

COMMENT

JAMMING THE REVOLVING DOOR:

LEGISLATIVE SETBACKS FOR MENTAL HEALTH COURT SYSTEMS IN VIRGINIA

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I. INTRODUCTION

Mental health courts (“MHCs”) have emerged throughout the United States in response to the overwhelming number of individuals with mental illness in the criminal justice system. Many individuals with mental illness who lack the social and financial resources necessary to receive treatment find themselves charged with criminal offenses. Often times, their arrests are more a product of mental illness than of criminality.¹ The growing presence of criminal defendants with mental illness imposes financial hardships upon the criminal justice system, while ill-equipped and overcrowded jails provide inadequate treatment for inmates with mental health problems.² Accordingly, both the criminal justice system and mentally ill offenders have suffered from the adverse effects that arise from budgetary constraints and inept staffing of community-based mental health care services.

Proponents of MHCs assert that alternative court systems will provide efficient jail diversion programs and reduce the number of individuals with mental illness in the criminal justice system by directing them to appropriate community treatment facilities.³ At the same time, MHCs must

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1. Bruce J. Winick & Susan Stefan, *A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL’Y & L. 507, 507 (2005).

2. See BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, NCJ 202949, STATE PRISON EXPENDITURES (2001), <http://www.ojp.usdoj.gov/bjs/pub/ascii/spe01.txt>. In 2001, state governments spent \$29.5 billion on prisoners, which included expenditures of only \$3.3 billion on medical care for that year – 12 % of operating costs. *Id.*

3. See generally Winick & Stefan, *supra* note 1, at 507.

serve as only one branch of a larger, cohesive community effort to deter individuals with mental illness from incarceration, if not from conviction.⁴ Both advocates and adversaries of MHCs remain wary of the potential misuse of mental health courts, which may subject people with mental illness to greater criminalization or lead to greater fragmentation of the mental health system.⁵

Part II of this comment will discuss the existing issues that effectuate the tension between the criminal justice system and mentally ill offenders, which provides important context to the debate surrounding the establishment of MHCs. Part III will examine the recent federal support for alternative approaches to handling mentally ill offenders and the different operational tactics implemented by existing MHC programs. Finally, Part IV will study the launch of Virginia's first MHC in Norfolk, while exploring the latest legislative defeat in Virginia, Senate Bill 158 of the 2010 General Assembly, which sought to establish MHCs statewide.⁶ The recent bill proposed to allow general district courts and circuit courts to voluntarily undertake separate mental health dockets.⁷ However, the Senate and the House were unable to agree on the methodology purported by the bill.⁸

II. THE BATTLE BETWEEN CRIMINAL LAW AND MENTAL ILLNESS

The strained relationship between the criminal justice system and the mentally ill offender is largely due to complex, structural deficiencies in community-based mental health care.⁹ The lack of access to basic treatment and support from the mental health system disconnects many people with mental illness from community services.¹⁰ Consequently, the criminal justice system encounters mentally ill offenders “with increasing

4. See Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform*, 7 U. D.C. L. REV. 143, 143–44 (2003).

5. See MENTAL HEALTH AMERICA, POSITION STATEMENT 53: MENTAL HEALTH COURTS, (2009), <http://www.mentalhealthamerica.net/go/position-statements/53> [hereinafter POSITION STATEMENT 53].

6. Compare S.B. 158, 2010 Gen. Assem., Reg. Sess. (Va. 2010) (as introduced Jan. 13, 2010), with S.B. 158, 2010 Gen. Assem., Reg. Sess. (Va. 2010) (as amended Mar. 8, 2010).

7. S.B. 158, 2010 Gen. Assem., Reg. Sess. (Va. 2010) (as introduced Jan. 13, 2010) (proposing to amend the Code of Virginia to include section 19.1-180.1, which would provide that any district court or circuit court may establish an MHC through a separate court docket within the existing calendar of a district or circuit court to offer judicial monitoring of the treatment and supervision of certain individuals with mental illness who are under the jurisdiction of the criminal court).

8. Compare S.B. 158, 2010 Gen. Assem., Reg. Sess. (Va. 2010) (as introduced Jan. 13, 2010), with S.B. 158, 2010 Gen. Assem., Reg. Sess. (Va. 2010) (as amended Mar. 8, 2010).

9. Winick & Stefan, *supra* note 1, at 511.

10. See Bernstein & Seltzer, *supra* note 4, at 143. “For most, the underlying issue is their need for basic services and supports that public systems have failed to deliver in meaningful ways.” *Id.*

frequency.”¹¹ According to the most recent data compiled by the U.S. Department of Justice, 16 percent of inmates in jails and prisons combined reported having a mental condition or requiring mental health hospitalization.¹² This translates to over a quarter-of-a-million individuals with mental illness presently incarcerated.¹³ Furthermore, studies by the National Alliance for the Mentally Ill (“NAMI”) show that “up to 40 percent of adults who suffer from a serious mental illness will come into contact with the American criminal justice system at some point in their lives.”¹⁴

Jails and prisons are not equipped to handle the growing presence of mentally ill inmates. Reportedly one-fifth of jails have absolutely no access to mental health services.¹⁵ Senator Mike DeWine, who sponsored federal legislation promoting MHC creation,¹⁶ observed that “correctional facilities simply do not have the means, or the expertise, to properly treat mentally ill inmates.”¹⁷ Due to inadequacies within the traditional criminal justice system, 83 percent of mentally ill state prisoners and 89 percent of mentally ill jail inmates do not receive treatment.¹⁸ The few individuals who do receive treatment must wait in long lines, with little incentive to participate, and endure stigmatization.¹⁹ Consequently, the inability of jails and prisons to address the needs of people with mental illness contributes to the high rate of recidivism.

Without the necessary treatment, most individuals re-offend and return to the criminal justice system “going through a ‘revolving door’ from street to court to cell and back again, without ever receiving the support and structure they need” to keep from re-offending.²⁰ Currently, nearly one-

11. *Id.*

12. BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, NCJ 174463, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS I (1999), <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhtip.pdf> [hereinafter NCJ 174463].

13. *Id.* (“ . . . 16% or an estimated 283,800 inmates reported either a mental condition or an overnight stay in a mental hospital, and were identified as mentally ill.”)

14. Pub. L. No. 108-414, § 2, 118 Stat. 2327, 2399 (2004) (finding, in accordance with the National Alliance of the Mentally Ill, that 25%-40% of America’s mentally ill come into contact with the criminal justice system).

15. Debra Baker, *A One-of-a-Kind Court May Offer the Best Hope for Steering Nonviolent Mentally Ill Defendants into Care Instead of Jail*, 84 A.B.A. J. 20, 21 (1998).

16. See *supra* text accompanying notes 32–36.

17. 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, 259 (2001) (citing Press, Release, Mike DeWine, Treatment for Mentally Ill Inmates (Oct. 20, 1999), at 1).

18. DEREK DENCKLA & GREG BERMAN, CTR. FOR COURT INNOVATION, RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS 3 (2001), http://www.courtinnovation.org/_uploads/documents/rethinkingtherevolvingdoor.pdf.

19. *Id.*

20. DENCKLA & BERMAN, *supra* note 18, at 4. See also Kondo, *supra* note 17, at 257. (“Mentally ill

fourth of prison and jail inmates who have a mental health problem have served three or more prior incarcerations, as compared to a fifth of those who are incarcerated without a mental illness.²¹ Such high recidivism among mentally ill offenders demonstrates the inefficient use of community resources. Inadequate community mental health services prevent the criminal justice system from achieving rehabilitation and deterrence for these individuals.²²

In addition to setbacks within the public mental health system, discriminatory practices by law enforcement officials greaten the criminalization of those with mental illness, and thus also attribute to recidivism.²³ In some jurisdictions, improper police response arises from community pressures to remove individuals with mental illness from the streets whose behaviors are seen as a nuisance to the public.²⁴ The stigma associating mental illness with violence perpetuates “the prejudice of communities that call on police to rid them of people they find uncomfortable.”²⁵ Many of the individuals arrested are charged with only minor offenses, such as disturbing the public order or trespassing, the arrests for which are often contingent upon police discretion.²⁶ Under some state statutes, the police may act as “street corner psychiatrists,” arresting those with mental illness on the streets “as substitute intake procedures, because arrest is deemed to be less burdensome than procedures for emergency psychiatric intervention.”²⁷ Ultimately, the lack of police training on how to deal with mental illness influences the inappropriate criminal confinement of many individuals.

offenders are often inextricably trapped in a ‘revolving door’ of petty crime, incarceration, release, homelessness, and re-imprisonment.”)

21. BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, NCJ 213600, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), <http://www.bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf>.

22. DENCKLA & BERMAN, *supra* note 18, at 4. “[U]pon release [from incarceration], [mentally ill individuals] are often unable to access available community treatment because of providers’ reluctance to serve them Many community mental health centers are unprepared or unwilling to treat people who have criminal records.” *Id.*

23. *See* Winick & Stefan, *supra* note 1, at 513. “When Congress was considering the Americans With Disabilities Act, testimony regarding discriminatory practices by police against people with disabilities was so common that it was noted in the legislative history . . . [W]hen the Department of Justice didn’t include specific regulations addressing police practices, the drafters of the regulations received numerous complaints. There have been literally hundreds of cases brought against prisons and jails for their treatment of people with psychiatric disabilities.” *Id.* (internal citations omitted).

24. NCJ 174463, *supra* note 12. “Over one-quarter of the inmates with mental illnesses in local jails were incarcerated for a public order offense.” *Id.*

25. Winick & Stefan, *supra* note 1, at 511.

26. *See id.* at 514–16 (discussing minor offenses observed by Florida’s Broward County MHC where defendants were arrested for drinking a cup of coffee in front of a bank or shoplifting a pack of gum).

27. Kondo, *supra* note 17, at 306 (citing MENTAL HEALTH AND LAW: RESEARCH, POLICY AND SERVICES 286, 288 (Bruce D. Sales & Saleem A. Shah eds., 1996)).

Traditional criminal courts have different methods for addressing defendants with mental illness, such as findings of “not guilty by reason of insanity” or “guilty but mentally ill.”²⁸ Some believe the primary concern for creating the “guilty but mentally ill” verdict was “to limit the number of persons who, in the eyes of the legislature, were improperly being relieved of all criminal responsibility by way of an insanity verdict.”²⁹ However, state courts rarely explore such avenues, and criminal justice officials occasionally treat these individuals worse than other defendants without mental illness.³⁰ In some jurisdictions, defendants who are found incompetent to stand trial may be transferred briefly to a local state psychiatric hospital, typically to offer stabilizing treatment, and then back to jail.³¹ While the validity of state statutes allowing transfers from reformatories to penal institutions have been upheld, the United States Supreme Court has cautioned that, “the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as treatment for mental illness, constitute the kind of deprivations of liberty that require procedural protections” under the Due Process Clause.³² Nevertheless, as the criminal justice system continues to flood with people who have serious psychiatric disabilities, discriminatory practices within the judicial process ensue.³³

III. THE GROWTH OF MENTAL HEALTH COURTS IN AMERICA

In a high-profile case in 1993, 25-year-old Aaron Wynn, who had been in and out of community mental health facilities, pushed an 85-year-old

28. *See Aizupitis v. Delaware*, 699 A.2d 1092, 1092–93 (Del. 1997) (affirming that a statutory plea and verdict of “guilty but mentally ill” may be invoked for the purpose of dealing with defendants who are not legally insane, but who nevertheless suffer from mental illness); *see also Ellis v. Georgia*, 336 S.E.2d 281, 284 (Ga. Ct. App. 1985) (finding that a verdict of “guilty but mentally ill” is authorized where the defendant is not legally insane, but is otherwise mentally ill at the time of his or her commission of the alleged criminal acts); *People v. Seaman*, 561 N.E.2d 188, 190 (Ill. App. Ct. 1990) (finding that before a jury may consider whether a defendant is guilty but mentally ill, it must have determined that the defendant is sane rather than insane).

29. *People v. Ramsey*, 375 N.W.2d 297, 301 (Mich. 1985).

30. DENCKLA & BERMAN, *supra* note 18, at 6–7. “More often than not, defendants with mental illness receive no special treatment whatsoever from the court — they are treated just like any other defendant. In fact, many are treated worse, because they are stigmatized by criminal justice officials with little experience dealing with mental illness.” *Id.*

31. *Wilson v. Coughlin*, 147 N.W.2d 175, 177 (Iowa 1966); *Uram v. Roach*, 37 P.2d 793, 793 (Wyo. 1934).

32. *Vitek v. Jones*, 445 U.S. 480, 494 (1980).

33. *See generally Winick & Stefan, supra* note 1, at 513 (discussing evidence of discriminatory practices by the criminal justice system against individuals with mental illness).

woman outside a supermarket in Fort Lauderdale.³⁴ The woman's injuries resulted in her death. Wynn was charged with manslaughter, but later found incompetent to stand trial.³⁵ The case led to a grand jury investigation of Florida's mental health network, which revealed an ineffective and fragmented system of care.³⁶ Frustrated by conventional approaches to handling mentally ill offenders, Circuit Court Judge Mark A. Speiser in Broward County established a Mental Health Task Force in 1994, which soon became the nation's first MHC by 1997.³⁷ Only two years later, King County District Court in Washington established the second MHC in the United States.³⁸ Both the King County and Broward County MHCs proved to be great successes, and it was not long before Congress noticed the benefits of supporting MHCs.³⁹

In 2000, Congress passed America's Law Enforcement and Mental Health Project statute to provide federal funds to local initiatives seeking to establish or expand mental health specialty courts.⁴⁰ The grant program may finance no more than 75 percent of the total costs to operate any eligible MHC, and qualified applicants are limited to the chief executive or chief justice of a state or of a unit of local government.⁴¹ In 2004, Congress broadened its support for MHCs by enacting the Mentally Ill Offender Treatment and Crime Reduction Act ("MIOTCRA").⁴² The MIOTCRA offers a more comprehensive approach by awarding nonrenewable grants to be used to create or expand: (1) MHCs or related specialized court-based systems, (2) programs offering "specialized training to the officers and employees of a criminal or juvenile justice agency and mental health personnel serving those with co-occurring mental illness and

34. Jenni Bergal, *Justice That Works; Mentally Ill Defendants Avoid the Revolving Door of Jail, Get Their Lives Back on Track Through Mental Health Court's Assistance*, SUN-SENTINEL (Ft. Lauderdale, Fla.), Nov. 24, 2002, at A1, available at http://articles.sun-sentinel.com/2002-11-24/news/0211240176_1_judge-ginger-lerner-wren-mentally-ill-defendants-mental-health/3.

35. *Id.*

36. *Id.*; see also JUDGE GINGER LERNER-WREN, BROWARD'S MENTAL HEALTH COURT: AN INNOVATIVE APPROACH TO THE MENTALLY DISABLED IN THE CRIMINAL JUSTICE SYSTEM 2 (2000), <http://contentdm.ncsconline.org/cgi-bin/showfile.exe?CISOROOT=/spcts&CISOPTR=184> (discussing the "scathing grand jury report" that revealed "severe shortfalls" in the county's mental health system).

37. OFFICE OF JUSTICE SYSTEM SERVICES, BROWARD COUNTY MENTAL HEALTH CRIMINAL JUSTICE TASK FORCE, THIRD ANNUAL MENTAL HEALTH COURT PROGRESS REPORT (2000), available at <http://web.archive.org/web/20010421092022/www.co.broward.fl.us/ojss/jsi00700.html>.

38. FREDESE WHITSETT AND MARK C. CHOW, KING COUNTY DISTRICT COURT, MENTAL HEALTH COURT 2001 REPORT (2001), available at <http://www.kingcounty.gov/courts/DistrictCourt/~//media/courts/DistrictCourt/pdfs/mhc2001rpt.ashx>.

39. See America's Law Enforcement and Mental Health Project, Pub. L. No. 106-515, § 2, 114 Stat. 2399, 2399 (2000) (lauding the "positive results" of Broward County, Florida and King County, Washington's MHCs).

40. Pub. L. No. 106-515, 114 Stat. 2399-2400 (2000).

41. §§ 2203-2205, 114 Stat at 2400-01.

42. Pub. L. No. 108-414, 118 Stat. 2327 (2004).

substance abuse problems,” and (3) collaborative programs between “criminal and juvenile justice agencies and mental health agencies to promote public safety by offering mental health treatment services.”⁴³ Through these congressional acts, the Department of Justice launched a number of programs to mobilize communities to address the criminalization of mentally ill persons.⁴⁴ By 2008, news sources reported the establishments of approximately 175 MHCs across the nation.⁴⁵

All MHCs exhibit a number of basic commonalities. State district courts and circuit courts employ separate mental health dockets to maneuver the judicial process to divert mentally ill offenders away from incarceration and into treatment programs with the assistance of community mental health services.⁴⁶ Every MHC involves a team-like approach by which court personnel and mental health care professionals determine an appropriate treatment plan tailored to the individual defendant.⁴⁷ Once the mentally ill defendant agrees to accept diversion to mental health court, the court holds periodic hearings to ensure the participant’s compliance with the program and resolve any difficulties that may arise during the treatment process.⁴⁸ MHCs feature therapeutic jurisprudence,⁴⁹ operating sensitive to the psychological impacts of the law on individuals with mental illness.⁵⁰ These problem-solving courts apply a multi-disciplinary approach and act as therapeutic agents “to motivate the individual to accept needed mental health treatment and to encourage and monitor treatment compliance.”⁵¹ Relaxed courtroom proceedings and supportive judge-participant

43. § 2991(b), 118 Stat. at 2330.

44. *E.g.*, BUREAU OF JUSTICE ASSISTANCE, U.S. DEP’T OF JUSTICE, MENTAL HEALTH COURT PROGRAMS, <http://www.ojp.usdoj.gov/BJA/grant/mentalhealth.html> (last visited Mar. 10, 2010).

45. Emma Schwartz, *Mental Health Courts: How Special Courts Can Serve Justice and Help Mentally Ill Offenders*, U.S. NEWS AND WORLD REPORT (Feb. 7, 2008), available at <http://www.usnews.com/articles/news/national/2008/02/07/mental-health-courts.html>.

46. Stacey M. Faraci, *Slip Slidin’ Away? Will our Nation’s Mental Health Court Experiment Diminish the Rights of the Mentally Ill?*, 22 QUINNIPIAC L. REV. 811, 825 (2004).

47. Winick & Stefan, *supra* note 1, at 520.

48. *Id.* at 521. “The individual is encouraged to discuss his or her experiences and problems in treatment. The hearing becomes an exercise in creative problem solving in which the judge and other members of the treatment team attempt to resolve difficulties and overcome obstacles that have arisen in the treatment process.” *Id.*

49. Professor David Wexler first coined the term therapeutic jurisprudence in 1987 in a paper to the National Institute of Mental Health. 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, 442 n.8 (1999).

50. See LAW IN A THERAPEUTIC KEY xvii (David B. Wexler & Bruce J. Winick eds., 1996). “Legal rules, legal procedures, and the roles of legal actors (such as lawyers and judges) constitute social forces that, like it or not, often produce therapeutic or antitherapeutic consequences. Therapeutic jurisprudence proposes that we be sensitive to those consequences, and that we ask whether the law’s antitherapeutic consequences can be reduced, and its therapeutic consequences enhanced, without subordinating due process and other justice values.” *Id.*

51. Winick & Stefan, *supra* note 1, at 521.

interactions encourage modified behavior,⁵² while judicial oversight and centralized case management provide regular supervision and improve efficacy.⁵³

In spite of the similarities described above, the operation of each MHC program is unique. Each bench employs its own manner of balancing concerns for public safety with the needs of the defendant. There are currently three basic court models for using criminal charges to mandate participation in community treatment: (1) the pre-adjudication model, (2) the post-plea model, and (3) the probation-based model.⁵⁴ The pre-adjudication model defers prosecution upon the defendant's decision to participate in treatment, usually through a contractual agreement with the judge.⁵⁵ The post-plea model, which is used by the majority of mental health courts, occurs after adjudication. It requires a plea of guilt from the defendant, but sentencing is deferred.⁵⁶ Lastly, the probation-based model convicts the defendant and sentences him or her to probation, while prescribing treatment as a condition of probation; the sentence may also include suspended or deferred jail time.⁵⁷ Regardless of the model selected, none of the courts dismiss the criminal charges prior to completion of the treatment plan.⁵⁸

MHC programs encourage non-coercive and de-stigmatizing approaches, as research shows that coercive standards may undermine treatment compliance and reduce the overall effectiveness of jail diversion systems.⁵⁹ Judges, prosecutors, defense attorneys, and other members of the MHC system work together to ensure that the mentally ill defendant has an informed and voluntary choice to either participate in the treatment program or opt for routine criminal court processing.⁶⁰ Some MHCs provide

52. See DENCKLA & BERMAN, *supra* note 17, at 9 (noting that MHCs have a non-adversarial dynamic).

53. Winick & Stefan, *supra* note 1, at 521. "The [mental health] judge at these hearings often functions to help shape the individual's behavior by praising treatment compliance or sanctioning those who miss appointments or otherwise fail to comply with the treatment program. The behavioral contract that the individual enters into with the court typically specifies the details of required participation and the sanctions that will be applied for noncompliance." *Id.*

54. LISA CONTOS SHOAF, OHIO OFFICE OF CRIMINAL JUSTICE SERVICES, EXECUTIVE SUMMARY ON MENTAL HEALTH COURTS (2005), <http://www.ocjs.state.oh.us/research/MHexec1.pdf>.

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

59. THE COUNCIL OF STATE GOVERNMENTS, A GUIDE TO MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION (May 2005), <http://consensusproject.org/mhcp/GuideMHCDesign.pdf> (this article was prepared by the Bureau of Justice Statistics from a compilation of observations and reports to explain the process and concerns of those wishing to establish mental health court programs).

60. See Berstein & Seltzer, *supra* note 4, at 150. "It is crucial from the outset that transfer to the mental health court be entirely voluntary. Otherwise, singling out defendants with mental illnesses for separate and different treatment by the courts would violate the equal protection guarantee of the 14th

defendants with a temporary, two-week placement in the treatment program to help them decide whether to participate in the program.⁶¹ By the end of the two-week period, the defendant must affirmatively “opt-in” in order to continue receiving treatment.⁶²

Despite the successful implementation of MHCs across the country, the alternative justice system is not without adversaries.⁶³ Although the selective prosecution of mentally ill offenders calls for jail diversion strategies, some fear that MHCs will further the criminalization of mental illness by prompting more charges against “people with mental illness for offenses for which they would not previously have been arrested.”⁶⁴ It has also been contended that MHCs may “impose greater stigma upon [those with mental illness], and result in a fragmentation of services, with those in the criminal justice system ironically receiving priority access to needed mental health services.”⁶⁵ Nevertheless, the development of MHCs continues to spread in response to the continuing shortfalls of local mental health delivery that agitate the problem of untreated mental illness in the community.

IV. THE DEBATE IN VIRGINIA

Since 2007, Senator John Edwards has introduced four MHC bills to the Virginia General Assembly during each regular session.⁶⁶ In the 2007 and 2008 sessions, the MHCs bills identically proposed a pilot program by directing the Office of the Executive Secretary of the Supreme Court to establish “at least two and no more than five mental health courts in the

Amendment and would likely violate the 6th Amendment right to a trial by jury and the prohibition against discrimination by a state program found in the Americans with Disabilities Act.” *Id.*

61. *See* DENCKLA & BERMAN, *supra* note 18, at 10. “For instance, the King County Mental Health Court in Washington gives defendants two weeks in a treatment placement to help them decide whether to participate in the program or not.” *Id.*

62. *See id.*

63. *E.g.*, Winick & Stefan, *supra* note 1, at 511. “The creation of mental health courts to solve the problems represented by people with psychiatric disabilities in the criminal justice system is similar to an unhappy teenager deciding to have a child to solve her problems.” *Id.*

64. *See id.* at 518. “There is a risk that mental health courts, if they are seen as an effective means of facilitating the treatment of people in the communities who cause problems as a result of their untreated mental illness, may prompt the police to begin arresting people with mental illness for offenses for which they would not previously have been arrested. In other words, a successful mental health court could have the effect of altering police arrest practices in the community aimed at dealing with people with untreated mental illness who may cause trouble.” *Id.*

65. *Id.* at 508.

66. *See* S.B. 1388, 2007 Gen. Assem., Reg. Sess. (Va. 2007); S.B. 18, 2008 Gen. Assem., Reg. Sess. (Va. 2008); S.B. 854, 2009 Gen. Assem., Reg. Sess. (Va. 2009); S.B. 158, 2010 Gen. Assem., Reg. Sess. (Va. 2010).

Commonwealth” within the following year.⁶⁷ The MHCs were to be “established and administered so as to be eligible for any federal funding that may become available under ‘America’s Law Enforcement and Mental Health Project.’”⁶⁸ However, the proposed legislation did not move forward from the Senate Finance Committee in either the 2007 or the 2008 session. The 2009 MHC bill mirrored the prior two bills, but included an additional qualification mandating that MHCs only be established in those circuits where “(i) the local community services board agrees to provide such services as are necessary for the establishment of the mental health court, and (ii) a district court or circuit agrees to establish a mental health court.”⁶⁹ Although the bill passed in the Senate, it did not leave the House Committee for Courts of Justice.⁷⁰

During the current 2010 regular session, Senate Bill 158 sought to enact legislation requiring MHC establishment.⁷¹ Such coercive legislation proved once again to be too aggressive for House members to support.⁷² Consequently, the House Committee for Courts of Justice offered a substitute bill to enact indirect legislation that did not specifically mention MHCs or their development.⁷³ Rather, the substitute proposed to amend and reenact sections 16.1-69.35 and 17.1-502 of the Code by simply allowing a chief general district judge of to establish separate dockets “when the work of the court may be more efficiently handled thereby.”⁷⁴ The House voted to pass the substitute; however, the Senate rejected it, and the legislative debate on MHCs continues.⁷⁵

The MHC bills introduced to the General Assembly over the last four years do not address a mental health program that is unknown to the Commonwealth. In 2004, the Norfolk Circuit Court started Virginia’s first

67. S.B. 1388, 2007 Gen. Assem., Reg. Sess. (Va. 2007); S.B. 18, 2008 Gen. Assem., Reg. Sess. (Va. 2008).

68. S.B. 1388, 2007 Gen. Assem., Reg. Sess. (Va. 2007); S.B. 18, 2008 Gen. Assem., Reg. Sess. (Va. 2008).

69. S.B. 854, 2009 Gen. Assem., Reg. Sess. (Va. 2009).

70. See Legislative Information System, Bill Tracking: S.B. 854, 2009 Sess., <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=091&typ=bil&val=SB854>.

71. S.B. 158, Gen. Assem., Reg. Sess. (Va. 2010) (as introduced Jan. 13, 2010).

72. See Legislative Information System, Bill Tracking: S.B. 158, 2010 Sess., <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=101&typ=bil&val=sb158>; cf. AUBREY FOX & ROBERT V. WOLF, CTR. FOR COURT INNOVATION, THE FUTURE OF DRUG COURTS: HOW STATES ARE MAINSTREAMING THE DRUG COURT MODEL 12–13 (2004), available at http://www.courtinnovation.org/pdf/future_of_drug_courts.pdf (discussing coercive legislation in the drug court context).

73. S.B. 158, Gen. Assem., Reg. Sess. (Va. 2010) (as amended Mar. 10, 2010); cf. FOX & WOLF, *supra* note 71, at 46 (discussing indirect legislation in the drug court context). For example, Ohio has no legislation prescribing drug court operation, yet numerous laws support their process. *Id.*

74. S.B. 158, Gen. Assem., Reg. Sess. (Va. 2010) (as amended Mar. 10, 2010).

75. See Legislative Information System, Bill Tracking: S.B. 158, 2010 Sess., <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=101&typ=bil&val=sb158>

MHC for mentally ill defendants charged with class one and class two misdemeanors.⁷⁶ The Norfolk MHC coordinates with the Norfolk Community Services Board (CSB) to devise individual treatment plans for nonviolent mentally ill defendants who choose to participate in the program.⁷⁷ Norfolk employs the probation-based model⁷⁸ of MHCs, where after the defendant is charged and convicted of a non-violent offense, the mentally ill offender may choose to participate in the MHC system.⁷⁹ Participants do not need to enter a guilty plea; however, they must be convicted before they can apply to the program.⁸⁰ The applicant must also undergo a screening process by a CSB representative and an Assistant Commonwealth's Attorney in order to determine eligibility.⁸¹ Once the program chooses to admit a participant, the court assigns a probation officer and a mental health caseworker to monitor the participant's compliance with the treatment plan.⁸² During scheduled court appearances, the judge gives praise and encouragement to participants who stay on their regimen, and imposes a set of graduated sanctions, including incarceration, in instances of noncompliance and relapse.⁸³

A recent study by Old Dominion University's Social Science Research Center reveals that Norfolk's MHC system successfully deters many offenders from incarceration, while keeping them stabilized in treatment programs and sober.⁸⁴ The study concluded that the six-year-old program helps mentally ill offenders "achieve stability over an extended period without incarceration and without risking public safety."⁸⁵ The number of days that program participants remained out of jail while in the program was more than 21,000 during the study period, which ultimately saved the Commonwealth approximately \$1.63 million in jail costs.⁸⁶ The report also found that the recidivism rate for program participants is significantly lower than that of other mentally ill offenders. Recidivism rates ranged from 3.5 percent for those who graduated from the program within the last six

76. Matthew Philips, *Norfolk Starts Virginia's First Mental Health Court*, VA. LAW. WKLY., Jan. 12, 2004, available at 2004 WLNR 22690153.

77. *Id.*

78. See SHOAF, *supra* note 54.

79. *Here & Now: Special Criminal Courts for the Mentally Ill* (Boston NPR broadcast July 6, 2009), available at <http://www.hereandnow.org/2009/07/3241/#2>.

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.*

84. Debbie Messina, *ODU Study Touts Success of Norfolk's Mental Health Courts*, THE VIRGINIAN-PILOT, Sept. 2, 2008, available at <http://hamptonroads.com/2008/09/odu-study-touts-success-norfolks-mental-health-courts>.

85. *Id.*

86. *Id.*

months to 30 percent for those who have been out of the program for two years; whereas, the national rate of recidivism is “around 70 percent at two years after release for mentally ill offenders who were not in such a program.”⁸⁷

In spite of the encouraging results reported from Norfolk’s MHC, legislative proposals to expand the court system continue to face rejection by the General Assembly. Some lawmakers believe that “judges should not be paid to ‘baby-sit’ drug addicts or the mentally ill.”⁸⁸ The hesitation expressed by certain members of the General Assembly parallels the uncertainty of numerous other state legislatures. Political orchestration requires maneuvering around “thorny political issues,” such as selecting a state agency to be responsible for the courts, promoting MHCs despite alternative community approaches, and convincing policymakers to continue supporting MHCs during economic downturns.⁸⁹ In short, persuading Virginia legislators to support MHCs is crucial to the development of such programs in the Commonwealth, especially since the General Assembly controls appropriations.

V. CONCLUSION

The central goal of MHC systems is to lessen the incarceration of individuals with mental illness. Mentally ill offenders often require rehabilitation through treatment rather than incarceration. Problem-solving courts aid rehabilitation by creating a supportive judicial environment, while court-monitored treatment plans ensure compliance to prevent recidivism. As described by one legal advocate:

These courts can screen mentally ill defendants for risk of violence, seek to motivate those who are nonviolent to obtain needed treatment, and facilitate their securing the treatment they need. Given the assumed relationship between these individuals’ mental illness

87. *Id.*

88. Dena Potter, *Mental Health Court Increase*, ASSOCIATED PRESS, May 5, 2009, available at http://www.myfoxtwincities.com/dpp/health/dpg_Mental_Health_Courts_fc_20090505_2463149.

2463149. Democrat Delegate Johnny S. Joannou stated, “I don’t want to pay a judge \$160,000 to \$175,000 a year to do a social issue when that’s not what their job is.” *Id.*; cf. Winick & Stefan, *supra* note 1, at 522. “Are the judges cast into these new roles always competent to perform them? Many are, but many are not. Courts playing these new roles—dealing with such intractable problems as substance abuse, domestic violence, child abuse and neglect, juvenile delinquency, and mental illness—are in many ways functioning as social workers.” *Id.*

89. See FOX & WOLF, *supra* note 72, at 46 (discussing legislation’s role in the proliferation of drug courts).

and their criminal behavior, these courts, by motivating and assisting them to participate in treatment, also function to protect the community from future crime.⁹⁰

The success stories reported from MHCs across the nation have yet to overcome legislative setbacks in Virginia. Until policymakers can gather state support for alternative programs, the Commonwealth's criminal justice system must convene to divert non-violent, mentally ill offenders to community-based mental health services when incarceration is inappropriate. Integrative system reform requires assertive collaboration amongst both diversion programs and related liaisons.⁹¹ To the extent that MHCs are effective mechanisms for reducing the incarceration of individuals with mental illness, their programs should provide additional treatment resources for community mental health care, rather than exhaust already limited existing resources.⁹² Finally, the creation of MHCs in the criminal justice system should not be an avoidance of the problem of inadequate community mental health services.⁹³ While MHCs may be helpful for filling in the gaps where comprehensive community outreach programs fall short, such alternative court systems should never be the only way, or even the primary way, to assure jail diversion.

90. Winick & Stefan, *supra* note 1, at 511.

91. See DENCKLA & BERMAN, *supra* note 18, at 10. "Mental health courts seek to promote reform with partners outside of the courthouse as well as within. For instance, mental health courts have encouraged mental health and drug treatment providers to come together to improve service delivery for offenders." *Id.*

92. Winick & Stefan, *supra* note 1, at 511.

93. *E.g., id.* Stefan makes the analogy that the creation of MHCs to address mentally ill defendants in the criminal justice system is "similar to an unhappy teenager deciding to have a child to solve her problems."

