shifted the way the American justice system functions.³ These philosophical shifts, coupled with the growing frustration of judges, prosecutors, and criminal defense attorneys, have resulted in the implementation of problem solving courts—also called “specialty courts”—which have flourished throughout the country since 1989.⁴ Drug courts were the primordial specialty court.⁵ Given their well-established operation, they have advanced the most and offer the most data on their operations and effectiveness.⁶ Other types of specialty courts include community courts, domestic violence courts, homelessness courts, and mental health courts (MHCs).⁷

Although all problem solving courts are rooted in the legal theories of

1. *Developments in the Law—The Law of Mental Illness*, 121 HARV. L. REV. 1168,1175 (2008) (stating that the once prevalent rehabilitative theory of punishment changed in 1984 with enactment of the Sentencing Reform Act and Federal Sentencing guidelines).

2. *See generally* PEW CENTER ON THE STATES, ONE IN 100: BEHIND BARS IN AMERICA 2008 (2009) [hereinafter ONE IN 100], http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/sentencing_and_corrections/one_in_100.pdf. Jail is the detention facility of a local government holding those awaiting trial and prison is “[a] state or federal facility of confinement for convicted criminals.” BLACK’S LAW DICTIONARY 1232 (8th ed. 2004).

3. *See* Andrea M. Odegaard, *Therapeutic Jurisprudence: The Impact of Mental Health Courts on the Criminal Justice System*, 83 N.D. L. REV. 225, 226-27 (2007).

4. GREG BERMAN & JOHN FEINBLATT, CTR. FOR COURT INNOVATION, PROBLEM-SOLVING COURTS: A BRIEF PRIMER 3 (2001) [hereinafter BRIEF PRIMER], *available at* http://www.courtinnovation.org/pdf/prob_solv_courts.pdf.

5. BRIEF PRIMER, *supra* note 4, at 3.

6. James L. Nolan Jr., *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 40 AM. CRIM. L. REV. 1541, 1542 (2003).

7. BRIEF PRIMER, *supra* note 4, at 4-5; *see also* Jonathan Lippman, *Achieving Better Outcomes for Litigants in the New York State Courts*, 34 FORDHAM URB. L.J. 813, 826-29 (2007).

therapeutic jurisprudence and restorative justice, MHCs are uniquely focused on problem solving in their approach.⁸ Since the advent of problem solving courts and the rise of their presence in the American judicial system, studies and reports from various agencies show that problem solving courts, and MHCs in particular, are very effective in reducing recidivism among participants.⁹ They focus on nonviolent recidivist misdemeanants and concentrate on treating the illness that led to the offense.¹⁰ Lower criminal recidivism rates means fewer prison inmates, which translates into increased savings in per capita incarceration costs to the state and, therefore, the taxpayer.¹¹

In 2009, Louisiana had the highest rate of adult incarceration of any state in the country with one in every fifty-five Louisiana residents behind bars.¹² At present, there is only one MHC in Louisiana operating one day a week and serving roughly eighty-five participants.¹³ This is simply not enough; it fails to meet the needs of the state's mentally ill and unduly burdens the taxpayer with expenses that can be easily reduced.¹⁴ This Comment argues that a statewide pilot program could install MHCs to significantly reduce the cost of incarceration to taxpayers, lower criminal recidivism thus increasing public safety, and further social justice. Part II of this Comment will examine the history of incarceration in the United States. The section focuses on the closing of America's mental health hospitals and the after-effects of that movement—primarily the rise in the number of incarcerated citizens. Furthermore, it will examine the rise in caseloads that prompted the development of the legal theories of restorative

8. Nolan, *supra* note 6, at 1544.

9. See KELLY O'KEEFE, CTR. FOR COURT INNOVATION, THE BROOKLYN MENTAL HEALTH COURT EVALUATION: PLANNING, IMPLEMENTATION, COURTROOM DYNAMICS, AND PARTICIPANT OUTCOMES 3-4 (2006) [hereinafter BMHCE], available at http://www.courtinnovation.org/_uploads/documents/BMHCEvaluation.pdf.

10. GREG BERMAN & DEREK DENCKLA, CTR. FOR COURT INNOVATION, RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS 8-9 (2001) [hereinafter REVOLVING DOOR], available at http://www.courtinnovation.org/_uploads/documents/rethinkingtherevolvingdoor.pdf.

11. 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, 272 (2001).

12. THE PEW CENTER ON THE STATES, ONE IN 31: THE LONG REACH OF AMERICAN CORRECTIONS 43 tbl.A-4 (2009) [hereinafter ONE IN 31], available at www.pewcenteronthestates.org/uploadedFiles/PSPP_1in31_report_FINAL_WEB_3-26-09.pdf.

13. Telephone Interview with the Honorable Arthur L. Hunter, Jr., Chief Judge, Orleans Parish Criminal District Court (Mar. 31, 2009) [hereinafter Judge Hunter Telephone Interview]. Louisiana's only Mental Health Court is operated by Judge Arthur Hunter in Section K of Orleans Parish Criminal District Court. *Id.*

14. See ONE IN 100, *supra* note 2, at 11-20; see also Tim Morris, *Louisiana's Incarceration Rate is No. 1 in Nation*, TIMES-PICAYUNE, Mar. 2, 2009, available at http://www.nola.com/news/index.ssf/2009/03/louisianas_incarceration_rate.html#.

justice and therapeutic jurisprudence, the latter being the basis for the advent of problem solving courts and specifically MHCs. Part III will outline how a problem solving court operates and selects its clients, using the generally employed model and structure of an MHC as illustration. Part IV will discuss the current national and local incarceration landscapes and their associated costs in relation to the cost of treatment for a jail diversion program like MHCs. Part V will analyze the national and local approach to incarceration and propose a statewide MHC pilot program in strategic cities to maximize effectiveness and allow for early and continued evaluation. Part VI will briefly conclude.

II. BACKGROUND

A. HISTORY OF THE CRIMINAL JUSTICE SYSTEM

At the beginning of the twentieth century, those suffering from mental illnesses were sent to treatment facilities. It was widely believed by psychiatrists and legal scholars that the protection of the mentally ill and society “demand[ed] that [they] be kept in a quiet and secluded residence, guarded by watchful attendants and not exposed to the public.”¹⁵ Laws assured that psychiatrists could, with some exceptions, appear in court to help the judge and jury better distinguish the gray, often elusive line between mental competency and insanity.¹⁶ However, there was widespread public skepticism of these psychiatric evaluations, resulting in a call for limited criteria of civil commitment proceedings.¹⁷

Because of the historic misunderstanding of mental illness, exacerbated by the advent of film and television, the mentally ill were labeled as violent and dangerous people.¹⁸ This view persisted into the 1950s and was well articulated in a report to the National Association for Mental Health (NAMI) in which Dr. Shirley Star stated that the reaction of the American people to the mentally ill was one of “fear, distrust, suspicion, and apprehension derived primarily from the assumption that the person could not really be cured.”¹⁹ Consequently, the Joint Commission on

15. See Peter McCandless, *Liberty and Lunacy: The Victorians and Wrongful Confinement, in MADHOUSES, MAD DOCTORS AND MADMEN* 339, 339 (A. Scull ed., 1981).

16. McCandless, *supra* note 15, at 339.

17. Kondo, *supra* note 11, at 267. A civil commitment proceeding determines whether one should be committed to an institution involuntarily. “[U]nlike criminal incarceration, civil commitment is for an indefinite period.” BLACK’S LAW DICTIONARY 262 (8th ed. 2004).

18. Kondo, *supra* note 11, at 267-68 (citing Ron Schraiber, *Stereotyping Mental Illness*, L.A. TIMES, Apr. 3, 1995, at F3 (noting a study of network television dramas over a twenty year period by the Annenberg School of Communication in Pennsylvania found that “mentally ill” characters were “the single most violent group on TV”)).

19. *Id.* (citing Shirley Star, *What the Public Thinks About Mental Health and Mental Illness*,

Mental Illness and Health was founded in 1955 to examine the state of mental illness in America and its treatment, as well as the negative stereotypes and stigmas associated with mental illness.²⁰ The Commission's report revealed that, in the 1950s, "there were approximately 565,000 people with severe mental illnesses in state psychiatric hospitals," that conditions in mental hospitals were horrific, and most notably, that the number of people in mental hospitals in 1955 (approximately 819,000) was larger than the number of inmates then incarcerated in prisons.²¹

1. DEINSTITUTIONALIZATION IN THE 1960S AND 1970S AND THE CRIMINALIZATION OF MENTAL ILLNESS IN AMERICA

The media exposure of atrocious conditions at some mental hospitals led to legal action.²² President Kennedy spoke out for alternatives to hospitalization, such as outpatient treatment facilities and halfway homes.²³ However, the government's failure to provide services, coupled with court intervention, heavily affected the process.²⁴ What followed was the movement now called "deinstitutionalization," which led to a nationwide closing of psychiatric hospitals.²⁵ It has been referred to as "the largest failed social experiment in twentieth-century America."²⁶

The jurisprudential effect of deinstitutionalization first involved the striking down of civil commitment statutes in many states.²⁷ Subsequent case law addressed the state of, and constitutional requirements for, health

Paper presented at the annual meeting of the National Association for Mental Health, Nov. 19, 1952, Chicago: University of Chicago Microfilms, at 23).

20. Kondo, *supra* note 11, at 268.

21. *Id.*

22. *Id.* The conditions in some psychiatric wards and hospitals were so bad, they were nicknamed "snake pits." *Id.* (citing ALEX DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THE CARE AND TREATMENT FROM COLONIAL TIMES* (2d ed. 1949)); *see also* Opinion, *Decriminalizing Mental Illness*, N.Y. TIMES, July 16, 2006 (discussing the closing of mental hospitals in the 1960s and 1970s), available at http://www.nytimes.com/2006/07/16/opinion/nyregionopinions/CI_prisonmental.html.

23. Stephen Allen, *Mental Health Treatment and the Criminal Justice System*, 4 J. HEALTH & BIOMEDICAL L. 153, 157 (2008) (citing Gerald E. Nora, *Prosecutor as "Nurse Ratched"?: Misusing Criminal Justice as Alternative Medicine*, 22 CRIM. JUST. 18, 18 (2007)).

24. *Id.* (citing Nora, *supra* note 23, at 18 ("Kennedy's vision was also arguably retarded by legislation brought forth by civil libertarians that largely restricted the capability to involuntarily commit mentally ill persons.")).

25. *Id.* at 157-58.

26. E. Fuller Torrey, Editorial, *Jails and Prisons—America's New Mental Hospitals*, 85 AM. J. PUB. HEALTH 1611, 1612 (1995).

27. Odegaard, *supra* note 3, at 231-32. A civil commitment statute is "law that provides for the confinement of a person who is mentally ill, incompetent, drug-addicted, or the like, often a sexually violent predator. Unlike criminal incarceration, civil commitment is for an indefinite period." BLACK'S LAW DICTIONARY 232 (8th ed. 2004).

care in America's jails and prisons, including mental health care.²⁸ The United States Supreme Court ruled in the 1975 case *O'Connor v. Donaldson* that a showing of mental illness alone, without the patient being a danger to society, was not an adequate basis for a state to confine the patient to a mental hospital.²⁹ After the *O'Connor* decision, states began to change their commitment statutes, striking them down in some cases.³⁰ This only marked the beginning of a "mass exodus" of mental health patients from hospitals back into the community.³¹ However, the community treatment options that promised to act as a substitute for inpatient treatment, were, for many reasons, ill-fated from the beginning.³²

Like the Kennedy administration, President Johnson's administration failed to overcome financial difficulties associated with implementing Kennedy's plan, and the promised services never materialized.³³ Dr. E. Fuller Torrey captured the movement's long lasting repercussions aptly when he said: "Approximately 92% of the people who would have been living in public psychiatric hospitals in 1955 were not living there in 1994. . . . [A]pproximately 763,391 severely mentally ill people . . . are living in the community today who would have been hospitalized 40 years ago."³⁴ The lack of necessary outpatient treatment for those leaving mental health facilities led to a "migration of . . . patient populations from mental health facilities to prisons."³⁵ Those who should have been in hospitals went to the streets, many being arrested and incarcerated.³⁶ This "migration" and the subsequent high rate of arrest of nonviolent mentally ill Americans—many of whom were homeless and or substance dependent—has been termed the "'criminalization' of the mentally ill in America."³⁷ This trend of criminalizing mental illness is one that continues today.

28. See discussion *infra* Part II.A.3.

29. *O'Connor v. Donaldson*, 422 U.S. 563 (1975). More recently, the Court in *Olmstead v. L.C.* held that where mental health professionals find that a patient's needs can be more effectively treated in the community rather than a mental health hospital, and the patient requests such treatment, states are required to provide community based treatment. *Olmstead v. L.C.*, 527 U.S. 581, 587 (1999).

30. Odegaard, *supra* note 3, at 233.

31. *Id.*

32. See Allen, *supra* note 23, at 158 (citing Nora, *supra* note 23, at 18).

33. Kondo, *supra* note 11, at 269.

34. E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 8-9 (1997). Dr. Torrey is a research psychiatrist specializing in schizophrenia and manic-depressive illness. He is the founder of the Treatment Advocacy Center and the Executive Director of the Stanley Medical Research Institute, which supports research on schizophrenia and manic-depressive illness. *Id.*

35. Allen, *supra* note 23, at 158 (citing Nora, *supra* note 23, at 23).

36. *Id.* at 157-58.

37. *Id.* at 158.

It is important to note that the intermediate stop in the journey from hospitals to the criminal justice system was, and still is in many cases, homelessness.³⁸ In the 1980s, the continuing effects of this failed movement were evinced by the fact that the number of homeless people in America rose dramatically because of the failure to implement “deinstitutionalization community-based substitutes” to mental hospitals.³⁹ Along with homelessness, substance abuse and dependence are considered “strong indicators of mental illness.”⁴⁰ Significant in the early to mid-1980s was an enormous increase in drug related crime in urban jurisdictions.⁴¹ In 1984, the Sentencing Reform Act established the Federal Sentencing Guidelines setting mandatory minimums and high statutory maximums for many crimes including drug abuse.⁴² Along with state changes in incarceration policy, the “War on Drugs” saw a 19% increase in the number of people arrested for drug abuse between 1985 and 1995.⁴³ Although seemingly unrelated to deinstitutionalization’s “criminalization” of mental health, the problematic effects of the close relationship between drug abuse and mental illness are obvious in the present day.⁴⁴

2. MENTAL ILLNESS IN THE PRISON SYSTEM TODAY

In 2003 President Bush created the New Freedom Commission on Mental Health to address the problems with the delivery of mental health treatment that “allow[s] Americans to fall through the system’s cracks.”⁴⁵ The Commission’s Report found that “today’s mental health care system is a patchwork relic—the result of disjointed reforms and policies.”⁴⁶ Although the report mainly focused on implementing a nation-wide transformation of America’s approach to mental health treatment, the Commission did make recommendations on mental health care in the

38. Allen, *supra* note 23, at 157-58.

39. Kondo, *supra* note 11, at 269 (citing the AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE, INVOLUNTARY COMMITMENT TO OUTPATIENT TREATMENT 1 (1987)).

40. Allen, *supra* note 23, at 159.

41. See Tamar M. Meekins, “Specialized Justice”: *The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense Paradigm*, 40 SUFFOLK U. L. REV. 1, 29 (2006).

42. *Developments in the Law—The Law of Mental Illness*, *supra* note 1, at 1175.

43. Meekins, *supra* note 41, at 2 (discussing some of the “failed attempts to rid society of the criminal element.” (citing FEDERAL BUREAU OF INVESTIGATION, UNIFORM CRIME REPORTS (1985-1995))).

44. See Allen, *supra* note 23, at 158-59.

45. PRESIDENT’S NEW FREEDOM COMM’N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 1 (2003) [hereinafter NEW FREEDOM COMM’N], available at <http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>.

46. NEW FREEDOM COMM’N, *supra* note 45, at 1.

criminal justice system.⁴⁷ Those with severe and persistent mental illness who enter the system “are likely to continually recycle through the . . . criminal justice system,”⁴⁸ because when they enter jail or prison “people with mental illnesses frequently do not receive appropriate mental health services.”⁴⁹

A 2005 study by the United States Department of Justice, Bureau of Justice Statistics, reported that over half of the inmate population had a mental illness that year.⁵⁰ Of these prisoners, less than one half had ever received treatment for their illnesses before entering the criminal justice system, and an even smaller fraction had ever taken medication for their illnesses.⁵¹ Of those prisoners with mental illnesses, 64% of federal prisoners, 74% of state prisoners, and 76% of jail inmates were substance dependent or abusive.⁵² Following the trend of homelessness caused in part by deinstitutionalization, mentally ill state prisoners and jail inmates were “twice as likely as inmates without a mental health problem . . . to have been homeless in the year before their incarceration.”⁵³

The study surveyed both state and federal prisoners and inmates of local jails, reporting data for each individual group, as well as statistics for the combined total numbers.⁵⁴ Of each of the three groups studied, inmates in local jails had the highest rate of symptoms of mental health disorders.⁵⁵ Local jails usually hold inmates for short periods of time, pending some

47. NEW FREEDOM COMM’N, *supra* note 45, at 32-33, 43.

48. *Id.* at 32.

49. *Id.* While conditions in mental hospitals have improved since the 1950s, some prisons now resemble the psychiatric wards of the 1950s. See Allen, *supra* note 23, at 166, 169-70 (discussing the New York Correctional Associations habitual practice of placing prisoners in solitary confinement up to 23 hours a day for thirty days making pre-existing mental illness worse and causing “[W]eeping in their cells’ . . . ‘mutilat[ion of] their own flesh,’ [and]. . . ‘smear[ing] feces on themselves’”).

50. DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, U.S. DEP’T. OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006) [hereinafter MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES], available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf>. This study used the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), to define “recent history of a mental health problem” and “symptoms of a mental health disorder.” *Id.*

51. *Id.* at 9 & tbl.14.

52. *Id.* at 6. “Substance dependency” and “substance abuse” included drugs and alcohol and were measured as defined by the DSM-IV. *Id.*

53. *Id.* at 4 & tbl.4.

54. MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES, *supra* note 50, at 3. This study did not take into account those adjudged not guilty by reason of insanity or mentally incompetent to stand trial. *Id.* at 3 n.1.

55. *Id.* at 3 tbl.1&2. 60.5% of jail inmates had symptoms of mental health disorders, compared with 49.2% of State prison inmates, and 39.8% of Federal Prisoners. *Id.* at 3 tbl.1.

stage in the criminal adjudication process.⁵⁶ The opportunity for inmates in a federal penitentiary to have their mental condition assessed, diagnosed, and professionally treated is higher because those facilities generally hold inmates for much longer periods of incarceration.⁵⁷

The most prevalent illness reported was depression, which is generally characterized by one or more major depressive episodes and accompanied by “social, occupational, or functional impairment in a clinically significant way.”⁵⁸ The next most prevalent severe and persistent mental illnesses among prisoners and inmates were schizophrenia and bi-polar disorder, both treatable illnesses.⁵⁹ It is a recognized fact that treatment for mental illness is most effective if diagnosis and intervention occur early in the disease’s progression.⁶⁰ In fact, if diagnosis occurs early enough, treatment for mental illness has a success rate comparable to common surgery.⁶¹ The result of deinstitutionalization is that huge numbers of citizens afflicted with mental illness are “inextricably trapped in a ‘revolving door’ of petty crime, incarceration, release, homelessness, and re-imprisonment.”⁶²

Most relevant to current situation in the Louisiana prison system is a report by the Civil Rights Division of the United States Department of Justice issued March 11, 2009, detailing the conditions in Orleans Parish Prison (OPP).⁶³ After extensive interviews with staff and inmates as well as onsite inspections, the report found that “OPP fails to adequately protect inmates from harm and serious risk of harm from staff and other inmates; fails to provide inmates with adequate mental health care; fails to provide adequate suicide prevention; [and] fails to provide adequate medication management”⁶⁴

56. MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES, *supra* note 50, at 3.

57. *Id.*

58. Allen, *supra* note 23, at 159-60 (citing MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES, *supra* note 50, at 3); AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 349 (4th ed. 2000) [hereinafter DSM-IV]).

59. Allen, *supra* note 23, at 161-62 (citing MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES, *supra* note 50, at 2). Allen notes that 11.8% of state prison population experience schizophrenic hallucinations and 7.9% of state prison population experience schizophrenic delusions. *Id.* at 164 (citing MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES, *supra* note 50, at 2).

60. *Id.* at 166.

61. *Id.*

62. Kondo, *supra* note 11, at 257.

63. LORETTA KING, CIVIL RIGHTS DIVISION, UNITED STATES DEPARTMENT OF JUSTICE, ORLEANS PARISH PRISON SYSTEM (2009), available at http://www.usdoj.gov/crt/split/documents/parish_findlet.pdf.

64. *Id.* at 5.

3. THE JURISPRUDENCE OF DEINSTITUTIONALIZATION

Substantive mental health jurisprudence delineates some constitutional requirements of the nation's prisons.⁶⁵ However, these standards set a high threshold.⁶⁶ In the 1976 case *Estelle v. Gamble*,⁶⁷ the United States Supreme Court created a two-pronged objective standard to evaluate whether treatment of prisoners constitutes an actionable civil rights claim for violation of the Eighth Amendment's prohibition of "cruel and unusual punishment."⁶⁸ To meet the test, it is required (1) that prison officials show "deliberate indifference"⁶⁹ to the medical needs of prisoners and that (2) those medical needs⁷⁰ be "serious."⁷¹ Gamble filed a § 1983 suit against the prison warden, guards, and other personnel alleging an Eighth Amendment violation for failure to effectively treat his back injury.⁷² The Court held that

deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain," proscribed by the Eighth Amendment. . . . This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care. . . .⁷³

In its discussion of the Eighth Amendment, the Court noted that the pain and suffering caused to inmates by denying them medical treatment "does not serve any penological purpose" and inflicts "unnecessary suffering . . . inconsistent with contemporary standards of decency as

65. See Allen, *supra* note 23, at 167; see also Odegaard, *supra* note 3, at 232-37.

66. See Allen *supra* note 23, at 167.

67. *Estelle v. Gamble*, 429 U.S. 97 (1976).

68. *Id.* at 106.

69. "Deliberate indifference to serious medical needs is shown when prison officials have prevented an inmate from receiving recommended treatment or when an inmate is denied access to medical personnel capable of evaluating the need for treatment." *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980) (discussing the two-pronged *Estelle* standard).

70. The *Ramos* court explained that "[a] medical need is 'serious' if it is 'one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.'" *Id.* (quoting *Laaman v. Helgemoe*, 437 F.Supp. 269, 311 (D.C.N.H. 1977)).

71. *Id.* at 575, 578 (holding that psychiatrist's visits to the prison once a month evidenced a "ridiculously pathetic" and "grossly inadequate" lack of mental health care and constituted a violation of the Eighth Amendment).

72. *Estelle v. Gamble*, 429 U.S. 97, 98 (1976). Section 1983 is a provision of the 1871 Civil Rights Act that is used to "petition the [federal] government for a redress of grievances" caused by a violation of constitutional rights. 42 U.S.C. § 1983 (2006); see also U.S. CONST. amend. I, cl. 6.

73. *Estelle*, 429 U.S. at 104-05 (citing, among others, *Williams v. Vincent*, 508 F.2d 541 (2d Cir. 1974) (where a prison doctor threw away a prisoner's ear and sutured the stump for efficiency)).

manifested in modern legislation”⁷⁴

Although *Estelle* did not directly address the issue of mental health treatment for inmates, federal courts have subsequently held that states have an obligation to “provide for the basic human needs of prison inmates,”⁷⁵ which includes mental health treatment.⁷⁶ However, the standard of “deliberate indifference” is a difficult one for prisoners to meet.⁷⁷ The Court held in *Wilson v. Seiter* that, when claiming that prison conditions violate the Eighth Amendment, the inmate must show that the prison officials possessed a “sufficiently culpable state of mind” to satisfy the “deliberate indifference” prong of the *Estelle* standard.⁷⁸ The Court reaffirmed its holding in *Estelle* that “allegations of [an] ‘inadvertent failure to provide medical care’ or of [a] ‘negligent diagnosis’ simply fail to establish the requisite culpable state of mind.”⁷⁹ Even though a few claims have met the high requisites dictated by the Court to prove a constitutional violation, most do not.⁸⁰ *Lawson v. Trowbridge*, one of the few successful § 1983 actions for a violation of an inmate’s Eighth Amendment rights, provides an example of the extreme circumstances required to satisfy the two-pronged *Estelle* standard.⁸¹

Scott Lawson, a veteran disabled by schizophrenia, was arrested for carrying a concealed weapon.⁸² Upon hearing of his arrest, one of his friends called the jail and informed police of Lawson’s mental illness and

74. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

75. *Coleman v. Wilson*, 912 F. Supp. 1282, 1297 (E.D. Cal. 1995) (citing *Farmer v. Brennan*, 511 U.S. 825 (1994)). The *Farmer* Court held that prison officials could be held liable under the Eighth Amendment for a denial of humane confinement conditions only if they disregard a known substantial risk of serious harm faced by inmates by not taking measures to abate the risk. *Farmer*, 511 U.S. at 837.

76. *Coleman*, 912 F. Supp. at 1298 (citing *Doty v. County of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994)).

77. *Allen*, *supra* note 23, at 167 (citing *Hallett v. Morgan*, 296 F.3d 732, 744 (9th Cir. 2002)).

78. *Wilson v. Seiter*, 501 U.S. 294, 297 (1991). *Wilson* was an Ohio prison inmate who brought a § 1983 action against prison personnel alleging cruel and unusual punishment and challenging circumstances of his confinement including overcrowding, inadequate heating and cooling, and unsanitary facilities. *Id.* at 296. The *Wilson* Court held, perhaps significantly, that the “deliberate indifference” standard articulated in *Estelle* for claims involving challenges for medical care generally applies to claims challenging circumstances of confinement under the Eighth Amendment. *Id.* at 297.

79. *Wilson v. Seiter*, 501 U.S. 294, 297 (1991) (quoting *Estelle v. Gamble*, 429 U.S. 97, 105-06 (1976)).

80. *See generally* *Lawson v. Trowbridge*, 153 F.3d 368 (7th Cir. 1998).

81. *See generally id.*

82. *Id.* at 370. Upon his arrest, Lawson had in his possession ten cents and two bottles of the medication Symmetrel which, along with the medication Proxilin, was used to treat his disease. *Id.* at 371.

need of medication.⁸³ Between his arrest on November 19, 1993 and March 3, 1994, Lawson was held in solitary confinement for 65 days and deprived of medication, after which he was transferred to a mental hospital, finally receiving medication.⁸⁴ The parties never gave a reason for his placement in solitary confinement.⁸⁵ Three months later, he was transferred back to the jail with an order from the judge that he be given access to medication.⁸⁶ On retrial, Lawson's § 1983 claim alleging reckless indifference on the part of Dale Trowbridge, the sheriff of the county in which he arrested, and Lee Robarge, the head jailor, was successful.⁸⁷ The jury awarded him \$400,000 in compensatory damages for past and future pain and suffering and \$5 million in punitive damages.⁸⁸

Lawson's case is one of the few claims that succeeded; the size of the punitive damages awarded by the jury "sends a strong message to both jail and mental health administrators that the public is concerned about the increasingly widespread incarceration of people with mental illness in jails and prisons and their inadequate treatment there."⁸⁹ However, despite this message and the minimal Eighth Amendment duty to provide adequate mental health treatment to affected inmates, succeeding in court is incredibly difficult.⁹⁰

4. THERAPEUTIC JURISPRUDENCE AND REHABILITATIVE JUSTICE

Amidst growing frustrations of judges and criminal attorneys on both sides of the courtroom with the "'revolving door' phenomenon of repeat offenders; the impersonal, assembly-line quality of 'McJustice'";⁹¹ and

83. *Lawson v. Trowbridge*, 153 F.3d 371 (7th Cir. 1998).

84. *Id.* at 372.

85. *Id.*

86. *See Lawson*, 153 F.3d at 372; *see also* Judge David L. Bazelon Center for Mental Health Law, *Federal Jury Awards \$5.4 Million in Damages for Solitary Confinement of Prisoner with Schizophrenia*, Mar. 10, 1999 [hereinafter Bazelon Center], <http://www.bazelon.org/newsroom/archive/1999/3-10-99lawson.htm>.

87. Bazelon Center, *supra* note 86.

88. *Id.*

89. *Id.* (quoting Linda Priebe, senior attorney with the Bazelon Center for Mental Health Law).

90. *See Allen*, *supra* note 23, at 167 (citing *Hallett v. Morgan*, 296 F.3d 732, 744 (9th Cir. 2002)).

91. Nolan, *supra* note 6, at 1541; *see also* BRIEF PRIMER *supra* note 4, at 7. Chief Justice Kathleen Blatz of Minnesota stated:

Judges are very frustrated. . . . The innovation that we're seeing now is a result of judges processing cases like a vegetable factory. Instead of cans of peas, you've got cases. You just move 'em, move 'em, move 'em. One of my colleagues on the bench said, "You know, I feel like I work for McJustice: we sure aren't good for you, but we are fast."

BRIEF PRIMER *supra* note 4, at 7.

other problems caused by the rising influx of offenders with mental health problems, several new theories of how to approach the problem have been proposed and acted on by legal scholars, practitioners, and members of the Judiciary.⁹² The main theories behind problem solving courts are restorative justice and therapeutic jurisprudence. Restorative justice is defined as “[a]n alternative delinquency sanction that focuses on repairing the harm done, meeting the victim’s needs, and holding the offender responsible for his or her actions. . . . Sanctions use a balanced approach, producing the least restrictive disposition while stressing the offender’s accountability and providing relief to the victim.”⁹³ One proposed solution submitted by proponents of restorative justice has been the establishment and proliferation of problem solving courts, an outgrowth of therapeutic jurisprudence.⁹⁴

Therapeutic jurisprudence is defined as “the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects.”⁹⁵ Yet it would be a mistake to view them as therapeutic justice incarnate.⁹⁶ Rather, it is more accurate to view therapeutic jurisprudence and restorative justice as the catalysts for the innovation of problem solving courts.⁹⁷ Thus, an examination of the basic tenets of the legal philosophies in which problem solving courts are rooted, and which have been used to justify their establishment and expansion by their proponents, is helpful to a full discussion of the issues. Both theories share many similarities with a few highlighted differences.⁹⁸ Although all problem solving courts are founded in notions of therapeutic jurisprudence, this is especially true of mental health courts.

Therapeutic jurisprudence requires a study of the law as an agent for

92. Nolan, *supra* note 6, at 1541.

93. BLACK’S LAW DICTIONARY 1340 (8th ed. 2004).

94. Nolan, *supra* note 6, at 1542-45. “Problem-solving courts involve principles and methods grounded in Therapeutic Jurisprudence, including integration of treatment services with judicial case processing, ongoing judicial intervention, [and] close monitoring of and immediate response to behavior” *Id.* at 1542 (internal quotation marks omitted).

95. Greg Berman, *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 41 AM. CRIM. L. REV. 1313, 1314 (2004) (quoting Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, in LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE 769 (David B. Wexler & Bruce Winick eds., 1996) [hereinafter LAW IN A THERAPEUTIC KEY]). Messrs. Wexler and Winick are regarded as the foremost scholars and proponents of the therapeutic justice movement. Nolan, *supra* note 6, at 1547.

96. Berman, *supra* note 95, at 1315.

97. *Id.* at 1314-15.

98. Nolan, *supra* note 6, at 1546-50.

needed therapy.⁹⁹ Thus, in the context of mental health courts, the focus becomes how best to treat the mental illness (the offense being viewed as a symptom thereof) in order to minimize the offender's future contact with the criminal justice system, hold him accountable for his crimes, and ensure the safety of the public.¹⁰⁰ Both theories stress that they do not seek to overrule or invalidate traditional notions of justice.¹⁰¹ Moreover, both theories are part of the school of thought labeled "rehabilitative justice," which stands in stark contrast to the old notion of "retributive justice," commonly referred to as the "just desert"¹⁰² theory of punishment.¹⁰³ Scholars of therapeutic jurisprudence emphasize maintaining standards of due process and ensuring the law is applied even-handedly, without discrimination.¹⁰⁴ Proponents of therapeutic jurisprudence have consistently maintained that "therapeutic goals should be achieved only within the limits of considerations of justice"¹⁰⁵

Although the two theories are similar, restorative justice differs from its co-catalyst in a few respects.¹⁰⁶ Restorative justice is broader in scope than therapeutic jurisprudence in that it contains a "wider net of consequences," which some proponents of the theory submit qualifies as a "more concrete commitment[] to just processes. . . ."¹⁰⁷ Both restorative justice and "therapeutic jurisprudence provide[] 'the legal and jurisprudential foundations of [problem solving courts].'"¹⁰⁸ Legal scholars have praised and criticized problem solving courts, using drug courts as the central focus of the argument, primarily because they are the oldest type of

99. Odegaard, *supra* note 3, at 226.

100. *See generally* BRIEF PRIMER, *supra* note 4; REVOLVING DOOR, *supra* note 10; LAW IN A THERAPEUTIC KEY, *supra* note 95.

101. Nolan, *supra* note 6, at 1546-47.

102. Black's Law Dictionary defines "just dessert" as "[w]hat one really deserves; the punishment that a person deserves for having committed a crime." BLACK'S LAW DICTIONARY 881 (8th ed. 2004).

103. *See generally* Berman, *supra* note 95; Morris B. Hoffman, *A Neo-Retributionist Concurs with Professor Nolan*, 40 AM. CRIM. L. REV. 1567 (2003); Nolan, *supra* note 6.

104. Nolan, *supra* note 6, at 1547 (citing John Braithwaite, *Restorative Justice and Therapeutic Jurisprudence*, 38 CRIM. L. BULL. 244, 254 (2002)).

105. *Id.* (quoting Bruce Winick, *The Jurisprudence of Therapeutic Jurisprudence*, in LAW IN A THERAPEUTIC KEY, *supra* note 95, at 665).

106. *Id.* at 1548 (quoting Braithwaite, *supra* note 104). Mr. Braithwaite is a leading scholar of restorative justice. *Id.* at 1546.

107. *Id.* at 1548 (quoting Braithwaite, *supra* note 104, at 244).

108. Berman, *supra* note 95, at 1314-15 (quoting Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 449 (1999)).

problem solving courts.¹⁰⁹ However, much less debate has been presented on the topic of mental health courts. To engage the criticisms of MHCs, an understanding of the structure and procedures therein employed must come first.

III. THE ADVENT, PROLIFERATION, AND OPERATIONS OF PROBLEM SOLVING COURTS

A. THE CATALYSTS BEHIND THE CREATION OF PROBLEM SOLVING COURTS

Problem solving courts have flourished across the country since 1989, when the first drug court in Dade County, Florida was founded.¹¹⁰ Greg Berman and John Feinblatt, the respective current and former directors of the Center for Court Innovation,¹¹¹ have stated that “this recent wave of [problem-solving] experimentation [can be traced back to] the opening of [that] first ‘drug court’”¹¹² The Miami court was founded in an effort to address the problem of “drug-fueled criminal recidivism” by sentencing “addicted defendants to long-term, judicially-supervised drug treatment” programs as an alternative to incarceration.¹¹³ Because of its high success rate¹¹⁴ among graduates of the program, the Miami drug court served as a model for over 700 drug courts that have since been established in the United States.¹¹⁵

A shining example of the continued success of problem solving courts is the Drug Treatment Alternative-to-Prison (DTAP) program established in Kings County (Brooklyn), New York, which focuses on nonviolent felony offenders.¹¹⁶ The first prosecution-run program of its kind, DTAP estimates

109. See generally BRIEF PRIMER, *supra* note 4. For a discussion of other types of problem-solving courts such as domestic violence courts, community courts, and reentry courts, see Lippman, *supra* note 7, at 826-29.

110. BRIEF PRIMER *supra* note 4, at 4.

111. The Center for Court Innovation is the “independent research and development arm” of the New York Court system. The Center for Court Innovation, About <http://courtinnovation.org/index.cfm?fuseaction=page.viewPage&pageID=471> (last visited Apr. 5, 2010). The CIC calls itself “a non-profit think tank that helps courts and criminal justice agencies aid victims, reduce crime and improve public trust in justice.” *Id.*

112. BRIEF PRIMER *supra* note 4, at 4.

113. *Id.*

114. See discussion *infra* Part III.B.4. The success of drug courts and other problem solving courts is measured by a number of factors among which are the rate of recidivism in graduates of the program, graduate’s employment rates post-program participation, and the amount of money saved by not incarcerating participants. *Id.*

115. Nolan, *supra* note 6, at 1542.

116. JUSTICE KENNEDY COMM’N, AM. BAR ASS’N, REPORT TO THE HOUSE OF DELEGATES 32 (2004) [hereinafter KENNEDY COMM’N REPORT], available at <http://www.abanet.org/media/>

that it costs the state of New York approximately \$38,000 less per year to treat a client in DTAP than to incarcerate him.¹¹⁷ Additionally, for fiscal year 2003, the United States Bureau of Justice Statistics estimated that New York's 106 drug courts saved the state \$254 million.¹¹⁸

However, the proliferation of problem solving courts was not only due to the establishment of the Dade County Drug Court.¹¹⁹ Every participating jurisdiction favors the problem solving courts for reasons unique to the problems faced in their communities; nonetheless, all agree that problem solving courts allow the judicial system to react to society's ills from the front lines.¹²⁰ Reasons advanced by legal scholars who promote problem solving courts include the breakdown of institutions¹²¹ in the community that traditionally addressed problems like mental health and low level "quality-of life crimes."¹²² Scholars also cite the burgeoning population of incarcerated Americans, and the arduous struggle of the federal and state government to address these issues, including the failure of the probation and parole system to help offenders find needed services.¹²³ However, the most prevalent reason given by judges, attorneys, and the public is the rise in case loads and the resultantly¹²⁴ ineffective system termed "McJustice".¹²⁵ Perhaps summarized most succinctly, problem solving courts can be generally defined as a "response to the frustrations engendered by over-whelmed [sic] state courts that struggle to address the problems that are fueling their rising caseloads."¹²⁶

kencomm/rep121a.pdf.

117. KENNEDY COMM'N REPORT, *supra* note 116, at 32.

118. KENNEDY COMM'N REPORT, *supra* note 116, at 33.

119. *See* BRIEF PRIMER *supra* note 4, at 4.

120. *See* David Rottman & Pamela Casey, *Therapeutic Jurisprudence and the Emergence of Problem-Solving Courts*, 1999 NAT'L INST. JUST. J. 12, 13 (1999), available at http://www.ncsconline.org/wc/publications/res_prosol_tjprobsolvcrtnijpub.pdf; *see also* Susan Daicoff, *The Role of Therapeutic Jurisprudence within the Comprehensive Law Movement*, in PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION 465, 465 (Dennis P. Stolle et al. eds., 2000).

121. These institutions include churches and families. BRIEF PRIMER, *supra* note 4, at 5.

122. These crimes include nonviolent misdemeanor offenses such as disorderly conduct, public drunkenness, trespassing, shoplifting, "dine-and-dash," spitting, loitering, and homelessness crimes in some jurisdictions. Kondo, *supra* note 11, at 272, 288-89.

123. BRIEF PRIMER, *supra* note 4, at 5.

124. BRIEF PRIMER, *supra* note 4, at 6 (citing a rise in the number of addiction, domestic violence, and low level crimes, including crimes committed by mentally ill citizens). For example, from 1989 to 1999 the number of misdemeanor cases in New York doubled. *Id.* Moreover, between 1984 and 1997, domestic violence cases in state courts rose 77%. *Id.*; *see also* Rottman & Casey, *supra* note 120, at 13 n.5.

125. *See supra* note 91 and accompanying text.

126. BRIEF PRIMER, *supra* note 4, at 8.

B. MENTAL HEALTH COURTS: IDENTIFICATION, TARGETING, PROCEDURE, PERSONNEL, AND RESULTS

Although MHCs are a somewhat recent development in problem solving courts, they are the most treatment-oriented courts, and an examination of their method is necessary to determine the proper procedure to introduce MHCs on a statewide landscape like Louisiana. Many MHCs have borrowed their organization and procedures from the first MHC established in Broward County, Florida in 1997. Establishing similar goals to its drug court predecessors, its primary aim was to “focus mental health services and resources on defendants whose mental illness was the primary reason for their recidivism.”¹²⁷ The court treats the underlying cause of the crime through court monitored treatment in an effort to reduce recidivism, improve community safety, and lower the costs of prosecution and incarceration of its clients.¹²⁸ Today, the Broward County MHC is a radiant example of a successful MHC, hearing about 450 cases a year.¹²⁹

Most MHCs limit their client base to nonviolent misdemeanants, but some have expanded their operations to low-level felons.¹³⁰ Like traditional courts, MHCs require a staff; new positions are added and created to better facilitate access to needed treatment. The selection and enrollment of defendants in the MHC is the first step of the process.

1. IDENTIFICATION AND TARGETING

The precise criteria required to “opt in” to MHC treatment varies somewhat between jurisdictions but is generally consistent. These courts focus on repeat offenders committing low level quality-of-life crimes, which are usually classified as misdemeanors.¹³¹ The first step in the screening process, called “identification,” describes how defendants with mental illness are identified; depending on the court, the point at which this is done will differ.¹³² Generally, identification takes place within twenty-four hours of arrest and is completed primarily by jail staff, defense lawyers, and the client’s family.¹³³ If intake staff at the jail identifies a prisoner charged with misdemeanors as someone with a mental illness, and

127. Meekins, *supra* note 41, at 24-25.

128. *See generally* REVOLVING DOOR, *supra* note 10; Kondo, *supra* note 11; Nolan, *supra* note 6.

129. Kondo, *supra* note 11, at 284 (citing Bill Douthat, *Group Weighs Need for Court for Mentally Ill Defendants*, PALM BEACH POST, June 22, 1999, at 2B).

130. *Developments in the Law—The Law of Mental Illness*, *supra* note 1, at 1170-72.

131. REVOLVING DOOR, *supra* note 10, at 8. For an illustrative list of common crimes dealt with by MHCs *see supra* note 122 and accompanying text.

132. REVOLVING DOOR, *supra* note 10, at 9.

133. *Id.*

he does not seem to present a danger to himself, they will refer him to clinicians at the public defender's office who conduct additional screening.¹³⁴ Currently, federal prisons conduct preliminary screening of the prisoners at intake for mental health issues.¹³⁵ When clinicians agree that the prisoner has mental health issues, they inform the defense attorney who may then request that the case is transferred to mental health court.¹³⁶

Before the case is transferred, a second phase must occur; this step is called "targeting."¹³⁷ All MHCs provide criteria detailing the kinds of mental illnesses that qualify for the program.¹³⁸ With some minor differences, MHCs dictate that a potential client must be suffering from a severe and persistent mental illness,¹³⁹ normally classified as one or more "Axis I Disorders"¹⁴⁰ as listed in a national psychiatric association's Diagnostic and Statistics Manual (DSM-IV).¹⁴¹ Candidates for the BMHC, for example, are required to have a severe and persistent mental illness so the court can narrow the number of those clinically eligible to participate and exclude those with other issues, such as personality disorders and mental retardation.¹⁴² For a mental illness on any axis to qualify as "severe,"¹⁴³ the DSM requires that "many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in a marked impairment in social or occupational functioning."¹⁴⁴ The most common illnesses found among

134. REVOLVING DOOR, *supra* note 10, at 8.

135. JAMES & GLAZE, *supra* note 50, at 9.

136. REVOLVING DOOR, *supra* note 10, at 8.

137. *Id.* at 9.

138. *Id.*

139. BRENT MOSS ET AL., *Mental Health Courts in Idaho*, Advocate, Sept. 2008, at 26, available at 51-SEP Advocate (Idaho) 26. Severe and persistent mental illnesses "include[] schizophrenia, schizoaffective disorder, bipolar disorder, and any other manifestation of psychosis." *Id.*

140. DSM-IV, *supra* note 58, available at <http://allpsych.com/disorders/dsm.html>. The DSM-IV is organized as a multi-axial system, Axis I mental illnesses include major mental disorders. AllPsych Online, Psychiatric Disorders, Diagnostic and Statistical Manual of Mental Disorders (DSM IV), <http://allpsych.com/disorders/dsm.html> (last visited Apr. 5, 2010). Along with the mentioned illnesses, Axis I includes Anxiety disorders and Impulse-Control disorders. *Id.*

141. ROGER H. PETERS ET AL., SCREENING AND ASSESSMENT OF CO-OCCURRING DISORDERS IN THE JUSTICE SYSTEM app. G at 62-69 (2008), available at <http://www.gainscenter.samhsa.gov/pdfs/disorders/ScreeningAndAssessment.pdf> (discussing various screening instruments for mental disorders).

142. BMHCE, *supra* note 9, at 57.

143. The DSM-IV uses the categories Mild, Moderate, Severe, In Partial Remission, In Full Remission, and Prior History to indicate severity after a diagnosis. See generally DSM-IV, *supra* note 58.

144. *Id.* at 411-16.

this group are bipolar disorder, schizophrenia, and depression.¹⁴⁵ Some MHCs, like the Brooklyn County MHC, have widened their targeting and selection process to include offenders with Axis II disorders as defined by the DSM-IV.¹⁴⁶ Axis II covers developmental disorders and “pervasive personality conditions” or personality disorders.¹⁴⁷ Developmental disorders, such as mental retardation or autism, often begin or first manifest themselves during childhood.¹⁴⁸ Pervasive personality conditions include “borderline personality disorder, antisocial personality disorder, and narcissistic personality disorder.”¹⁴⁹ Once the case is removed to an MHC, the procedure differs between some jurisdictions.

2. MHC PROCEDURE

The procedure and atmosphere of MHCs are less adversarial than those of a traditional courtroom.¹⁵⁰ The court focuses on the individual and on how best to change future behavior, rather than punishing past actions.¹⁵¹ Although participation in all MHCs is voluntary, defendants must opt-in to receive treatment; however, there is a difference between pre-adjudication diversion and post-adjudication treatment.¹⁵² In the former, the judge will review the case and recommend pre-adjudication diversion into treatment.¹⁵³ Once the accused is in a treatment program, the court will monitor the defendants for up to, and possibly more than, one year.¹⁵⁴ In the pre-adjudication diversion model, depending on the severity of the offense, the prosecution may drop the charges completely or hold them in abeyance.¹⁵⁵ If the prosecution is stayed, the charges are dropped upon

145. Kondo, *supra* note 11, at 257 (noting that “at least 7% of jail inmates and 14% of all prison inmates suffer from schizophrenia, bipolar disorder, or major depression”).

146. Odegaard, *supra* note 3, at 247 (citing DSM-IV, *supra* note 58, at 28-29). The Hennepin County MHC in Hennepin County Minnesota requires participants to have either an Axis I or II mental illness. *Id.*

147. *Id.* at 247 n.232.

148. DSM-IV, *supra* note 58, at 39, 70.

149. Odegaard, *supra* note 3, at 247 n.232 (citing DSM-IV, *supra* note 58, at 29).

150. *Developments in the Law—The Law of Mental Illness*, *supra* note 1, at 1170-71.

151. Lippman, *supra* note 7, at 824 (explaining that “the judge is a proactive, . . . agent for change who views his . . . role as an opportunity . . . to intervene and not only punish the individual, but, just as critically, achieve a better outcome for that litigant and her family, and for our communities and public safety”).

152. Meekins, *supra* note 41, at 17 n.75 (discussing the differences between the pre-adjudication and post-adjudication models). The King County MHC in Washington allows defendants to be placed in treatment for two weeks to decide whether they wish to opt-in, during which time the attorneys can handle initial discovery to evaluate the strength of the case against their client. REVOLVING DOOR, *supra* note 10, at 10.

153. Meekins, *supra* note 41, at 8.

154. *Id.*

155. *Id.*

successful completion of the program.¹⁵⁶ However, “defendants with serious criminal histories may be required to plead guilty and get credit for time served in treatment in lieu of incarceration.”¹⁵⁷ Depending on the jurisdiction, some programs will expunge the client’s record of arrest.¹⁵⁸

With the post-adjudicative treatment model, the defendant must plead guilty to receive treatment, and the charges are either vacated or lessened upon completion of the program.¹⁵⁹ Graduation requires successful compliance with treatment and meetings with counselors and the judge on a scheduled basis for a general term of a year¹⁶⁰ in accordance with the treatment plan designed specifically for that client by court personnel.¹⁶¹ Both models use a system which rewards participants and sanctions non-compliance with a variety of punishments, including court-ordered jail time.¹⁶² Like any other court, a trained and dedicated staff is necessary for an MHC to effectively serve both the public and the defendants involved; however, in MHCs, the staff and their roles are somewhat different from those of traditional courts.¹⁶³

3. MHC PERSONNEL

Like drug courts before them, MHCs have altered some traditional staff positions, as well as the roles of the involved players.¹⁶⁴ The majority of every MHC staff member’s responsibilities are within that court, and each is trained in psychology, mental illness and treatment, as well as the underlying cause of criminal behaviors.¹⁶⁵ The staff is typically comprised of a judge, prosecutors, public defenders, and caseworkers, each of whose docket involves only MHC cases.¹⁶⁶ Permanently assigning a judge to a specialty court like an MHC, rather than a typical system of rotating judicial

156. Meekins, *supra* note 41, at 8.

157. REVOLVING DOOR, *supra* note 10, at 8.

158. Nolan, *supra* note 6, at 1543.

159. See Meekins, *supra* note 41, at 16-17 (voicing concern that this approach creates legitimate concerns of due process and possible ethical violations by defense counsel for a failure to zealously advocate in the traditional adversarial method).

160. REVOLVING DOOR, *supra* note 10, at 8. Many mental illnesses, specifically severe ones, require at least a year of treatment to see results, and almost always require continued treatment. *Id.* at 10.

161. *Id.* at 8.

162. Meekins, *supra* note 41, at 18-19. Although the use of incarceration as a sanction is generally approved of in drug courts, some debate exists as to whether it is appropriate for participants in MHCs. *Id.* at 16, 20; see also Nolan *supra* note 6, at 1547.

163. Meekins, *supra* note 41, at 20-21; see also discussion *infra* Part III.B.3.

164. See *id.* at 20-22.

165. *Developments in the Law—The Law of Mental Illness*, *supra* note 1, at 1170.

166. *Id.*

assignments, allows the MHC judge to master the subtleties of the body of law, as well as the mental illnesses involved.¹⁶⁷ In addition to traditional courtroom positions, such as bailiffs, externs, and court reporters, MHCs employ secondary personnel, including psychiatric expert witnesses, other mental health counselors, and social workers.¹⁶⁸ These additional staff members help screen cases and develop treatment plans for each client.¹⁶⁹ Both essential and ancillary staff meet with the parties' representatives to discuss each client and how best to proceed in order to transition the individual into an effective treatment plan.¹⁷⁰ The conventional roles of traditional court actors are also shifted in MHCs.¹⁷¹

In some cases, prosecution and defense attorneys work together to decide the best course of action for the defendant. The judge may act as a broker between parties and an out-of-court service provider.¹⁷² Chief Administrative Judge Jonathan Lippman explains that, in MHCs, "the judge is not just a detached and distant arbiter. . . . [He] is a proactive, hands-on agent for change who views his . . . role as an opportunity for the entire justice system to intervene and not only punish the individual but . . . achieve a better outcome for that litigant and . . . our communities" ¹⁷³ While these new, non-traditional roles raise concerns about the expansive power of MHCs, the statistical data presented below ¹⁷⁴ proves that MHCs are working.¹⁷⁴

4. MHC RECIDIVISM RESULTS

Because MHCs are relatively new, there has not been a system-wide assessment of effectiveness; however, results from the internal studies of MHCs highlight positive trends. For example, after its first six years of operation, the Bonneville County MHC in Idaho saw a 98% drop in the number of psychiatric hospitalizations and a 90% drop in incarcerations of program participants.¹⁷⁵ Graduates of the Bonneville County MHC had a recidivism rate of 24%, a number that "continues to decrease with more

167. Kondo, *supra* note 11, at 285.

168. *Id.* at 291.

169. REVOLVING DOOR, *supra* note 10, at 9.

170. *Id.*

171. Meekins, *supra* note 41, at 39-47 (discussing the role of defense attorneys in specialty courts).

172. REVOLVING DOOR, *supra* note 10, at 9.

173. Lippman, *supra* note 7, at 824.

174. *Id.*; see generally Meekins, *supra* note 41; Frank V. Williams, III, *Reinventing the Courts: The Frontiers of Judicial Activism in the State Courts*, 29 CAMPBELL L. REV. 591 (2007).

175. Moss, *supra* note 139, at 27.

graduates and the increased maturity of the program.”¹⁷⁶

The Brooklyn MHC was founded in 2002 as a “demonstration project” within the Supreme Court of Kings County in Brooklyn.¹⁷⁷ Similar to all mental health courts, the court was instituted to “reduce recidivism and stop the ‘revolving door’ of the mentally ill. . . .”¹⁷⁸ Of those participants studied, 78% had been arrested as adults at least once prior to the arrest and subsequent screening which qualified the offenders for the MHC in Brooklyn.¹⁷⁹ In the first year of operations, only 16% of participants committed a new offense.¹⁸⁰

Other MHCs have reported similar results. For example, an evaluation of 236 participants in the King County, Washington MHC reported that in the year proceeding graduation from the program, participants are 75% less likely to reoffend.¹⁸¹ Of the 41% of defendants referred to the MHC in Washington who chose to receive treatment (or opted-in), there was a “sharp drop in the rate of new arrests . . . compared to those who chose not to participate.”¹⁸² Similarly, a study of the Clark County MHC in Vancouver, Washington “found reduced recidivism among [MHC] participants post- compared with pre-enrollment”¹⁸³ These rates encourage a comparison to the country’s current state of incarceration.

IV. THE CURRENT NATIONAL AND LOCAL COST OF INCARCERATION: THE HOLDING PATTERN¹⁸⁴

A. THE NATIONAL STATE OF INCARCERATION

In the late 1970s and through the 1980s, the federal government implemented changes in the parole and sentencing guidelines in an effort to address, among other things, rising crime.¹⁸⁵ Corresponding changes in the sentencing, release, and other correctional policies of state governments furthered this trend.¹⁸⁶ The result was a steady and unprecedented rise in

176. Moss, *supra* note 139, at 27.

177. BMHCE, *supra* note 9, at iii.

178. *Id.*

179. *Id.* at 53.

180. BMHCE, *supra* note 9, at 53.

181. *Developments in the Law—The Law of Mental Illness*, *supra* note 1, at 1173.

182. REVOLVING DOOR, *supra* note 9, at 11.

183. BMHCE, *supra* note 9, at 4.

184. Morris, *supra* note 14 (quoting Louisiana Secretary of Public Safety and Corrections James Leblanc (“Some states are paroling people out, but we’re not in a position to do that in my opinion We’re kind of in a holding pattern”)).

185. KENNEDY COMM’N REPORT, *supra* note 116, at 16.

186. ONE IN 31, *supra* note 12, at 4.

the number of people incarcerated.¹⁸⁷ The rate of incarceration multiplied five times between 1974 and 2002, from 216,000¹⁸⁸ inmates in federal and state prisons to 1,355,748.¹⁸⁹ The incarceration rate of inmates held in local jails more than doubled: going from 256,615 in 1985 to 665,475 in 2002.¹⁹⁰ Including federal and state prison inmates and prisoners held in local jails, the count of adult inmates in America at the beginning of 2008 totaled 2,319,258.¹⁹¹ Following this upward trend, the period of incarceration has lengthened in the past two decades.¹⁹² Between 1980 and 1992, the average time served was eighteen months.¹⁹³ The subsequent decade saw that period increase to an average of five years.¹⁹⁴ Not surprisingly, with the growth of inmate populations and the lengthening of sentences, incarceration has become increasingly more expensive to federal, state, and local government.¹⁹⁵

The amount spent on incarceration in America surpasses that spent on education, transportation, and public assistance.¹⁹⁶ The only program whose spending has grown faster than incarceration was Medicaid, which has quadrupled in the last twenty years.¹⁹⁷ In fact, states' total general fund spending on corrections across the country for fiscal year 2008 is estimated to have been \$47 billion.¹⁹⁸ This marks a 303% increase in this category in

187. KENNEDY COMM'N REPORT, *supra* note 116, at 17.

188. *Id.* at 17 (citing BUREAU OF JUSTICE STATISTICS, U.S. DEP'T. OF JUSTICE, PREVALENCE OF IMPRISONMENT IN THE U.S. POPULATION, 1974-2001, at 1 tbl.1 (August 2003), *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/piusp01.pdf>).

189. *Id.* (citing BUREAU OF JUSTICE STATISTICS, U.S. DEP'T. OF JUSTICE, PRISON AND JAIL INMATES AT MIDYEAR 2002, at 1 (Apr. 2003) [hereinafter PRISON AND JAIL INMATES AT MIDYEAR 2002], *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/pjim02.pdf>). The U.S. prison population for 2007 was 1,596,127, people not counting those held in local jails. ONE IN 100, *supra* note 2, at 5.

190. KENNEDY COMM'N REPORT, *supra* note 116, at 17 (citing BUREAU OF JUSTICE STATISTICS, U.S. DEP'T. OF JUSTICE, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 1997, at 21 tbl.2.4 (Nov. 2000), *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/cpus97.pdf>; PRISON AND JAIL INMATES AT MIDYEAR 2002, *supra* note 189, at 1).

191. ONE IN 100, *supra* note 2, at 5. America has an adult population of about 230 million which placed the actual incarceration rate in 2008 at 1 in every 99.1 adults. *Id.*

192. KENNEDY COMM'N REPORT, *supra* note 116, at 17.

193. *Id.*

194. *Id.*

195. *Id.* at 17-18.

196. Solomon Moore, *Prison Spending Outpaces All But Medicaid*, N.Y. TIMES, Mar. 3, 2009, at A-13, *available at* http://www.nytimes.com/2009/03/03/us/03prison.html?_r=1.

197. ONE IN 31, *supra* note 12, at 1. Cumulative state corrections spending from general funds was more than \$47 billion for the fiscal year of 2008, an increase of \$35.611 billion since 1988. *Id.* at 11.

198. *Id.* at 11.

the twenty years since 1988.¹⁹⁹ Of all the dollars spent directly on state corrections, a survey of the eight states, which could provide data for the past twenty-five years,²⁰⁰ 88% of the increased corrections spending went to prisons.²⁰¹ These numbers do not account for the “collateral costs” incurred by the state or federal government when someone is incarcerated.²⁰² These costs include increased spending for the maintenance and health of those dependent upon inmates, lost taxes on any income that inmates would earn, or expenditures they would make were they not incarcerated.²⁰³ These national figures on the incarcerated population and the costs associated therewith become more pronounced when looked at from the view of the State of Louisiana.

B. THE COST OF INCARCERATION IN LOUISIANA

On March 2, 2009, the Pew Center for the States²⁰⁴ released a study entitled *One in 31: The Long Reach of American Corrections*,²⁰⁵ which found that Louisiana, while not number one on any other list, did receive first place for having the highest incarceration rate of any state in the nation at year end 2007.²⁰⁶ Specifically, one in every fifty-five adults in Louisiana is incarcerated.²⁰⁷ Additionally, one in every twenty-six adults in the state is under correctional control.²⁰⁸ The population of adults under “correctional control” accounts for in-state federal prisoners, community-supervised offenders, and those on probation or parole, in addition to the inmates in state prisons and local jails.²⁰⁹ At the end of 2007 there were

199. ONE IN 31, *supra* note 12, at 1; *see also* KENNEDY COMM’N REPORT, *supra* note 116, at 17-18 (noting a \$40 billion or 440% increase on “direct expenditures by federal, state and local governments on corrections” from 1982 to 1999) (citing BUREAU OF JUSTICE STATISTICS, U.S. DEP’T. OF JUSTICE, DIRECT EXPENDITURES BY CRIMINAL JUSTICE FUNCTION, 1982-99 (n.d.); ONE IN 100, *supra* note 2, at 15 (comparing the fiscal year 2007 state general fund spending corrections to a 21% increase of the same on higher education over the same period).

200. ONE IN 31, *supra* note 12, at 11-12. These states were Alabama, Georgia, Louisiana, Missouri, Montana, New York, Oregon, and Wyoming. *Id.*

201. *Id.* at 11.

202. *See id.*

203. *Id.*

204. The Pew Center for the States is a policy institute that provides “comprehensive and independent” information on state management, as well as “fiscally sound, research-based sentencing and corrections policies and practices that protect public safety, hold offenders accountable and control costs.” The Pew Center on the States, Research and Policy Initiatives, <http://www.pewcenteronthestates.org/> (last visited April 6, 2010).

205. *See generally* ONE IN 31, *supra* note 12.

206. *Id.* at 43 tbl.A-4.

207. *Id.* at 43 tbl.A-4.

208. *Id.* at 45 tbl.A-6.

209. *See generally* ONE IN 31, *supra* note 12, at 45 tbl.A-6.

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54,108 offenders housed in state prisons and jails.²¹⁰ The most recent data reveals a 272% increase in Louisiana's adult incarceration rate between 1982 and 2007.²¹¹ The state spent approximately \$39.75 per inmate per day in 2008.²¹² In the two years since 2006, Louisiana increased corrections spending by \$89 million.²¹³ For fiscal year (FY) 2008, Louisiana spent an estimated \$715 million on corrections.²¹⁴

V. ANALYSIS**A. WHY MHCs ARE NEEDED**

The nation's incarceration rate is higher than it has ever been in history. The enormous number of mentally ill prisoners warrants a mechanism to both treat these individuals and prevent future similarly situated citizens from becoming incarcerated. Moreover, the ability to reduce the amount spent on incarceration, simultaneously reducing recidivism and improving public safety, makes this viable option very attractive. The emerging shift in the way legal scholars, lawyers, judges, and Americans think about the justice system, as well as the purpose of punishment, encourages additional jurisdictions to implement these inspiring methods, which have had proven, documented success.

B. CONCERNS WITH MHCs

MHCs are new, they use non-traditional methods, and the personnel roles are shifted far from the traditional personnel roles in ordinary criminal courts.²¹⁵ Because of MHCs' somewhat recent arrival on the judicial scene, most criticisms are directed at problem solving courts in general, although

210. PEW CENTER ON THE STATES, ONE IN 31: THE LONG REACH OF AMERICAN CORRECTIONS: FACT SHEET: LOUISIANA 1 (2009) [hereinafter ONE IN 31 FACT SHEET (LOUISIANA)], available at http://www.pewcenteronthestates.org/news_room_detail.aspx?id=49600.

211. ONE IN 31, *supra* note 12, at 43 (citing a jump from 1 in every 205 Louisiana adults being incarcerated in 1982 to 1 in every 55 adults being incarcerated in 2007).

212. ONE IN 31 FACT SHEET (LOUISIANA), *supra* note 210, at 1.

213. NAT'L ASS'N OF STATE BUDGET OFFICERS, FISCAL YEAR 2007 STATE EXPENDITURE REPORT 56 tbl.32 (2008) (noting that in 2006 Louisiana spent \$626 million in correction expenditures, while in 2008, the state spent \$715 million in corrections expenditures), available at www.nasbo.org/ (select "State Expenditure Report" under Publications Tab, select archived reports link and download 2007 State Expenditure Report). Money spent on "Juvenile Delinquency Counseling" and "Institutions for the Criminally Insane" were not included in these calculations for the State of Louisiana. *Id.* at 60 tbl.36.

214. *Id.* at 56 tbl.32. Louisiana spent an estimated \$625 million from the general fund, \$87 million from other state funds and bonds, and \$3 million in federal funds on corrections. *Id.* at 56 tbl.32.

215. Odegaard, *supra* note 3, at 230-31, 238-39; Meekins, *supra* note 41, at 24-25.

some specifically focus on MHCs.²¹⁶ The focus on treatment, rather than the adversarial nature of trial, has concerned many legal scholars.²¹⁷ For some, the mention of an “alternative to incarceration” brings to mind images of hardened criminals loose in the streets at worst and guilty people going free by faking a mental illness at best. One judge summed up the concerns about problem solving courts quite well, saying: “There is a danger when talking about problem solving courts that the uninitiated will perceive them to be performing social services work—unbecoming for courts of law. Let’s be clear: the reason these courts work so well is because they emphasize offender accountability”²¹⁸ Indeed, many MHC mandated treatment periods are longer than a jail sentence for the same offense because of the nature of psychiatric treatment.

Other commentators have criticized the structure of problem solving courts. They argue that the relaxed nature of the proceedings ignores the procedural safeguards of justice.²¹⁹ This is not the case; Chief Administrative Judge Lippman explains that “[t]he process and rules are still there, but they form the context of the proceeding, not the focus.”²²⁰ Some critics have argued that the new court room structure “emasculates” the traditional role of the zealous defense attorney, reducing her to a “collaborator . . . relegated to the role of [a] team player whose only purpose serves to fulfill a constitutional mandate.”²²¹ However, this criticism is inaccurate: the defense attorney’s role is shifted from an adversarial one to one that focuses on a solution that is truly in the client’s best interest.

The post-adjudicative model of the MHC has come under attack as being coercive, forcing the defendant to choose treatment over prison

216. See, e.g., Meekins, *supra* note 41, at 24-25 (acknowledging the various criticisms associated with “requiring mental health treatment as a condition of probation or release from jail”); see generally Nolan, *supra* note 6 (considering problem-solving courts, namely in the context of drug courts).

217. See generally Meekins, *supra* note 41; Williams, III, *supra* note 174.

218. Lippman, *supra* note 7, at 824.

219. See Meekins, *supra* note 41, at 37 (noting that the “subordinat[ion]” of the criminal defense attorney’s role to the “notion of teamwork” “means that the zealousness that is essential to the functioning of the defense attorney, as well as the intervention that is necessary to protect important rights, may be lost in specialty courts”). Professor Meekins notes that “[t]he standard premise behind these courts is the emasculation of the traditional role of the criminal defender as a zealous advocate fighting against the system.” *Id.* at 3. Moreover, “[t]he defense bar’s mandate to ensure adherence to procedural justice principles is seen by a great number of defense attorneys as more important than winning trials.” *Id.* at 10 n.33.

220. Lippman, *supra* note 7, at 824.

221. Meekins, *supra* note 41, at 3-4.

time.²²² However, the complaints one would expect to arise if this were the case have yet to manifest. First, this argument ignores the fact that MHCs are not open to all. There are specific criteria required to be met for eligibility for multiple stages of screening. For those to whom this option is given, treatment is a viable choice at a new life. Additionally, defendants are not coerced into choosing treatment over incarceration; instead, their defense lawyer stands as a bulwark against any such compulsion. The defense lawyer's role is expanded, not lessened. In more convenient terms, defense attorneys could "shut down [MHCs] . . . by refusing to participate or let their clients plead guilty and enter treatment."²²³

In fact, it is exactly this criticized structure and process that makes MHCs a better way for certain offenders to receive the treatment they would not otherwise receive in the traditional justice system.²²⁴ For the many nonviolent recidivist misdemeanants in the traditional court system whose offense was a result of their mental illness, MHCs offer both an alternative to prison and assistance to those eligible.²²⁵ MHCs have proven to lower rates of incarceration and recidivism in program graduates, and they have created a more productive life for mentally ill individuals, who would otherwise suffer the well-documented effects of the traditional prison system on the mentally ill.

Despite the positives, problem solving courts have still received criticism for several reasons. Critics of problem solving courts compare them not to the current judicial system, but to the ideal judicial system—without regard for those exact shortcomings of the traditional justice system that in so many ways inspired the creation of problem solving courts.²²⁶ In actuality, the converse is correct. The current "traditional" state courts do not operate on the "classical adversarial model," as only a small percentage of criminal cases actually go to trial; rather, most are resolved through plea bargaining.²²⁷ When compared to the traditional system, the argument against problem solving courts and for maintaining business as usual for these particular classes of people, especially the mentally ill, is simply unpersuasive.

America's jails and prisons have become "de facto custodians of

222. Meekins, *supra* note 41, at 18.

223. Berman, *supra* note 95, at 1316.

224. *See* Odegaard, *supra* note 3, at 253 (noting that opponents argue that MHCs "provide a way to move 'a particular group of people to the head of the line' . . .").

225. *Id.* at 250-51.

226. Nolan, *supra* note 6, at 1553.

227. Berman, *supra* note 95, at 1317-18.

people with mental illness.”²²⁸ Moreover, because our prisons were never designed to operate as psychiatric hospitals, they were, and still are, unprepared to adequately meet the needs of mentally ill prisoners.²²⁹ As one study revealed, prison officials in the New York Correction’s system routinely place mentally ill inmates in solitary confinement, the conditions of which exacerbate the prisoner’s condition.²³⁰ Even those who denounce MHCs admit that treatment for mental illness in jails and prisons is “inappropriate or insufficient” and that “time spent in jail . . . often has a negative effect on the mental health of the defendant.”²³¹ In addition, the overrepresentation of mentally ill persons in the prison system is indicative of the inadequacy and unavailability of public mental health systems to serve those in need.²³² Furthermore, present case law effectively illustrates the need for reform of a system never designed to treat mental illness and its consequential inadequate treatment availabilities.²³³

MHCs offer an alternative with palpable results—not only to the participants—but also to those who have traditionally had to pay the high and rising cost of incarceration, the taxpayers. Incarceration of the nonviolent mentally ill fails to deter future criminal behavior and exacerbates already debilitating illnesses, making successful reentry into society upon release close to hopeless and eventual return to prison statistically inevitable.

C. THE PROPOSED LOUISIANA MENTAL HEALTH COURT PILOT PROJECT

Currently, Louisiana has only one MHC, operated by Judge Arthur L. Hunter, Jr.²³⁴ Former Judge Calvin Johnson created New Orleans’ MHC after Hurricane Katrina in an effort to address the inadequate availability of mental health care in the city.²³⁵ Because the court is so new, there are

228. Mary Beth Pfeiffer, *Cruel and Unusual Punishment*, N.Y. TIMES, May 7, 2006.

229. This crisis has gained national attention. Kondo, *supra* note 11, at 259 (“[C]orrectional facilities simply do not have the means, or the expertise, to properly treat mentally ill inmates” (quoting Press Release, Sen. Mike DeWine, Treatment for Mentally Ill Inmates (Oct. 20, 1999), at 1)).

230. See Allen, *supra* note 23, at 169-70.

231. Meekins, *supra* note 41, at 25.

232. Odegaard, *supra* note 3, at 234-37 (discussing the “revolving door” of mentally ill offenders through the criminal justice system and the fact that jails and prisons are ill-equipped to provide for mentally ill inmates).

233. *Id.* at 235-36.

234. Judge Hunter Telephone Interview, *supra* note 13.

235. Interview by Charles Henry Rowell with Judge Calvin Johnson, Judge, Orleans Parish Criminal District Court, in New Orleans, La. (Nov. 30, 2007).

currently no statistics on program graduates.²³⁶ Defendants are referred to the court by the public defender's office and in some cases by the defendant's family.²³⁷ The mental illnesses most common among defendants are paranoid schizophrenia, bipolar disorder, depression, and post-traumatic stress syndrome.²³⁸ Most defendants enter the MHC pre-trial and are put in contact with a psychiatrist who prescribes medication and people who help defendants find housing, employment, or GED programs, if applicable.²³⁹ As of March 6, 2009, the court served approximately eighty-five defendants.²⁴⁰ For the state with the highest incarcerated adult population in the country, the availability of alternative methods to reduce crime, which would also lower state spending, serves as a mandate to act.

The establishment of MHCs in both urban and rural centers on a three-year trial basis will allow effective studies on crime and recidivism rates to be conducted and hopefully will aid in the proliferation of MHCs. The proposed program would create four pilot MHCs in Baton Rouge, Shreveport, Lake Charles, and Alexandria, while expanding the current MHC in New Orleans to a full-time court with a non-rotating primary and ancillary staff.

Screening will first require training of intake staff at local jails and state prisons to identify symptoms and behaviors commonly associated with specific mental illness. It is advised that this initial screening and report be conducted before the defendant's first appearance in court so that the defendant's counsel can be notified. In the case of indigent defenders, more advanced screening by better trained individuals should be conducted at the public defender's office. Preliminarily, allowing only those defendants arrested for nonviolent misdemeanors and found to have schizophrenia, bipolar disorder, or major depression, amongst other severe and persistent mental illnesses, will target the most severely affected individuals.²⁴¹ However, when the program proves successful at helping defendants and lowering recidivism in its graduates, the possibility of expanding the targeting criteria could be considered. If the success rate encourages these preliminary courts to be permanently established, allowing defendants charged with nonviolent felonies who have severe and persistent mental illnesses on Axis I to opt-in may be a viable option. However, even with a successful trial program, widening the net to those offenders with

236. Judge Hunter Telephone Interview, *supra* note 13.

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.*

241. See discussion *supra* Part III.B.1. The top three illnesses included are schizophrenia, bipolar disorder, and major depression. *Id.*

personality disorders would create a number too large to be handled by MHCs within the first five years of operation.

Once the defendant is identified and meets the criteria, he would be given the choice to opt-in after discussion with counsel. After opt-in, the judge would review the case and meet with court counselors, prosecution and defense attorneys, and when required, experts, to plan a treatment program based on the individual offender's case. The new pilot courts would operate on the pre-adjudicatory model of other MHCs which, with the exception of more serious offenses, does not require the defendant to plead guilty before receiving treatment. This would assuage concerns, however misplaced, of coercion eroding the voluntariness of the choice to opt-in. Charges would be held in abeyance and credit for time served in treatment would be given upon successful graduation of the program.

The judges would have a full array of tools at their disposal to ensure the defendant conforms to court orders, including sanctions. Defendants would be required, as in drug courts, to report regularly to the judge, and court officers receiving reports from outside treatment staff will monitor compliance. One possible sanction for non-compliance, in each judge's discretion, would be to reserve the right to extend the offender's initially agreed on treatment period. Non-compliance with the prescribed treatment plan will result in mandated service at the court, increased monitoring, and possibly jail time with court ordered continuation of treatment.

Key to the successful implementation of the MHC will be finding the necessary funding. Louisiana's only MHC is currently funded entirely by a federal grant set to expire in 2010.²⁴² The state legislature should convene a committee to study the feasibility and implementation/operation costs of the pilot project. Legislators and their staff should work closely with the Center for Court Innovation and MHC judges from around the country to determine the most effective practices for implementing the pilot program as soon as possible. This committee should examine well known avenues for funding including available federal grants²⁴³ and the possibility of reallocating funds from the budgets of other state departments, like the Department of Corrections and Department of Health and Hospitals, as well as the state general fund. Innovative funding solutions successfully employed by other states with MHCs should also be considered. For example, Illinois allows counties to impose a ten dollar mental health court

242. Judge Hunter Telephone Interview, *supra* note 13.

243. BMHCE, *supra* note 9, at 2, 19. For information on federal grants, see Bureau of Justice Assistance, BJA Programs, Mental Health Court Programs, <http://www.ojp.usdoj.gov/BJA/grant/mentalhealth.html> (last visited Apr. 6, 2010).

fee on all criminal defendants once convicted.²⁴⁴ This is only one of the many ideas implemented in other states that should be researched and discussed by the legislature while working with existing MHCs around the country.

Also paramount to the pilot project's success is immediate data collection on each defendant, including the crime charged, the evaluation performed, and the treatment mandated in the program. Regular reports should provide information beyond merely the number of cases handled to include how many defendants were connected with housing, employment, or education services, how many received treatment mandates, and their rates of compliance and rearrest.²⁴⁵ This will provide the basis for an internal efficacy study to be published at the end of the three-year period. Because successful mental health treatments often produce positive results after at least a year, the three-year period will provide the information on recidivism rates necessary to make the determination to terminate or continue the program appropriately.

VI. CONCLUSION

The current state of mental health treatment in America is wholly inadequate, demonstrated quite aptly by the overwhelming number of mentally ill people behind bars. The availability of mental health treatment in the corrections system is even worse, and the jurisprudence on the state and federal governments' duty to provide mental health treatment to prisoners and inmates has created a high burden, resulting in a very low number of successful claims. This is the present day legacy of the twentieth century's criminalization of mental illness.

Currently, Louisiana has the highest rate of incarceration of any state in the country, and the cost to taxpayers is enormous. MHCs provide needed services to mentally ill citizens—viewing the crime through the lens of therapeutic justice. These courts have statistics showing that program graduates have dramatic decreases in recidivism within a year of leaving the program.

A three-year, five-city MHC pilot project would allow Louisiana to study and gauge the effectiveness of MHCs in Louisiana. If the statistics

244. 55 ILL. COMP. STAT. 5/5-1101(d-5) (West 2006). *Cf.* *People v. Price*, 873 N.E.2d 453, 468-469 (Ill. App. Ct. 2007) (upholding the constitutionality of the statute as not violative of due process); *People v. Paige*, 880 N.E.2d 675, 680-84 (Ill. App. Ct. 2007) (upholding the constitutionality of 55 ILL. COMP. STAT. 5/5-1101).

245. GREG BERMAN, CTR. FOR COURT INNOVATION, *THE HARDEST SELL? PROBLEM-SOLVING JUSTICE AND THE CHALLENGES OF STATEWIDE IMPLEMENTATION* 4 (2004), available at www.courtinnovation.org/_uploads/documents/Hardest%20Sell1.pdf.

and results of other MHCs are any indicator of what to expect, the MHC pilot program would produce a drop in recidivism in its graduates, a rise in public safety, and most importantly, an initial projection of the money to be saved by diverting defendants away from incarceration and into treatment.

An expanded MHC in New Orleans alone would put the relief delivered by the new and expanded MHCs under a magnifying glass. After Hurricane Katrina, the city's judicial system is overburdened by the closing of mental health facilities like Charity Hospital and other community based programs. Today, the largest public ward for treating the mentally ill in New Orleans is Orleans Parish Prison, with a total of sixty in-patient beds. Judge Hunter, Louisiana's only MHC judge, understands the need for this program, calling the current state of affairs "more than just a public crisis. This is a dangerous situation."²⁴⁶ The Louisiana MHC Pilot Program would take the initial steps toward helping a class of citizens currently without aid, gain the relief they deserve, while lowering an expense that is already costing Louisiana residents too much.

John E. Cummings*

246. Rick Jervis, *Mental Health Crisis Plagues New Orleans*, USA TODAY, Mar. 5, 2008, available at http://www.usatoday.com/news/nation/2008-03-04-katrina-health_N.htm.

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