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# Rehabilitation Through Empowerment: Adopting the Consumer-Participation Model for Treatment Planning in Mental Health Courts

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— Note —

REHABILITATION THROUGH  
EMPOWERMENT: ADOPTING THE  
CONSUMER-PARTICIPATION MODEL  
FOR TREATMENT PLANNING IN  
MENTAL HEALTH COURTS

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INTRODUCTION

In 1773, the Governor of Virginia voiced his concerns that he was “forced to authorize the confinement of [persons with mental illnesses] . . .’ because of lack of appropriate services.”<sup>1</sup> Over 200 years later, the problem is still with us. In 2011, the guards at Central Prison in Raleigh, North Carolina, held David Harold, a mentally ill inmate, naked in an isolation cell filled with feces and urine and denied him access

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1. CTR. FOR MENTAL HEALTH SERVS., BUILDING BRIDGES: CONSUMERS AND REPRESENTATIVES OF THE MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS IN DIALOGUE 3 (2005) (alterations in original).

to medical or mental health treatment.<sup>2</sup> Similarly, in 2012, the staff at the Colorado State Penitentiary mistreated another man, a schizophrenic and psychotic inmate convicted of stealing a Buddha statue worth \$1,000 during a psychotic episode, by denying him access to proper mental health treatment.<sup>3</sup> This lack of treatment led to the Colorado man's sentence increasing from one to four years for the resulting uncontrolled behavior.<sup>4</sup> The 1773 Virginia Governor's concerns and the plight of both men illustrate that the incarceration of and inadequate care for people with mental illness in the American criminal justice system is an issue that predates even the United States, and the same problems—high recidivism rates and over-penalization, to name a few—persist today.<sup>5</sup>

That state and federal prisons incarcerate nearly two million adults with serious mental illness each year, often for terms far exceeding those given to non-mentally ill adults who commit similar offenses, compounds these problems.<sup>6</sup> Nearly sixteen percent of the total prison population is diagnosed with a severe mental illness, whereas only about four percent of men and two percent of women in the general population are diagnosed with similar mental illnesses.<sup>7</sup> The difficulty of providing adequate access to treatment contributes to these disproportionately

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2. Amanda Lamb, *Father Says Central Prison Mistreated His Mentally Ill Son*, WRAL (Jan. 4, 2012), <http://www.wral.com/news/local/story/10557210/> [<https://perma.cc/YS98-324J>].
  3. Kathy Brandt, *In Prison with Schizophrenia and Psychosis*, KATHY BRANDT AUTHOR (Mar. 28, 2013), <http://kathybrandtauthor.com/mental-health/in-prison-with-schizophrenia> [<https://perma.cc/UQR7-MX9B>].
  4. *Id.*
  5. See SETH JACOB PRINS & LAURA DRAPER, COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, *IMPROVING OUTCOMES FOR PEOPLE WITH MENTAL ILLNESSES UNDER COMMUNITY CORRECTIONS SUPERVISION: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 7* (2009) [hereinafter *IMPROVING OUTCOMES*] (suggesting that a lack of faith in treatment resources, fear, and misconceptions regarding mental illness result in disproportionately high delays in release and higher willingness in the criminal justice system to force mentally ill offenders to serve the maximum sentence allowed).
  6. Allison D. Redlich et al., *Is Diversion Swift? Comparing Mental Health Court and Traditional Criminal Justice Processing*, 39 CRIM. JUST. & BEHAV. 420, 421 (2012) (noting that jail stays are “2.5 to 8 times longer” for mentally ill inmates).
  7. CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT, *MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS 2* (2008) [hereinafter *MENTAL HEALTH COURTS PRIMER*].

long prison terms for the mentally ill.<sup>8</sup> Further, mentally ill prisoners often lack the ability to consistently follow prison rules and orders, exposing them to increased discipline.<sup>9</sup> These factors, though, are more related to mental illness than the actual crimes precipitating incarceration.<sup>10</sup>

In an effort to confront this problem in the late 1990s, states began developing diversion opportunities to avoid disproportionate punishment.<sup>11</sup> These opportunities came in the form of mental health courts. And, by 2013, the mental health court system had expanded to over 340 mental health courts in forty-three states.<sup>12</sup>

While mental health courts have been generally successful in reducing participant recidivism, increasing participant access to treatment, improving participant quality of life, and reducing government costs,<sup>13</sup> some scholars have questioned whether mental health courts'

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8. *Position Statement 53: Mental Health Courts*, MENTAL HEALTH AMERICA (Dec. 6, 2014), <http://www.mentalhealthamerica.net/positions/mental-health-courts> [<https://perma.cc/8UUG-2MEN>].
  9. HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* 60 (2003). *See also* Redlich et al., *supra* note 6, at 421 (“[I]nfractions can lead to longer stays because of increased sanctions.”).
  10. *See* Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1272 (2000) (noting that violence and mental illness appear connected).
  11. MENTAL HEALTH COURTS PRIMER, *supra* note 7, at 1; It is important to note that some states attempted, unsuccessfully, to establish Mental Health Courts in the 1980s, often considered the heart of the “deinstitutionalization” era; however, despite the popular belief that most state psychiatric hospitals closed in the 1970s and 1980s, “more . . . closed in the 1990s than in the 1970s and ’80s combined.” RISON N. SLATE ET AL., *THE CRIMINALIZATION OF MENTAL ILLNESS: CRISIS AND OPPORTUNITY FOR THE JUSTICE SYSTEM* 38–39 n.29 (2d ed. 2013). The increased deinstitutionalization in the 1990s likely raised awareness for and heightened the need to address the plight of the mentally ill in the criminal justice system, perhaps resulting in the more successful establishment of Mental Health Courts during this later period.
  12. Beth Gilbert, *The Use and Effectiveness of Mental Health Courts*, PSYCHIATRY ADVISOR (Mar. 30, 2015), <http://www.psychiatryadvisor.com/practice-management/the-use-and-effectiveness-of-mental-health-courts/article/406221/> [<https://perma.cc/NT5X-QVJC>]; *see* *Mental Health Treatment Court Locators*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <http://www.samhsa.gov/gains-center/mental-health-treatment-court-locators> [<https://perma.cc/A5NY-P7JC>] (last updated Aug. 19, 2015) [hereinafter GAINS Center Database] (compiling self-reported data on the various Mental Health Courts across the United States); *see generally* SLATE ET AL., *supra* note 11, at 379–84 (describing the emergence and proliferation of Mental Health Courts).
  13. *See infra* Part I.A.

efficacy has come at too high a cost to participants' liberty interests.<sup>14</sup> The objective of this Note is to explore one of the espoused safeguards to participant liberty: the requirement that participation in mental health courts be voluntary. It suggests that, though structural and clinical barriers may inhibit voluntariness in mental health court participation, adopting the consumer-participation model employed in some private health treatment settings will improve mental health court participants' capacity for voluntary participation. Further, it suggests that the improved voluntarism that the adoption of this model obtains will help avoid several of the legal issues that mental health court opponents raise—conflicts with the right to a jury trial, the right to counsel, the Americans with Disabilities Act, and the informed consent doctrine.

For the purposes of this Note it is important to separate the voluntariness question from other important, related inquiries like competence and informed consent for treatment (a related but different inquiry). A competence adjudication is a preliminary (often presumed) threshold requirement for all criminal defendants, including mental health court participants.<sup>15</sup> Generally, the court must determine that a defendant “has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and . . . a rational as well as factual understanding of the proceedings against him.”<sup>16</sup> On the other hand, the informed consent inquiry, occurs at the point of clinical treatment and requires that participants (1) be informed of the benefits, risks, and alternatives to treatment; (2) understand those benefits, risks, and alternatives; and (3) voluntarily consent to the treatment.<sup>17</sup>

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14. See, e.g., 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, 853 (2004) (arguing that Mental Health Court defendants “endure much more liberty restrictions and privacy intrusions” and that labeling the “sentence ‘treatment,’ rather than ‘punishment,’” allows the Court to exert more coercion over the participant than would otherwise be available); Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses*, 11 PSYCHOL. PUB. POL'Y & L. 570, 574 (2005) (arguing that the absence of voluntariness raises concerns regarding 14th Amendment equal protection, 6th Amendment rights, and discrimination prohibited under the ADA).
  15. See MENTAL HEALTH COURTS PRIMER, *supra* note 7, at 5.
  16. *Dusky v. United States*, 362 U.S. 402, 402 (1960); see also COUNCIL OF STATE GOV'TS, A GUIDE TO MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION 43 (2005) [hereinafter GUIDE TO DESIGN AND IMPLEMENTATION] (noting that this standard may vary across different states).
  17. See JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 65 (2d ed. 2001) (noting that the doctrine of informed consent is comprised of “[t]he duty of disclosure, or the duty to inform, . . . [and] two other essential features: . . . understanding . . . [and]

Though this inquiry may arise several times throughout the mental health court process (i.e., when treatment strategies change), its scope is relatively narrow—limiting voluntariness to only the point of treatment.<sup>18</sup> Unlike competence and informed consent, the voluntariness question is not confined to a specific time but continues throughout the mental health court process as the defendant makes participation choices, such as the decision not to withdraw.<sup>19</sup> Further, even when a defendant is competent and gives informed consent to treatment, issues may still arise as to whether the defendant’s participation is voluntary—that is, whether the decision to participate is free of coercion and made with the understanding of its consequences.<sup>20</sup>

Part I of this Note is a brief overview of the mental health court system. It is broken into two subparts: first, a brief description of the system’s goals and success; and, second, a brief overview of mental health courts’ general structure. The theme here is that the term “system” is really a misnomer, and there is plenty of room for development.

In Part II, I introduce some of the barriers to achieving voluntary participation. This section also has two subparts: first, a discussion on target participants’ reduced capacities; and, second, a description of the structural shortcomings in mental health courts. The general theme here is that target participants do not suffer from a depreciated decision-making capacity despite not having the tools to control their illnesses. Instead, it suggests that participants have a reduced capacity for voluntarism that can be improved through increasing education and empowerment.

Finally, in Part III, I discuss the possible adoption of the consumer-participation model from private mental health treatment as a tool for improving access to information and reducing coercion in the mental health court process. I suggest that this model will help alleviate some of the problems with voluntariness in mental health court programs. Further, I suggest that the benefits obtained from adopting the consumer-participation model also address many of the concerns that mental health court opponents raise.

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voluntariness”). “Voluntariness,” here, is an “ill-defined” concept generally meaning free of coercion. *See id.* at 67–70.

18. GUIDE TO DESIGN AND IMPLEMENTATION, *supra* note 16, at 45.
19. *See id.*; Seltzer, *supra* note 14, at 575.
20. *See* JOHN S. GOLDKAMP & CHERYL IRONS-GUYNNE, BUREAU OF JUSTICE ASSISTANCE, EMERGING JUDICIAL STRATEGIES FOR THE MENTALLY ILL IN THE CRIMINAL CASELOAD: MENTAL HEALTH COURTS IN FORT LAUDERDALE, SEATTLE, SAN BERNARDINO, AND ANCHORAGE xi (2000) (noting that voluntariness is difficult and important to safeguard and that what is perceived as voluntary choices may actually be coerced).

## I. THE MENTAL HEALTH COURT SYSTEM

In order to understand the voluntarism discourse discussed in this Note, it is necessary to understand the mental health court framework. This section begins by discussing the purpose behind the development of mental health courts as a tool for improving criminal justice outcomes for cases involving mentally ill offenders. This section then addresses how mental health courts operate. Overall, this section illustrates that, while mental health courts appear to be achieving their goals, there is significant need for development and standardization of their practices—most importantly, improving the level of voluntary participation.

### A. *The Goals and Successes of Mental Health Courts*

The primary purpose of mental health courts is to provide better outcomes for both the community and mentally ill offenders by reducing the disproportionate incarceration of mentally ill offenders and connecting them to treatment resources.<sup>21</sup> While mental health court practices vary widely among jurisdictions,<sup>22</sup> the Bureau of Justice Administration recognizes four common goals geared toward the realization of this primary purpose:

- [1] Increased public safety . . . by . . . lowering the high recidivism rates for [mentally ill offenders];
- [2] Increased treatment engagement by participants;
- [3] Improved quality of life for participants; [and]
- [4] More effective use of resources.<sup>23</sup>

Mental health court opponents, while recognizing that these goals are paramount, believe that mental health courts are not the correct avenue toward achieving those goals.<sup>24</sup> Instead, they suggest that a multitude of different changes in the criminal justice and mental health systems would better achieve them.<sup>25</sup> Still, mental health courts have

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- 21. See MENTAL HEALTH COURTS PRIMER, *supra* note 7, at 3 (stating that Mental Health Courts attempt to address the root cause of the behavior).
  - 22. See *infra* Part I.B.
  - 23. MENTAL HEALTH COURTS PRIMER, *supra* note 7, at 8.
  - 24. See Seltzer, *supra* note 14, at 583 (stating that mental health courts “are not the appropriate front door to access mental health care”).
  - 25. See *id.* at 584–86 (detailing fundamental flaws in mental health courts that cannot be corrected and suggesting that mental health courts impede the real root of the behavior from being addressed).

been, and will likely continue, spreading as they appear to achieve these goals.

Reducing the high recidivism rates among mentally ill offenders is the top priority and measure of mental health court success.<sup>26</sup> Studies have shown that, among those who successfully graduate from mental health court programs, recidivism rates and contacts with the criminal justice system are significantly lower than the rates participants experienced before receiving treatment.<sup>27</sup> Further, studies have also shown that, when compared to mentally ill offenders who went through traditional processing, those who went through mental health court programs had significantly lower recidivism rates.<sup>28</sup> Though these studies use an imperfect proxy to measure recidivism—post-treatment arrest rates<sup>29</sup>—the reduction in arrest rates suggests that mental health courts have been relatively successful in achieving the goal of reducing recidivism among mentally ill offenders.

Much like with reducing recidivism rates, connecting mentally ill offenders to treatment resources is among mental health courts' top priorities, largely because treatment helps reduce recidivism and results in improved clinical outcomes in participants' functioning.<sup>30</sup> Linkage to

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26. See NAT'L CTR. FOR STATE COURTS, MENTAL HEALTH COURT PERFORMANCE MEASURES (2010) [hereinafter NCSC BROCHURE] (listing in-program and post-program recidivism as the first and last among fourteen measures of mental health court performance).
  27. See, e.g., Henry J. Steadman et al., *Effect of Mental Health Courts on Arrests and Jail Days: A Multistate Study*, 68 ARCH. GEN. PSYCHIATRY 167, 167–68 (2011); Virginia A. Hiday & Bradley Ray, *Arrests Two Years After Exiting a Well-Established Mental Health Court*, 61 PSYCHIATRIC SERVS. 463, 465 (2010) (finding that participants who completed the program had lower recidivism rates than their pre-treatment rates sustained for two years after ceasing court-mandated treatment and monitoring).
  28. See, e.g., Dale E. McNiel & Renee L. Binder, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 AM. J. PSYCHIATRY 1395, 1401 (2007) (finding that, at eighteen months after graduation from mental health courts, the rate of recidivism among participants was roughly thirty-nine percent lower than the recidivism rate among mentally ill persons in “treatment as usual” settings); SHELLI B. ROSSMAN ET AL., URBAN INST., CRIMINAL JUSTICE INTERVENTIONS FOR OFFENDERS WITH MENTAL ILLNESS: EVALUATION OF MENTAL HEALTH COURTS IN BRONX AND BROOKLYN, NEW YORK 124 (2012) (finding that recidivism rates among participants in the Bronx and Brooklyn mental health courts were six to seventeen percentage points lower than recidivism rates among nonparticipants in the same jurisdictions).
  29. This measure is imperfect because criminal recidivism may go unreported or police may choose not to arrest. *But cf.* Seltzer, *supra* note 14, at 573 (suggesting that police are more likely to arrest a person with mental illness).
  30. See IMPROVING OUTCOMES, *supra* note 5, at 22–27 (summarizing the results from studies regarding community treatment programs' effects on mentally ill people's criminal justice and clinical outcomes); see also NCSC BROCHURE,

community treatment is accomplished in three ways: (1) encouragement to continue with or return to previous treatment providers already familiar with the participant, (2) judicial referrals to providers for the staff's recommended services after participant evaluations, and (3) providing general information or lists of providers to participants whose cases are milder.<sup>31</sup> This court-facilitated engagement with treatment and court-mandated compliance with the treatment plan serve to improve access to mental health services after program entry.<sup>32</sup> They also increase treatment utilization in both incidence and volume for participants as compared to treatment utilization rates for mentally ill offenders in traditional processing.<sup>33</sup> Despite this general success, opponents are quick to point out that mental health courts are hindered, especially in rural areas, because they rely on already available, finite community treatment resources rather than creating new resources.<sup>34</sup> Still, the strain caused when access to finite community-based mental health treatment resources seems preferable to the alternative: effectively cordoning off treatment from people whose offense history illustrates their need for it. Further, where community-based treatment is available, mental health courts appear to have been successful in connecting participants to it.

The last two goals' accomplishment is part and parcel to that of the first two: where recidivism is decreased and access to treatment is increased, it follows that governmental and societal costs will go down and quality of life for mental health court participants will increase. Consistent with this concept and the studies reflecting decreased recidivism, studies have also shown that mental health court programs have resulted in modest annual savings, mostly due to lower incarceration

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*supra* note 26 (using participants' connection to and participation in treatment as two of the fourteen performance measures in mental health courts).

31. Roger A. Boothroyd et al., *The Broward Mental Health Court: Process, Outcomes, and Service Utilization*, 26 INT'L J.L. & PSYCHIATRY 55, 59 (2003).
32. See Karli J. Keator et al., *The Impact of Treatment on the Public Safety Outcomes of Mental Health Court Participants*, 57 AM. BEHAV. SCIENTIST 231, 232 (2013) (stating that Mental Health Courts "generally increase participants' access and utilization of community treatment").
33. See Boothroyd et al., *supra* note 31, at 63–67 (analyzing data collected from two groups of individuals for an eight-month period following an appearance in a mental health court).
34. SLATE ET AL., *supra* note 11, at 402. It is also problematic that increased utilization of finite mental health treatment services results in "rationing [that] may delay or even prevent intervention for . . . persons who are in need of mental health services" but are not participants due to lack of illegal activity. *Id.* at 404. A danger, here, is that non-offenders with restricted access to treatment may suffer adverse outcomes and an increased propensity toward criminal behavior—the very thing mental health courts are trying to combat.

costs and larger governmental savings for both incarceration and treatment services over an extended period.<sup>35</sup> Further, studies also suggest that, in step with increased treatment access, mental health court participants have an improved quality of life through improved functioning,<sup>36</sup> fewer bookings and jail days,<sup>37</sup> and greater perceived fairness and respect for the criminal justice system.<sup>38</sup> These decreased incarceration and treatment costs coupled with the improved functionality and quality of life that mental health court participants experience suggest that these programs are capable of meeting their goals to more efficiently use resources while also achieving higher-quality outcomes for mentally ill offenders.

Though these studies are limited by their narrow scope and the difficulty in collecting data across a multitude of jurisdictions with diverse programs,<sup>39</sup> their findings suggest that mental health courts are capable of providing better outcomes. These improved outcomes reduce the over-representation of the mentally ill in the criminal justice system and increasing access to treatment resources—benefiting both mentally ill offenders and the community at large.<sup>40</sup> The next section will introduce the general structure and operation of mental health courts.

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35. M. SUSAN RIDGELY ET AL., RAND CORP., JUSTICE, TREATMENT, AND COST: AN EVALUATION OF THE FISCAL IMPACT OF ALLEGHENY COUNTY MENTAL HEALTH COURT 20 (2007) (finding that participants with more severe cases of mental illness, low functioning, and criminal activity yielded higher savings, though these savings were statistically “[in]significant in the first year”). *But cf.* ROSSMAN ET AL., *supra* note 28, at 127 (finding it “prohibitively difficult to estimate the costs of regular MHC operations and impossible to estimate the social costs of sanctions and treatment,” but suggesting a model for future analysis).
36. *See, e.g.*, Merith Cosden et al., *Evaluation of a Mental Health Treatment Court with Assertive Community Treatment*, 21 BEHAV. SCI. & L. 415, 424 (2003) (noting that mental health court patients “demonstrated improvements in life satisfaction, psychological distress, independent functioning, and drug problems”).
37. *See, e.g.*, Steadman et al., *supra* note 27, at 170–72.
38. *See, e.g.*, Boothroyd, *supra* note 31, at 68 (finding that procedural fairness increases while participants’ perceptions of coercion decrease). This perception of fairness has important implications for mental health court effectiveness because “when participants . . . view the mental health court process as procedurally fair, they are more likely to be cooperative.” SLATE ET AL., *supra* note 11, at 401.
39. *See* MENTAL HEALTH COURTS PRIMER, *supra* note 7, at 14 (noting that mental health court studies tend to focus on individual programs or jurisdictional areas).
40. *Id.* at 8.

*B. Mental Health Court Structure and Operation*

Though mental health courts are rapidly proliferating and have enjoyed some success in their mission, they lack a standardized definition, largely due to their general status as “experimental” and due to local differences in needs and resources.<sup>41</sup> Still, the Bureau for Justice Administration has pieced together the various commonalities among mental health courts to create a generalized working definition:

[A] specialized court docket for . . . defendants with mental illnesses . . . identified through mental health screening and assessments and *voluntarily participat[ing]* in a judicially supervised treatment plan . . . [with i]ncentives reward[ing] adherence . . . and success . . . defined according to predetermined criteria.<sup>42</sup>

This definition, in itself, illustrates several areas where ambiguity exists regarding mental health court practices. This section discusses a generalized picture of mental health court process, though some procedural and substantive inconsistencies exist across jurisdictions.

The mental health court process begins with a referral, which may come from a multitude of sources: arresting officers, booking officers, jail staff, prosecutors, defense attorneys, judges, and even the defendant.<sup>43</sup> At this stage, the referrer evaluates the offender for a number of criteria—namely the criminal charge and a severe mental illness diagnosis.<sup>44</sup> There is no uniform charge criterion across all mental health

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41. *But see* Gregory L. Acquaviva, Comment, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 993–95 (2006) (recognizing the “pilot model” status as the reason mental health courts still face problems). *See also* SLATE ET AL., *supra* note 11, at 395 (“There is no single model of a mental health court that is suitable to all communities.”).

42. MENTAL HEALTH COURTS PRIMER, *supra* note 7, at 4 (emphasis added).

43. GUIDE TO DESIGN AND IMPLEMENTATION, *supra* note 16, at 47; COUNCIL OF STATE GOV'TS JUSTICE CENTER, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT 3 (2007); *see, e.g.*, STATE COURT ADMIN. OFFICE, MICHIGAN SUPREME COURT, DEVELOPING AND IMPLEMENTING A MENTAL HEALTH COURT IN MICHIGAN 8 (AUG. 2013); MISSOURI THIRTEENTH JUDICIAL CIRCUIT COURT, INTRODUCTION TO MENTAL HEALTH COURT 6, [http://www.courts.mo.gov/hosted/circuit13/documents/ASC\\_MCHPoliciesAndProceduresManual.pdf](http://www.courts.mo.gov/hosted/circuit13/documents/ASC_MCHPoliciesAndProceduresManual.pdf) [<https://perma.cc/5VVM-K9HG>] (last visited Jan. 29, 2016); YORK CTY., YORK CTY. MENTAL HEALTH COURT MANUAL 4 (2005).

44. Ursula Castellano & Leon Anderson, *Mental Health Courts in America: Promises and Challenges*, 57 AM. BEHAV. SCIENTIST 163, 164 (2013). While these are the primary criteria considered by Mental Health Court referrers, the Bazelon Center for Mental Health Law suggests that an additional criterion should be whether other diversion routes are available because “the proper role [of Mental Health Courts] is to address the needs of those who

courts: some restrict eligibility to offenders charged with misdemeanors, many others restrict or extend eligibility to offenders charged with felonies, and others use additional restrictive criteria, like requiring that the charged crime be nonviolent.<sup>45</sup> Likewise, there is no uniform diagnosis criterion.<sup>46</sup> (Though many referrers and mental health courts use a pre-referral severe mental illness diagnosis—typically along the lines of schizophrenia, major depression, bipolar disorder, or other clinically significant mental conditions—as a proxy for determining whether the serious mental illness eligibility requirement is achieved.<sup>47</sup>) If the referrer believes the offender fits the appropriate criteria, she files a referral form with the court for further processing.<sup>48</sup>

Following referral, the mental health court screens the candidate to determine whether she is within the target population, gathers additional background information on the candidate, and makes a final

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cannot [otherwise] be diverted without arrest or at pre-booking or arraignment, but for whom punishment through incarceration is not appropriate.” JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH LAW, *THE ROLE OF MENTAL HEALTH COURTS IN SYSTEM REFORM 5* (2004) [hereinafter BAZELON CTR. ON THE ROLE OF MENTAL HEALTH COURTS].

45. GAINS Center Database, *supra* note 12. Among reporting mental health courts, twenty-four percent restrict participation to charged misdemeanants, thirty percent restrict participation to charged felons, and forty-six percent permit participation by both charged misdemeanants and felons. Four percent of the courts allowing misdemeanor participation and thirty-six percent of the courts allowing felon participation require the charged misdemeanor or felony be non-violent.
46. *Cf.* Castellano & Anderson, *supra* note 44, at 164 (discussing the variance in “treatment modalities” and other processes across mental health courts that may deal with different kind of “defendants, funding sources, and . . . political and cultural climate[s]”).
47. *Id.* (discussing the use of the DSM-IV diagnoses). A DSM-IV Axis I diagnosis indicates a Clinical Mental Disorder. AMERICAN PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL ON MENTAL DISORDERS 28* (4th ed. 2000). This is defined as a “clinically significant behavior or psychological syndrome or pattern that occurs in an individual and that is associated with present distress . . . or disability, . . . [though n]either deviant behavior . . . nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual.” *Id.* at xxxi. Recently, the American Psychiatric Association has developed the DSM-V, and this has generally replaced the use of DSM-IV as a more accurate diagnostic tool. The difference here, however, is immaterial—whichever manual diagnoses are based on, it serves as the proxy for mental health court eligibility. For more information about DSM-V, see AMERICAN PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL ON MENTAL DISORDERS* (5th ed. 2013).
48. *See, e.g.*, GUIDE TO DESIGN AND IMPLEMENTATION, *supra* note 16, at 89 (providing a sample screening and referral form).

determination of eligibility.<sup>49</sup> In addition to an evaluation regarding the requisite charge and diagnosis, mental health courts also evaluate the candidate for participation requirements, like legal competence,<sup>50</sup> and may require a guilty plea.<sup>51</sup> If the court determines that the eligibility requirements are fulfilled and the offender makes an informed, voluntary choice to participate, then he will become enrolled in the mental health court.<sup>52</sup>

The next phase is split into two parts: staffing and status hearings. During staffing, the court team—the judge, defense attorney, prosecutor, case manager, treatment provider, and other supervisory agents—discusses and defines the defendant’s compliance, goals, and treatment plan.<sup>53</sup> The treatment plan often consists of several phases marked by interim treatment goals like abstinence from substance abuse, participation in designated therapy, and increased stability in housing and financial arrangements.<sup>54</sup> One of the more striking features of staffing meetings in mental health courts is the changed roles for the court officers involved. Judges leave the formal, neutral adjudicator role and become deeply involved in planning, facilitating, and encouraging treatment.<sup>55</sup> Prosecutors abandon advocacy for punishment and seek to forward treatment in the best interests of the defendant and the community.<sup>56</sup> Defense attorneys abandon advocacy for the least restrictive sentence and instead act as advisors to the court on how to attain treatment goals while protecting the rights of their clients. And treatment professionals shift from not only providing care to also recommen-

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49. *Id.* at 48–51.

50. *Id.* at 43. Generally, a defendant is competent if she “can understand the legal situation and the proceedings and can also assist . . . her attorney in the defense.” *Id.* If determined incompetent, the court may order certain treatment or even civil commitment assessment. Faraci, *supra* note 14, at 828–29. It is important to note that having a severe mental illness does not automatically render someone legally incompetent or insane. SLATE ET AL., *supra* note 11, at 301.

51. See Seltzer, *supra* note 14, at 576 (“[H]alf [of the Mental Health Courts studied by the Bazelon Center] required guilty or no-contest pleas as a condition of participation.”). See also *Position Statement 53: Mental Health Courts*, *supra* note 8 (opposing guilty pleas as a requirement for participation in Mental Health Courts).

52. GUIDE TO DESIGN AND IMPLEMENTATION, *supra* note 16, at 43.

53. MENTAL HEALTH COURTS PRIMER, *supra* note 7, at 7; see also, GUIDE TO DESIGN AND IMPLEMENTATION, *supra* note 16, at 56, 61.

54. See, e.g., YORK CTY., *supra* note 43, at 14–17 (dividing the treatment plan into three six-month phases).

55. SLATE ET AL., *supra* note 11, at 388–91.

56. *Id.*

ding to the court whether advancement, rewards, or sanctions are appropriate.<sup>57</sup> Most importantly, though, the participant is excluded from these staffing meetings.

Following staffing, the court brings in the participant and conducts nonadversarial status hearings to monitor participants' compliance with the plan and other participation requirements, to reward those who are compliant, and to sanction those who are noncompliant.<sup>58</sup> Through these hearings, the court informs participants of the treatment plan and goals for the period before the next status hearing. Although participants may be allowed to speak during these hearings, the plans and goals are mandates created in the staffing meeting, and participants' input during status hearings has little influence on them.<sup>59</sup>

The final step in the mental health court process is termination. If the participant satisfactorily completes the phases of the program, she moves on to graduation; however, if noncompliant, she will either continue participation until the phases are completed or be removed from the program either by herself or the mental health court.<sup>60</sup> Graduation from the program often means that the charges against the participant are dismissed or, if the court required a guilty plea for enrollment, that the plea is dismissed or expunged.<sup>61</sup> Expulsion or withdrawal, on the other hand, typically results in the former participant being processed through traditional court mechanisms, which can have important consequences like the use of information revealed in staffing and status hearings or automatic conviction if the court required a guilty plea for participation.<sup>62</sup>

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57. *Id.* at 390–91.

58. MENTAL HEALTH COURTS PRIMER, *supra* note 7, at 7.

59. Author's Observations from the Juvenile Mental Health Court, Cuyahoga County on February 9, 2015. Though processes in juvenile court and adult court often differ, the staffing meetings and status hearings are present in both juvenile and adult mental health courts. *See, e.g.*, STATE COURT ADMIN. OFFICE, MICHIGAN SUPREME COURT, *supra* note 43, at 12 (discussing staffing meetings and status hearing reviews in the Michigan mental health court system).

60. GUIDE TO DESIGN AND IMPLEMENTATION, *supra* note 16, at 73–76.

61. BAZELON CTR. FOR MENTAL HEALTH LAW, *supra* note 44, at 8–10. While over a third of the programs dismiss or expunge charges automatically, many require the participant to request the dismissal or expungement, which can take a substantial amount of time, during which the danger of relapse is high due to complications in finding employment and housing with a conviction record. *Id.* Because of this issue, the Bazelon Center recommends that, where courts do require guilty pleas, those pleas be automatically dismissed upon graduation. *Id.* at 9.

62. Seltzer, *supra* note 14, at 575 (noting that about half of the courts permitted withdrawal without prejudice within certain time restrictions, but most put no restrictions on prosecutors' use of information obtained through

Since participation in these processes has important implications for participants' rights, all mental health courts include in their participation criteria the requirement that enrollment be voluntary. The next section, and the remainder of this Note, is devoted to the voluntariness criterion and the consumer-participation model's effect on it.

## II. BARRIERS TO VOLUNTARINESS IN MENTAL HEALTH COURT PARTICIPATION

Despite the importance of voluntariness, significant barriers to reaching it exist in the mental health court context. These barriers can be split into two categories: first, some voluntariness problems may arise due to participants' diminished capacities stemming from their mental illness; and, second, some structural issues also create roadblocks to voluntariness. This section discusses these barriers, finding that a lack of voluntariness is not due to any immutable traits in mental health patients, but is rooted in the current structure of mental health courts. This structure, however, can be manipulated to improve voluntariness.

### *A. Mental Health Court Participants' Diminished Capacities for Voluntariness*

Serious concerns arise as to mental health court participants' capacity to make voluntary decisions to participate as a result of their clinical diagnoses—serious mental illnesses like schizophrenia, major depression, and bipolar disorder. One of the concerns is participants' reduced decisional capacity. People with schizophrenia, for example, are by definition afflicted with distorted perception and thought, characteristics vital to the decision-making process.<sup>63</sup> Several studies have shown that there is a correlation between schizophrenia and diminished decision-making capacity, especially in regard to *appreciation* (understanding conditions and consequences).<sup>64</sup> The results of similar studies

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the defendant's participation). The problems associated with guilty pleas in graduation, withdrawal, and expulsion have led advocacy groups to oppose the guilty plea as a requirement for enrollment. *See, e.g., Position Statement 53: Mental Health Courts*, *supra* note 8; BAZELON CTR. FOR MENTAL HEALTH LAW, *supra* note 44, at 8–9.

63. *See* William T. Carpenter et al., *Decisional Capacity for Informed Consent in Schizophrenia Research*, 57 ARCHIVES OF GEN. PSYCHIATRY 533, 533 (2000).
64. *See, e.g.,* Paul S. Appelbaum, *Decisional Capacity of Patients with Schizophrenia to Consent to Research: Taking Stock*, 32 SCHIZOPHRENIA BULL. 22, 22–23 (2006) (noting that a study has shown that people with schizophrenia scored significantly worse on measures of understanding and appreciation but not on reasoning or choice and concluding that a diagnosis of schizophrenia does not per se indicate that a patient cannot competently consent to research participation); Jeffrey A. Kovnick et al., *Competence to Consent to Research Among Long-Stay Inpatients with Chronic Schizophrenia*,

seem to indicate that people with severe depression also have impaired decisional capacity.<sup>65</sup> Further, even if a person with a severe mental illness makes the decision to participate, this decision may not equate to an ability to voluntarily carry out that decision.<sup>66</sup>

While these studies suggest that mental health courts' target participants may be less able to voluntarily participate due to diminished capacities for decision-making or voluntarism, this is not to say that mental health court participants are necessarily incapable of voluntary participation. First, people with severe mental illnesses generally have a range of cognitive and functional characteristics, allowing many the ability to make decisions on a "normal" level.<sup>67</sup> Second, many of the deficiencies in decisional capacity may potentially be overcome through adherence to medication regimens and education.<sup>68</sup> The education that may be necessary for mental health court participants to make a truly voluntary decision to participate touches upon the next subsection's topic: the structural barriers to voluntary participation in mental health courts.

#### *B. Structural Barriers to Voluntary Participation*

As discussed above, education may improve mental health court participants' decision-making and voluntariness capacities. Still, many

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54 PSYCHIATRIC SERVS. 1247, 1247 (2003), <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.54.9.1247> [<https://perma.cc/SB3C-2FBD>] (finding a negative correlation between degree of illness and decisional capacity in patients with schizophrenia); Carpenter, *supra* note 63, at 537. *But see* Dilip V. Jeste et al., *Magnitude of Impairment in Decisional Capacity in People with Schizophrenia Compared to Normal Subjects: An Overview*, 32 SCHIZOPHRENIA BULL. 121, 126 (2006) (finding that, in four examined studies, "a majority of people with schizophrenia was deemed to have adequate decision-making capacity"). "Appreciation" is the ability to understand the "effects of . . . participation (or failure to participate) on subjects' own situations," Paul S. Appelbaum et al., *Competence of Depressed Patients for Consent to Research*, 156 AM. J. OF PSYCHIATRY 1380, 1381 (1999), and/or the ability to understand one's own condition, Jeste et al., *supra*, at 121.

65. *See, e.g.*, Appelbaum et al., *supra* note 64, at 1381 (noting that the frequency of such impairment and its relation to the degree of depression present remain unclear).
66. *See* Laura Weiss Roberts, *Informed Consent and the Capacity for Voluntarism*, 159 AM. J. PSYCHIATRY 705, 705 (2002) (distinguishing the diminished capacity for voluntarism as from decisional capacity).
67. *See* Jeste et al., *supra* note 64, at 126–27 ("Persons with schizophrenia may be generally at risk for impaired decision-making capacity, yet such impairment is not invariable.").
68. *See* Appelbaum, *supra* note 64, at 23 (noting that "educational intervention" helped bring patients with schizophrenia "who scored poorly on understanding into the range of performance of the comparison group").

mental health courts have built-in structural barriers to educating participants regarding the processes and consequences of participation: complexity caused by the changed roles of court officers and the exclusion of participants from treatment-planning.

While participants may find much of the information regarding mental health court processes in their participation manuals,<sup>69</sup> it is incumbent upon defense counsel to explain this information to their clients to help them determine whether mental health court participation is the most appropriate option.<sup>70</sup> Several studies have shown, however, that many mental health court participants are not even aware that participation is optional, much less aware of its consequences.<sup>71</sup> Some scholars blame this lack of understanding on the courts' cursory inquiry into participants' actual voluntariness;<sup>72</sup> however, it may be more deeply rooted in the complexity faced by defense attorneys. In the mental health court context, the defense attorney may be uncomfortable shifting her concern from solely the patient's rights to considering factors outside the normal criminal case, such as clinical options for treatment and medication.<sup>73</sup> Still, this shortcoming can be mitigated through the court requiring more explicit statements regarding participant choice, increased mental health training for the court

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69. See, e.g., MERRIMACK CTY/6TH CIRCUIT-DIST. DIV.-CONCORD, MENTAL HEALTH COURT PARTICIPANT MANUAL (2011) (detailing mental health court procedures).
70. GUIDE TO DESIGN AND IMPLEMENTATION, *supra* note 16, at 44.
71. See Allison D. Redlich, *Voluntary, but Knowing and Intelligent? Comprehension in Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 605, 610 (2005) (finding participants unaware of the voluntary nature of mental health court participation in one mental health court); Norman G. Poythress et al., *Perceived Coercion and Procedural Justice in the Broward Mental Health Court*, 25 INT'L J.L. & PSYCHIATRY 517, 530 (2002) (noting that "a number of defendants reported that they were unaware that they had a choice regarding their participation in the [mental health] court."); see also Alison D. Redlich & Alicia Summers, *Voluntary, Knowing, and Intelligent Pleas: Understanding the Plea Inquiry*, 18 PSYCHOL. PUB. POL'Y & L. 626, 639 (2012) (finding that, though mental health court participants understood that their plea was voluntary, the majority of participants understood only sixty percent of the terms and consequences of that plea).
72. See Poythress et al., *supra* note 71, at 530 (noting that, though the court sometimes elicits explicit statements of assent from the defendant, many times the court's determination of consent is more implicit).
73. See Seltzer, *supra* note 14, at 574 (noting that the complexities of mental health courts may "undermine the defense attorney's ability to assess the prosecutor's case and, thus, his or her ability to properly advise the client"); see also SLATE ET AL, *supra* note 11, at 390-91 ("Defense attorneys are often resistant to diversion, particularly for misdemeanors, because more extensive probation may expose their clients to longer periods under control of the criminal justice system.").

team, and other adjustments improving the dissemination of information to participants.<sup>74</sup>

Moreover, one of the most important processes in the mental health court is conducted without participant input: determining the course of treatment and goals. As discussed earlier in this Note, the court team plans treatment and goals for the participant during the staffing meeting, at which only the court team is present.<sup>75</sup> This closed-doors planning not only excludes the participant from making important clinical decisions, but also inhibits the dissemination of important information, such as the motivations behind the planning decisions and goals. Further, these decisions are handed down to the participant as mandates regardless of whether the participant voices disagreement or concern about her ability to comply.<sup>76</sup> Since this lack of inclusion avoids a real dialogue between the court and the participant, the court misses an opportunity to educate and empower the participant to fully understand the decision to comply. Further, since noncompliance is met with drastic consequences—expulsion for noncompliance, for example, may carry with it conviction if a guilty plea is required for enrollment<sup>77</sup>—participants' inability to shape these treatment decisions results in a heightened degree of coercion. Here, excluding participants from treatment planning results in both coercion and a lack of understanding, negating voluntariness.<sup>78</sup>

These structural barriers to information dissemination and participation inhibit the education necessary for mental health court participants to overcome their diminished capacities for voluntarily deciding to participate. Still, these structural barriers can be manipulated to increase voluntarism in mental health court participation and alleviate

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74. See Poythress et al., *supra* note 71, at 530 (noting that “making explicit to defendants that they have a choice whether to remain in [the mental health court] may further reduce perceived coercion”); Seltzer, *supra* note 14, at 576 (recommending that defense attorneys have “at their disposal trained clinicians” to assist in making sure clients are properly informed).

75. See *supra* Part I.B.

76. See *supra* Part I.B.

77. Guilty pleas are required by approximately half of Mental Health Courts. BAZELON CTR. ON THE ROLE OF MENTAL HEALTH COURTS, *supra* note 44, at 8; see Patricia A. Griffin et al., *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVS. 1285, 1286 (2002), <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.53.10.1285> [<https://perma.cc/4BQR-R5VD>] (noting specific courts that require guilty pleas for access to Mental Health Courts); see also GUIDE TO DESIGN AND IMPLEMENTATION, *supra* note 16, at 38 (citing COUNCIL OF STATE GOV'TS, MENTAL HEALTH COURTS PROGRAM 2 (2003)) (Roughly forty percent of the Mental Health Courts studied required a guilty plea by all participants, while slightly more required a guilty plea from at least some participants.).

78. Voluntary participation requires a lack of coercion and an understanding of the decision and its consequences. See *supra* Introduction.

some of the legal concerns raised by mental health court opponents. The next section considers the consumer-participation model, the implementation of which would allow for the increased dissemination of information necessary for voluntary participation.

### III. THE CONSUMER-PARTICIPATION MODEL FOR MENTAL HEALTH COURTS

If the main obstacle for voluntariness is the insufficiency of information necessary for defendants to voluntarily participate, the solution must be a system change capable of disseminating this vital information. One method for ensuring that information is available to mental health court participants is taking the treatment and goals planning process out from behind closed doors to include the participant: the consumer-participation model. This section proposes that mental health courts will benefit by incorporating the consumer-participation model for clinical mental health treatment. Adopting this model will improve the level of voluntariness through participants' access to information and, in doing so, address many of the legal concerns that mental health court opponents field.

#### *A. The Consumer-Participation Model and Improved Access to Information*

Consumer-participation models for mental health services emerged in the 1970s, when activists reacted against the marginalization of mental health patients in clinical settings and advocated for an increased level of control and responsibility for the patient over her own life.<sup>79</sup> Scholars have identified three types of consumer-participation models: (1) individual discussion and engagement as part of the decision-making process, (2) participation on the organizational level, and (3) active involvement with the community's planning and policy decision-making.<sup>80</sup> This Note recommends that mental health courts adopt the first type, which emphasizes individual choice and exposes individuals to a range of information and opportunities for treatment.<sup>81</sup>

Hickey & Kipping call the individual level consumer-participation model "user involvement" and identify four levels on the continuum of

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79. Nora Jacobson & Laurie Curtis, *Recovery as Policy in Mental Health Services: Strategies Emerging from the States*, 23 *PSYCHIATRIC REHAB. J.* 333, 333-34 (2000).

80. Margaret Tobin et al., *Consumer Participation in Mental Health Services: Who Wants It and Why?*, 25 *AUSTRALIAN HEALTH REV.* 91, 92 (2002).

81. Jacobson & Curtis, *supra* note 79, at 335.

participation.<sup>82</sup> The base level is information/explanation, in which the individual is given a higher degree of information regarding the motivations behind the decisions but has no decisional authority.<sup>83</sup> The second level is consultation, in which the decision-makers gather input from the participant but still retain all the decisional authority.<sup>84</sup> The third level, partnership, would go a step further and split decisional authority equally between the treatment supervisors and the participant.<sup>85</sup> Finally, the fourth level gives the ultimate decisional authority regarding treatment to the participant.<sup>86</sup>

Mental health courts ought to adopt something between the consultation and partnership levels. The first two levels—information/explanation and consultation—would only slightly improve the level of participation and do little to negate mental health courts' coercive elements because there would be no shift in decisional authority. On the other hand, the partnership and user-control levels create too great a power-shift and would undermine the court's authority, inviting increased criticism from retributivists. Instead, a middle level of user involvement, a gradual increase in limited deference to participant choice with the court team retaining the ultimate choice, is appropriate. This mid-level approach would avoid the court genuflecting to participants' will while still allowing participants to assent or dissent to the proposed treatment plan.<sup>87</sup> Further, it would allow for adjustments as participants' decisional-capacity increases through participation.

Adopting this mid-level of the user involvement consumer-participation model would increase the level of voluntariness in mental health courts through increased information and reduced coercion. The access to information would be improved almost as a matter of course because, instead of being shut out of the treatment planning process,<sup>88</sup> the participant would become an integral part of that process. As a part of that process, the participant would become privy to the discussions and

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82. Gary Hickey & Cheryl Kipping, *Exploring the Concept of User Involvement in Mental Health Through a Participation Continuum*, 7 J. CLINICAL NURSING 83, 84–85 (1998).

83. *Id.* at 85.

84. *Id.*

85. *Id.*

86. *Id.*

87. See FRED C. OSHER & IREN S. LEVINE, BUREAU OF JUSTICE ASSISTANCE, NAVIGATING THE MENTAL HEALTH MAZE: A GUIDE FOR COURT PRACTITIONERS 18 (2005) (“Full consumer approval in the court process is not warranted, but soliciting defendant input and offering choices among treatment options can improve both short-term compliance and long-term outcomes.”).

88. See *supra* Part I.B.

motivations behind certain treatment proposals as well as different options for which she could voice her preference. On the other hand, coercion would decrease because, instead of allowing “defense counsel and/or the court [to] make decisions . . . [even though the participant] is thoroughly confused and afraid,”<sup>89</sup> the court team would be forced to help alleviate participant confusion and consider a participant’s input. Since improving voluntariness requires a reduction in coercion and an improvement in understanding,<sup>90</sup> adopting this mid-level model of the user involvement consumer-participation model would improve the level of voluntariness in mental health court participation.

This manipulation to the structural barriers to voluntary participation would also help reduce the clinical barriers to voluntary participation. As discussed above, the key clinical barrier to voluntary participation is mental health court participants’ diminished decisional and voluntarism capacities.<sup>91</sup> Not only will the structural change caused by adopting the consumer-participation model allow opportunities for education regarding the decision to participate,<sup>92</sup> but also the empowerment that participants experience through increasing their involvement will have its own benefits. One of the problems causing participants’ diminished capacities is that people with severe mental illnesses are often “conditioned to be compliant and often come to believe they are powerless.”<sup>93</sup> Combating both perceived and actual powerlessness through increasing choice and control helps mental health patients develop stronger decision-making and cognitive abilities, including realizing and achieving personal goals.<sup>94</sup> Further, empowerment helps participants recognize their self-worth, which is necessary to confront the stigmatization of mental illness, a factor contributing to decompensation.<sup>95</sup> Through empowerment, the use of the consumer-participation model in mental health courts will help overcome the barriers to voluntary

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89. Faraci, *supra* note 14, at 846–47.

90. *See supra* Introduction.

91. *See supra* Part II.A.

92. *See supra* Part III.A.

93. Geoffrey Nelson et al., *Empowerment and Mental Health in Community: Narratives of Psychiatric Consumer/Survivors*, 11 J. COMMUNITY & APPLIED SOC. PSYCHOL. 125, 126 (2001).

94. *See id.* at 126–27.

95. *See* E. Sally Rogers et al., *A Consumer-Constructed Scale to Measure Empowerment Among Users of Mental Health Services*, 48 PSYCHIATRIC SERVS. 1042, 1043 (1997) (discussing methods for measuring empowerment); IMPROVING OUTCOMES, *supra* note 5, at 16 (noting probationers with mental illness perceived themselves as “needy and time-consuming,” reflecting a low self-worth). Decompensation is the “failure of defense mechanisms such as occurs in initial and subsequent episodes of acute mental illness.” TABER’S CYCLOPEDIA MEDICAL DICTIONARY 586 (Donald Venes ed., 21st ed. 2009).

participation caused by participant's diminished capacities for decision-making and voluntarism.

Since the beginning level of involvement is unaffected by consumer-participation and its benefits are not realized until after enrollment, adopting this model may open the door for opponents to argue that this model would not improve voluntariness at the enrollment stage. Indeed, many opponents and supporters have recognized that true voluntariness is unlikely at the early stages and advocate for one important safeguard: the right to withdraw without prejudice.<sup>96</sup> This right allows for participants to reach back in time and elect a traditional adjudicatory path (with all its constitutional safeguards) if they find that they cannot comply with or fully participate in the mental health court.<sup>97</sup> This Note supports a more widespread adoption of this withdrawal right,<sup>98</sup> however, the right to withdraw's potential cannot be realized without giving participants greater education on its existence and consequences and empowering them to invoke it. In this manner, the right to withdraw is enhanced by adopting the consumer-participation model because it would help ensure that the decision to invoke or to *not* invoke the right is made with an improved level of information and decision-making capacity.<sup>99</sup>

The consumer-participation model focuses on two of the keys to improving decision-making and voluntariness capacities in people with mental illnesses: education and empowerment.<sup>100</sup> Since the adoption of a consumer-participation model using mid-level user involvement would help improve the dissemination of information, reduce coercion, and empower participants to make choices regarding their treatment and participation, the adoption of this model would help improve participants' capacities for voluntariness in mental health courts.

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96. See Seltzer, *supra* note 14, at 575 (discussing the importance of the right to withdraw from mental health court participation); *Position Statement 53: Mental Health Courts*, *supra* note 8 (noting that voluntary participation is key aspect of mental health courts).

97. Seltzer, *supra* note 14, at 575.

98. Only roughly half of the reporting mental health courts included the right to withdraw. *Id.*

99. There still may be other barriers to invoking the right to withdraw, such as time limits or plea requirements, but a full discussion on these barriers is outside the scope of this paper. I agree with Seltzer and the MHA that these barriers should be lifted. See *id.* (discussing the importance of the right to withdraw); *Position Statement 53: Mental Health Courts*, *supra* note 8 (noting ways to avoid coercion in mental health courts).

100. See *supra* Part II.A. (citing Paul S. Appelbaum, *Decisional Capacity of Patients with Schizophrenia to Consent to Research: Taking Stock*, 32 SCHIZOPHRENIA BULL. 22, 23 (2006)).

Still, even if voluntarism is improved, the adoption of the consumer-participation model would be of little use if opponents are able to succeed in dismantling the mental health court system by arguing that it trammels participants' rights. The next subsection will address how improving the level of voluntariness will affect these mental health court opponents' legal arguments.

*B. Consumer-Participation's Effect on Opponents' Legal and Practical Arguments Against Mental Health Courts*

While increasing mental health courts' level of voluntary participation through adopting the consumer-participation model has its own benefits to the legitimacy of mental health courts, it has the added benefit of addressing many of the legal and practical issues that opponents raise.<sup>101</sup> As discussed above, adopting the consumer-participation model will allow for a greater flow of information because it facilitates a higher level of communication between court teams and participants, who are no longer locked outside the court's planning. This heightened communication will help ensure that participants have access to the resources necessary to understand their rights, waivers, and the consequences of their decisions.

1. Constitutional Issues

Many opponents suggest that mental health court participation conflicts with defendants' constitutional rights, namely the right to a jury and the right to counsel.<sup>102</sup> While participation likely does impact these rights, adopting the consumer-participation model will help avoid violations because it will help ensure that participants are informed in waiving them.

First, mental health courts using the consumer-participation model may improve the capacity for participants to understand and waive their jury trial right. Opponents argue that mental health court participation conflicts with the right to a jury trial,<sup>103</sup> which is especially

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101. The legal issues discussed in this Note are concerned with federal constitutional standards and federal statutes applicable to the states, though state standards may also apply to Mental Health Courts.

102. Seltzer, *supra* note 14, at 574. Opponents often also raise concerns regarding equal protection. *Id.* However, the equal protection argument would likely fall on rational basis scrutiny because improving rehabilitation and reducing adverse prison populations is likely a legitimate state interest. *See generally* Cleburne v. Cleburne Living Ctr., 473 U.S. 432 (1985) (limiting the courts' inquiry into laws affecting mentally disabled persons to rational basis "with bite" scrutiny).

103. Faraci, *supra* note 14, at 839; *see, e.g.*, Cty. of Skagit, Sup. Ct. of Wash., Agreement, Waiver and Statement of Defendant on Submittal or Stipulation of Facts and Order to Participate in Mental Health Court, <http://www.skagitcounty.net/SuperiorCourt/Documents/MHC/Stipulation%20and%20Order%20to%20Participate%20in%20MHC.pdf> [<https://perma.cc/>

important where the participant is charged with a serious crime, such as a high misdemeanor or a felony.<sup>104</sup> This right, established by the Sixth Amendment and extended to the states by the Fourteenth Amendment,<sup>105</sup> provides that “the accused shall enjoy the right to a speedy and public trial, by an impartial jury.”<sup>106</sup> Still, it may be waived under certain circumstances,<sup>107</sup> and courts have ruled that this waiver must be “voluntary, knowing, and intelligent.”<sup>108</sup> In other words, the defendant must have access to enough information and understanding regarding this right, and his waiver must be free of coercion.<sup>109</sup>

Assuming that mental health courts implement the right to withdraw without prejudice as briefly discussed above,<sup>110</sup> adopting the consumer-participation model would help ensure that participants have greater access to the court team, thereby increasing their access to information regarding the jury trial right. Here, since not exercising the right to withdraw would be almost a continuous waiver of that right, the increased access to information resources through improved involvement and communication would help participants make these continuous waivers with greater understanding.

Similarly, mental health courts using the consumer-participation model may improve the capacity for participants to waive conflicts with their right to counsel. While mental health courts do not require participants to abandon this right,<sup>111</sup> problems may arise due to the different role the defense attorney must take on as a contributing member of a

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Y66Q-8NR6] (requiring the waiver of a jury trial right as part of the enrollment form).

104. *See Lewis v. United States*, 518 U.S. 322, 324 (1996) (ruling that there is no Sixth Amendment right to a jury trial for some lesser offenses).

105. *Gideon v. Wainwright*, 372 U.S. 335, 341 (1963).

106. U.S. CONST. amend. VI.

107. *See Singer v. United States*, 380 U.S. 24, 26 (1965) (recognizing that limitations, such as requiring the waiver to be in writing, are permissible because “the ability to waive a jury trial [is not] of equal importance to the right to demand one”).

108. *Spytma v. Howes*, 313 F.3d 363, 370 (6th Cir. 2002). This requirement is consistent with the Supreme Court’s requirements for waiving other rights of the accused. *See, e.g., Moran v. Burbine*, 475 U.S. 412, 421 (1986) (ruling that the waiver of *Miranda* rights must be “voluntary in the sense that it was . . . a free and deliberate choice . . . [and] made with a full awareness of . . . the right being abandoned and the consequences”).

109. *Spytma*, 313 F.3d at 370.

110. *See supra* Part III.A.

111. *See Seltzer, supra* note 14, at 574 (noting that defense attorneys perform a crucial role in Mental Health Courts by informing participants of the consequences of participation and their options).

non-adversarial treatment team.<sup>112</sup> While some scholars have classified this altered role as creating a “competing set of loyalties” giving rise to a conflict of interest,<sup>113</sup> it seems unlikely that an actual conflict of interest arises because this altered role neither changes the defense attorney’s pecuniary interests nor diverts his attention from the best interests of his client.<sup>114</sup> Instead, the mental health court defense attorney simply must work to achieve what is best for his client in cooperation with the other members of the team, rather than advocate for what would be considered the “best deal” in more traditional settings.<sup>115</sup> This represents more of a shift in the defendant’s interests rather than the creation of conflicting interests for the defense attorney.

The more likely danger inherent in defense attorneys’ shifting roles is to the attorney-client privilege.<sup>116</sup> Though this privilege is not itself a constitutional doctrine,<sup>117</sup> it is part and parcel to the execution of the Sixth Amendment right to counsel.<sup>118</sup> Since defense attorneys may need to reveal potentially privileged information that could be used against participants who withdraw and return to the traditional process, it is imperative that they reveal this risk as part of the duty to ensure that their clients understand the possible consequences of participation.<sup>119</sup> As discussed above, the participant in the consumer-participation model would have access to the discussions in which these revelations are normally made, so using this model will help attorneys “manage [the]

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112. Faraci, *supra* note 14, at 844.

113. *Id.* (quoting Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L.Q. 1205, 1213 (1998)).

114. The standard here is that the Sixth Amendment right to counsel carries with it “a correlative right to representation that is free from conflicts of interest,” *Wood v. Georgia*, 450 U.S. 261, 271 (1981), which is violated when “the attorney could have pursued a plausible alternative [to a problematic course of action, but it was] not undertaken due to the attorney’s other interests or loyalties.” *Bucuvalas v. United States*, 98 F.3d 652, 656 (1st Cir. 1996).

115. Christin E. Keele, Note, *Criminalization of the Mentally Ill: The Challenging Role of the Defense Attorney in the Mental Health Court System*, 71 U. MO. KAN. CITY L. REV. 193, 206 (2002).

116. See ROGER C. PARK ET AL., *EVIDENCE LAW: A STUDENT’S GUIDE TO THE LAW OF EVIDENCE AS APPLIED IN AMERICAN TRIALS* 439 (3d ed. 2011) (noting that most states have adopted this privilege either by statute or in common law).

117. *Maness v. Meyers*, 419 U.S. 449, 466 n.15 (1975).

118. See Michael B. Dashjian, *People v. Meredith: The Attorney-Client Privilege and the Criminal Defendant’s Constitutional Rights*, 70 CALIF. L. REV. 1048, 1050 (1982) (noting that the attorney-client privilege is an essential part of protecting defendants’ fifth and sixth amendment rights).

119. Seltzer, *supra* note 14, at 574.

clash of expectations and responsibilities” through the participant’s own observations and increased access to information.<sup>120</sup>

Because adopting the consumer-participation model for the mental health court setting would result in an increased flow of information and inclusion in the processes, it is likely that participants would have a better understanding and ability to exercise or waive their rights to a jury trial and the attorney-client privilege.

## 2. The Americans with Disabilities Act

In addition to the constitutional issues, opponents suggest that mental health court participation may violate Title II of the Americans with Disabilities Act’s (ADA) “prohibition against discrimination by a state program.”<sup>121</sup> This prohibition provides that: “[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”<sup>122</sup>

Under this prohibition, states cannot require defendants to completely abdicate their access to the traditional court system.<sup>123</sup> Here, participants’ understanding that they can withdraw from the mental health court system to return the traditional court system plays a vital role in protecting this access.<sup>124</sup> This remains true even if mental health courts are couched as an accommodation under the ADA, as some scholars have suggested.<sup>125</sup> This is because states cannot use their duty to accommodate as an excuse for “fail[ing] to provide individuals with a meaningful right of access to the courts.”<sup>126</sup> This access, however, may

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120. Faraci, *supra* note 14, at 844.

121. Seltzer, *supra* note 14, at 574.

122. Americans with Disabilities Act of 1990 § 202, 42 U.S.C. § 12132 (2012).

123. See Ronda Cress et al., *Mental Health Courts and Title II of the ADA: Accessibility to State Court Systems for Individuals with Mental Disabilities and the Need for Diversion*, 25 ST. LOUIS U. PUB. L. REV. 307, 345 (2006) (“[A] public entity, such as a state’s judicial system, cannot require an individual with a mental disability to accept diversion into a mental health court if he or she wants to participate in the mainstream state courts . . .”).

124. *Id.* at 343 (arguing that “so long as individuals who are diverted into [mental health courts] still have the option to participate in the ‘regular’ court system,” mental health courts can “pass muster under the ADA”).

125. *Id.* at 347 (“[M]ental [H]ealth [C]ourts are arguably necessary to bring the state[s]’ court system[s] into compliance with the ADA.”).

126. *Tennessee v. Lane*, 541 U.S. 509, 533 (2004). See also DEPT. OF JUSTICE, THE AMERICANS WITH DISABILITIES ACT: TITLE VII TECHNICAL ASSISTANCE MANUAL II-3.4300 (1993), <http://www.ada.gov/taman2.html> [<https://perma.cc/MN34-BRNJ>] (suggesting that defendants “may not be required to accept [participation] if they choose not to do so”).

be hindered if participants lack the knowledge necessary to understand their ability to elect traditional court processing.<sup>127</sup> The increased access to information and the improved decisional capacities created through adopting the consumer-participation model will help ensure that participation comes without denying access to traditional court process, improving compliance with the ADA.<sup>128</sup>

### 3. Informed Consent

Finally, incorporating the consumer-participation model for treatment planning in mental health courts may avoid conflicts with the doctrine of informed consent. This doctrine requires that patients choose their treatment with an “understanding of alternatives to and risks of the therapy.”<sup>129</sup> The fulfillment of this standard is tripartite: (1) the participant is informed, (2) the participant understands, and (3) the participant voluntarily consents to the treatment.<sup>130</sup>

Although mental health courts may be able to forgo informed consent by asserting the exception available when a valid court order authorizes treatment,<sup>131</sup> adopting the consumer-participation model may be a less polemical approach.

As discussed above, the consumer-participation model will help achieve the information element of informed consent. As user involvement in discussion and decision-making increases, participants are exposed to a higher degree of information regarding the motivations behind and potential consequences of treatment.<sup>132</sup>

Additionally, the consumer-participation model will help achieve the understanding element through an increase in participants’ cognitive abilities. As discussed above, one of the key factors in increasing the understanding of people with mental illnesses is improving edu-

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127. See Allison D. Redlich et al., *Enrollment in Mental Health Courts: Voluntariness, Knowingness, and Adjudicative Competence*, 34 LAW & HUM. BEHAV. 91, 92 (2010) (“[C]lients who claimed not to know they had a choice in enrolling [and withdrawing] had significantly higher perceived coercion scores than those claiming to be aware.”).

128. Compare *supra* Part III.A. (discussing the improved access to information and decisional capacities created through the consumer-participation model), with Redlich et al., *supra* note 127, at 93 (suggesting that mentally ill offenders are “known to have deficits in legal comprehension” and are “under significant stress and instability,” such that they will have trouble making a knowing and intelligent decision).

129. *Canterbury v. Spence*, 464 F.2d 772, 780 n.15 (D.C. Cir. 1972).

130. See BERG ET AL., *supra* note 17, at 65 (discussing the components of the informed consent).

131. *Id.* at 90–91.

132. *Supra* Part III.A.

cation. Therefore, the increased education that participants gain through the consumer-participation model will help increase their ability to understand the information they receive and decisions they make.

Finally, it will improve the chances that participants will voluntarily consent to treatment to meet the third prong of informed consent. First, the consumer-participation model's improvement of information dissemination will help participants gain the education necessary for enhanced voluntarism. Second, rather than allowing the court to simply issue orders declaring the treatment that participants must comply with, participants will be able to articulate their points of view and affect treatment decisions. Coupling both enhancement of voluntarism capacities and allowing participants to use those enhanced capacities by articulating their own views will help empower participants to voluntarily consent to treatment in mental health courts.

Since the heightened involvement and access to information resources involved in implementing the consumer-participation model will help address mental health court opponents' legal concerns, adopting the consumer-participation model has an additional layer of attraction beyond just improving the level of voluntariness in participation.

#### CONCLUSION

Although mental health courts have been generally successful in improving the disproportionate incarceration and over-punishment of mentally ill offenders, their status as voluntary diversion programs has come under opponents' criticism. Adopting a consumer-participation model to bring treatment-planning out from behind closed doors by involving participants will help improve participants' access to information and understanding and reduce the coerciveness of treatment mandates. Further, since this increased involvement will facilitate greater communication between mental health court participants and the court team, the consumer-participation model will help address many other arguments that opponents have fielded. Although a full realization of the consumer-participation model's benefits may hinge on the co-availability of a right to withdraw (a full discussion of which was outside the purview of this Note), it is nonetheless an important opportunity for improving the structural and clinical barriers to voluntariness in mental health court participation.

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