Drug Courts and Mental Health Courts: Implications for Social Work

Sabrina W. Tyuse and Donald M. Linhorst

In recent years communities across the United States have instituted specialized criminal courts for defendants with substance abuse disorders and mental illness. These specialized courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. The authors describe two types of specialized courts: drug courts and mental health courts. They critically examine the strengths and weaknesses of these courts and conclude with implications for social work education, practice, research, and advocacy.

KEY WORDS: *drug courts; mental health courts; mental illness; specialized courts; substance abuse*

In 2004, roughly 2.1 million people were incarcerated in U.S. jails and prisons (Harrison & Beck, 2004), many of whom can be expected to have substance abuse problems. Surveys of inmates conducted in 1997 and 1998 found, for example, that 70 percent of jail inmates committed a drug-related offense or used drugs regularly (Wilson, 2000) and that more than 80 percent of state prisoners and more than 70 percent of federal prisoners reported prior drug use (Mumola, 1999). The 1997 survey also found that more than half of state prisoners and one-third of federal prisoners used drugs or alcohol at the time of their offense.

The large number of inmates with substance abuse problems is attributable in part to the increased number of people convicted for drug offenses. In 1980, for example, 19,000 state inmates were convicted for drug offenses; the number increased to 251,000 by 1999 (U.S. Department of Justice, Bureau of Justice Statistics, n.d.). Much of the increase in drug-related convictions is a function of changes in criminal behavior, drug laws, expanded drug law enforcement efforts, sentencing policies, and release practices (Blumstein & Beck, 1999; Field, 2002).

Another survey conducted in 1997 estimated that 16 percent of jail and state prison inmates and 7 percent of federal inmates—a total of 283,000 inmates—had a mental illness (Ditton, 1999). The high number of inmates with mental illness has led some people to refer to jails as America's new mental hospitals, because on any given day, there are twice as many people with mental illness in jails than there are in public psychiatric hospitals (Torrey, 1995; Torrey et al., 1992). It is widely accepted that the high number of inmates with mental illness is attributable to the deinstitutionalization of psychiatric services that began in the 1960s (Lamb & Weinberger, 1998; Smiley, 2001). Deinstitutionalization resulted in the discharge of a large number of patients from public psychiatric hospitals without adequate mental health and support services to maintain them in the community (Bachrach, 1983).

Drug courts and mental health courts have been developed to reduce the number of incarcerated people with substance abuse disorders and mental illness. These specialized courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. The number of different types of specialized courts is increasing. In addition to drug courts and mental health courts, some jurisdictions, for example, operate specialized courts for people who are homeless and for people who engage in domestic violence (Binder, 2001; Rottman, 2000). Rottman described the therapeutic value of specialized courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes

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Drug courts can be held postsentence, wherein drug court program graduates receive reduced probation sentences or avoid incarceration.

emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs" (pp. 23–24).

DESCRIPTION OF COURTS

Drug Courts

The first drug court was opened in 1989 in Miami's Dade County to divert nonviolent offenders to mandatory and intensive treatment programs (Belenko, 2002; Cooper, 2000). This court worked with defendants at the presentence stage of the judicial process and included periodic drug testing, ongoing judicial supervision, sanctions and incentives, and close monitoring. The majority of drug courts follow the presentence or diversion model, wherein if defendants complete the program requirements, criminal charges against them are dismissed (Belenko). Drug courts also can be held postsentence, wherein drug court program graduates receive reduced probation sentences or avoid incarceration (Belenko). As of 2002, a total of 1,238 drug courts were operated or planned, and existed in all 50 states, the District of Columbia, Puerto Rico, and Guam (Cooper, 2000; Office of Justice Programs, 2002). They are also a part of Native American Tribal Courts in 14 states (Cooper, 2000). Based largely on the U.S. model, drug courts have also been developed in Australia, Canada, and Great Britain and are in the planning stages in Brazil and several other countries (Turner et al., 2002).

In response to the recognition that traditional enforcement and punishment of drug offenders has had little impact on substance abuse and the cycle of criminal recidivism, the federal government provided funds for the development of drug courts (Belenko, 2002). Specifically, the development of drug courts nationwide was facilitated by federal funds distributed by the U.S. attorney general to local jurisdictions through the Violent Crime Control and Law Enforcement Act of 1994. Between 1995 and 1999, this act provided more than 100 million dollars for the development and implementation of drug courts (Belenko).

Some drug courts have been modified to address the unique problems faced by families, women, juveniles, and Native Americans residing on reservations (Cooper, 2002; McNeece, Springer, & Arnold, 2001). Family drug courts, for example, are designed to mandate substance abuse treatment for parents who are in danger of losing custody or visitation rights of their minor children as a consequence of their drug use or drug-related criminal offenses (Cooper, 2000). Tribal drug courts in the Native American justice system adapt the drug court model to meet the specific needs of the Native American reservation community devastated by generational drug and alcohol abuse (Cooper, 2000; Tribal Court Clearinghouse, 2002).

As the number of drug courts expanded and diversified, the need arose for a defining set of components of drug courts to ensure their integrity. The federal Drug Courts Program Office provided funding to the National Association of Drug Court Professionals for such an endeavor. That organization issued a set of 10 components of drug courts in 1997 (Hora, 2002) (Table 1). These components have helped define what constitutes drug courts and to guide development and implementation thereof.

Mental Health Courts

The first criminal court to focus solely on mental health issues was opened in Broward County, Florida, in 1997, although the application of the term "mental health court" first appeared in the early 1980s (Sipes, Schmetzer, Stewart, & Bojrab, 1986). A July 2004 survey identified 98 mental health courts in local jurisdictions in 33 states (*Survey of Mental Health Courts,* 2004). To promote development of mental health courts, the federal Bureau of Justice Assistance provided grants of approximately $150,000 each to 24 local mental health courts in 2002 and 14 courts in 2003 (Bureau of Justice Assistance, 2004; Criminal Justice/Mental Health Consensus Project, 2004).

Mental health courts arose from the popularity of drug courts. Like drug courts, mental health courts can be used at the presentence stage to divert defendants with mental illness from the criminal justice system or at the postsentence phase to prevent incarceration and reduce time on probation (Goldkamp & Irons-Guynn, 2000). Unlike

Table 1: Key Components of Drug Courts, Office of Justice Programs, 1997

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a nonadversarial approach, prosecution and defense counsels promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

Source: Hora, P. F. (2002). A dozen years of drug treatment courts: Uncovering our theoretical foundation and the construction of a mainstream paradigm. *Substance Use and Misuse, 37,* 1469–1488.

drug courts, mental health courts do not have an accepted set of guidelines, which has led some to conclude that the term "mental health courts" has little meaning (Steadman, Davidson, & Brown, 2001). Steadman and colleagues (2001) offered four criteria that help define what constitutes a mental health court: (1) a court docket specifically set aside for people with mental illness; (2) a team of criminal justice and mental health professionals to recommend a treatment and supervision plan and identify a responsible party; (3) assurance that the recommended treatment is available to the defendant or client; and (4) court monitoring with possible sanctions for noncompliance, such as reinstituting charges or sentences. The National Mental Health Association (2001), a leading mental health advocacy organization, recently developed a position paper on mental health courts and offered its own guidelines. In the absence of other guidelines, these can be useful for local communities considering development and implementation of mental health courts. Table 2 provides most of these guidelines.

CRITICAL REVIEW OF DRUG COURTS AND MENTAL HEALTH COURTS

Positive Aspects

One of the most positive aspects of drug courts and mental health courts is that they largely serve a vulnerable population. One review of drug courts found, for example, that 25 percent of participants were female, 48 percent were racial minorities, 74 percent had prior felony convictions, 49 percent were unemployed at the time of arrest, 76 percent had undergone prior failed drug treatment, 20 percent had attempted suicide, and between 15 percent and 56 percent reported past sexual or physical abuse (Belenko, 2002). A review of two of the largest mental health courts found that approximately 25 percent were women, about 25 percent were from racial minority groups, between 25 percent and 45 percent had a major mental illness and a substance abuse disorder, more than half were not receiving mental health treatment at the time of arrest, most were receiving disability income, and 25 percent were homeless at the time of arrest (Goldkamp & Irons-Guynn, 2000). The two specialized courts also provide an alternative to incarceration. This is particularly important for people with severe mental illness who tend to do poorly in correctional settings (Smiley, 2001; Torrey et al., 1992). Incarceration can exacerbate psychiatric symptoms, and inmates with mental illness are at increased risk of suicide and being assaulted and raped by other inmates.

As an alternative to incarceration, drug courts and mental health courts provide access to an array of community treatment and support services. A survey of drug court treatment found that the vast majority of drug courts offered participants outpatient treatment, access to Alcoholics Anonymous and Narcotics Anonymous support groups, mental health treatment, relapse prevention, educational and vocational training, and residential services (Peyton & Grossweiler, 2000). Mental health courts also seek to offer a variety of services. An

Table 2: Mental Health Court Guidelines, National Mental Health Association, 2001

1. Comprehensive mental health outreach to prevent the need for mental health courts.
2. Maximum diversion when a voluntary treatment plan is a reasonable alternative to the use of criminal sanctions.
3. No requirement for a guilty plea because it precludes criminal justice system diversion.
4. Voluntary and noncoercive participation with the nature of the terms and treatment plan requirements fully discussed and documented.
5. Treatment provided in the least restrictive alternative manner available.
6. Protection of the right to refuse treatment at least to civil commitment procedural levels.
7. Provision of an advocate/counselor, in addition to competent legal counsel, to help the accused person to reach an informed decision.
8. Systems in place to ensure confidentiality through the judicial process.
9. Cultural competence tailored to the specific needs of the community and the individual.
10. Oversight by community coalitions made up of criminal justice agencies, mental health and substance abuse agencies, mental health consumers, and family members of consumers.
11. Comprehensive outreach and training to criminal justice personnel at all levels.
12. Integrated treatment of co-occurring disorders, especially substance abuse.
13. Focus in on the individual, not on the use of criminal sanctions to force treatment.
14. An individual's time under jurisdiction of the mental health court should not be extended as a result of relapses that are inevitable during the recovery process.
15. Evaluation of the process and outcomes to ensure that mental health courts are responses to consumers and are held accountable for consumer outcomes.

Source: National Mental Health Association. (2001, November 17). *Mental health courts* (Position paper). Retrieved July 2002, from http://www.nmha.org/position/mentalhealthcourts.cfm

examination of the four pioneering mental health programs in the United States found that these programs usually seek to duplicate drug court program principles and use of existing community-based mental health treatment services (Goldkamp & Irons-Guynn, 2000). One mental health court, for example, had intensive support teams that linked clients to psychiatric treatment and skill training, provided housing vouchers to participants who were homeless, and paired participants with volunteer peer mentors to provide additional long-term support (Linden, 2000).

These specialized courts can adapt to meet the needs of the participants and the communities in which the courts are enacted. In Anchorage, Alaska, for example, although a local culture of criminal responsibility would not permit a pretrial diversion component to its mental health court, the community created a postsentence mental health court (Watson, Luchins, Hanrahan, Heyrman, & Lurigio, 2000). These specialized courts can also be tailored to the special needs of rural areas, suburban areas, and large cities (Watson, Hanrahan, Luchins, & Lurigio, 2001). Drug courts, especially, have demonstrated the ability to adapt to participants' needs, as evidenced by the creation of subdivisions of drug courts that focus on juveniles, families, women, and people with mental illness (Belenko, 2002; Cooper, 2000, 2002; McNeece et al., 2001).

Drug courts and mental health courts, overall, have demonstrated positive outcomes. In a review of research on drug courts, Belenko (2002) concluded that participation in drug courts reduced substance abuse and reoffences both during and after court supervision. He also found that drug courts were cost-effective because of reduced costs in comparison with incarceration. However, as we note in the next section on negative aspects of drug courts, this research is based on relatively weak methodologies. In an evaluation of Seattle's two mental health courts, Trupin and Richards (2003), using a relatively small sample, found that participants were less likely to be reincarcerated, to spend fewer days in jail, and to be more engaged in treatment than those who chose not to take part in the mental health court program.

Finally, the establishment of drug courts and mental health courts has resulted in a positive unintended outcome in many communities. The coalition of diverse parties that often formed to create these courts has remained together in many instances to work on other related projects and lobby

for increased substance abuse and mental health resources. This was particularly noted in the formation of mental health courts (Petrila, Poythress, McGaha, & Boothroyd, 2001; Watson et al., 2000). Petrila and colleagues went so far as to say that the coalitions that formed as a result of mental health courts represent an important development in the mental health field, particularly when judges are involved in mental health services planning and advocating for increased funding for mental health services.

Negative Aspects

Drug courts and mental health courts can serve only a limited number of people with substance abuse disorders and mental illness. Although the number of courts has rapidly increased in recent years, many jurisdictions still do not offer them. Hunter (2000) found, for example, that only 2 percent of drug users are able to participate in drug court programs because of availability issues. This limitation stems in part from a lack of funding and resistance to specialized courts on the part of some judges and prosecutors (Tashiro, Cashman, & Mahoney, 2000).

Another significant limitation is the lack of ongoing resources to operate drug courts and mental health courts and a shortage of substance abuse and mental health treatment services to support them (Goldkamp & Irons-Guynn, 2000; Peyton & Gossweiler, 2000; Tashiro et al., 2000). Existing services typically do not include an adequate range of services, and access can be difficult. Drug court services include residential treatment, mental health treatment for participants with dual disorders, and specialized services for women and racial and ethnic minority groups (Peyton & Gossweiler). Mental health court services include housing, treatment for the dual diagnosis with substance abuse, monitoring of compliance with agreed-on treatment, and specialized services for women who have been traumatized, participants with head injuries, and those with a history of aggressive behavior (Petrila et al., 2001; Steadman et al., 2001; Trupin, Richards, Wertheimer, & Bruschi, 2001). Steadman and colleagues (2001) concluded that without access to a range of mental health and supportive services, mental health courts have limited impact on the people most in need of help.

In addition, a "creaming" process may occur in the selection of participants, particularly in drug courts. For example, Peyton and Gossweiler (2000) found that the majority of drug courts eliminate candidates whom they judge to lack motivation for treatment, and that more than one-third of drug courts exclude people with co-occurring disorders of substance abuse and mental illness. Mental health courts, however, are typically designed to address the needs of people with mental illness or co-occurring disorders (substance abuse and mental illness) who become involved with the criminal justice system (Goldkamp & Irons-Guynn, 2000).

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Another concern held by some is the use of these courts to force offenders into substance abuse and mental health treatment (Goldkamp & Irons-Guynn, 2000; Goldsmith & Latessa, 2001; Watson et al., 2000). Given that prosecutors, judges, and defense attorneys must work in concert to divert the offender to treatment resources, the adversarial system is set aside and may result in the offender being coerced into treatment (Goldkamp & Irons-Guynn; Watson et al., 2000). Although participation in these programs is typically voluntary, an element of coercion exists when defendants are presented with an option of going to jail or participating in the treatment program. This is a particular concern for defendants with mental illness who may lack the capacity to make informed disposition decisions (Goldkamp & Irons-Guynn; Watson et al., 2000). Others, however, are less concerned about perceptions of coercion. They view these courts as offering defendants an additional option (Lamb, Weinberger, & Reston-Parham, 1996; Mikhail, Akinkumi, & Poythress, 2001). In addition, coerced treatment for substance abuse and mental illness produces outcomes as good as or better than those of noncoerced treatment (Farabee, Prendergast, & Anglin, 1998; Farabee, Shen, & Sanchez, 2002; Lamb et al.; Miller & Flaherty, 2000).

Another concern about drug courts is the variability of outcomes. Although substantial evidence exists that drug courts are effective, overall, in reducing substance use and new criminal behavior, considerable variation exists. For example, Belenko

(2002) found that rates of completion of drug court programs ranged from 36 percent to 60 percent, and rates of one positive drug screen ranged from 18 percent to 71 percent. In addition, he found that two of six major programs that conducted follow-up studies after program completion reported similar outcomes from drug court participants and comparison groups. One can speculate that these variations can be attributable to many factors, including differential admission criteria, variation in the intensity of monitoring compliance with treatment, the degree to which noncompliance results in sanctions, and the availability of treatment services in the community. It remains to be seen whether outcome studies of mental health courts will produce similar variable outcomes.

Some believe that mental health courts further stigmatize and criminalize mental illness (Watson et al., 2000). Holders of this view believe that stigma is increased when criminal courts are involved in the mental health system. They also fear that if services associated with mental health courts are adequately funded, more charges may be filed against people with mental illness to get them services, further criminalizing them. Others, however, contend that mandated treatment of mental illness should be a function of the court, because judges attempt to balance public safety with the rights and needs of defendants (Lamb et al., 1996).

A final concern is the quality of drug court outcome studies. The U.S. General Accounting Office (2002) concluded that data on drug courts collected by the Justice Department were inadequate for evaluating drug court effectiveness. This study suggested that a federally funded national longitudinal evaluation is needed to gauge the overall impact and efficacy of drug courts in reducing criminal behavior and drug relapse. In a similar vein, when RAND conducted evaluations of 14 drug treatment programs, it found that treatment providers failed to gather in-depth or comparable data to permit rigorous evaluations (Harrison & Scarpitti, 2002). Moreover, Harrison and Martin (2001) suggested that longitudinal outcome studies covering at least five years are needed to effectively evaluate client outcomes.

IMPLICATIONS FOR SOCIAL WORK

Social workers may interact with drug courts and mental health courts in a variety of ways. They may be members of a task force that develops a specialized court, or they may fill administrative or direct services positions in substance abuse, mental health, or criminal justice agencies that are parts of the court system and network of service providers. Social workers also may have sporadic contact with drug courts and mental health courts, such as when a client or a client's family member encounters the criminal justice system and has a substance abuse disorder or mental illness. Regardless of the type of involvement with drug courts or mental health courts, social workers should have basic knowledge of the criminal justice system, substance abuse, and mental illness, as well as the availability of substance abuse and mental health treatment services at the local levels.

To promote effective social work practice, the curriculums of schools of social work should reflect the changing incarceration demographics that include increased numbers of inmates with substance abuse disorders and mental illness by including content on drug use, mental illness, and the intersection of these with the criminal justice system. In addition, social work students should receive training in working with coerced clients and their family members to ensure they are competent to use their authority comfortably and appropriately. A number of excellent resources are available that facilitate work with coerced or involuntary clients (for example, Dennis & Monahan, 1996; Ivanoff, Blythe, & Tripoli, 1994; Trotter, 1999). Schools of social work should also offer practicum opportunities in criminal justice settings to further develop students' knowledge and skills in working effectively with criminal justice populations, particularly those with substance abuse disorders and mental illness.

The need continues for research on drug courts, mental health courts, and other jail diversion projects (McNeece et al., 2001; Steadman et al., 1999). Given the variability of program outcomes, social work researchers should evaluate court program processes and outcomes. Particular attention should be paid to comparing outcomes across race and ethnicity, age, gender, and other socioeconomic variables. Further study is also needed on the long-term consequences to diverted offenders, with research focusing especially on their outcomes several years after completion of the court program.

Clearly, drug courts cannot solve the drug-related crime problem, nor can mental health courts solve the problems faced by people with mental

illness when they come into contact with the criminal justice system. However, these courts may benefit some members of these highly vulnerable populations. With their long history of working with and advocating on behalf of disadvantaged populations, social workers can advocate at the local level for the creation of drug courts, mental health courts, and other projects that divert people with substance abuse disorders and mental illness from the criminal justice system. At the state and federal levels, social workers should work to influence change in social policies regarding the substance abuse, mental health, and criminal justice systems. HSW

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Sabrina W. Tyuse, PhD, MSW, MA, *is assistant professor, School of Social Service, Saint Louis University, 3550 Lindell Boulevard, St. Louis, MO 63103; e-mail: tyuses@slu.edu.* ***Donald M. Linhorst, PhD, MSW,*** *is associate professor, School of Social Service, Saint Louis University.*

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