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MENTAL HEALTH COURT JUDGES AS DYNAMIC RISK MANAGERS: A NEW CONCEPTUALIZATION OF THE ROLE OF JUDGES

*Shauhin Talesh**

> The work of a judge is in one sense enduring and in another sense ephemeral. What is good in it endures. What is erroneous is pretty sure to perish. The good remains the foundation on which new structures will be built. The bad will be rejected and cast off in the laboratory of the years. Little by little the old doctrine is undermined. Often the encroachments are so gradual that their significance is at first obscured. Finally we discover that the contour of the landscape has been changed, that the old maps must be cast aside, and the ground charted anew.[1]

INTRODUCTION

The most significant development in mental health law in the past decade is the emergence of problem-solving courts that deal with mentally ill individuals. Mental health courts are criminal courts that divert people with serious mental illness into treatment programs rather than jails or prisons.[2] Mental health courts developed in response to the rising number of people with severe mental illnesses incarcerated in jails and prisons, the lack of treatment mentally ill individuals receive in carceral institutions, and the high likelihood that mentally ill defendants will recidivate if untreated.[3] Three rationales

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1. BENJAMIN N. CARDOZO, THE NATURE OF THE JUDICIAL PROCESS 178 (1921).

2. *See* Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform*, 7 UDC/DCSL L. REV. 143, 143–44 (2002); Derek Denckla & Greg Berman, *Rethinking the Revolving Door: A Look at Mental Illness in the Courts*, Ctr. for Court Innovation 2 (2001). Carceral institutions, such as jails, where inmates are typically housed either when arrested or convicted of small crimes with less than one year, and prisons, where inmates with longer sentences for more serious offenses are housed, have long struggled with problems associated with mentally ill persons.

3. *See* Allison D. Redlich, *Voluntary, But Knowing and Intelligent? Comprehension in Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 605 (2005) (noting the factors that brought about the creation of mental health courts); Bernstein & Seltzer, *supra* note 2, at 143–45; COUNCIL OF STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT (June 2002);

underlie mental health courts' therapeutic approaches: (1) when mentally ill individuals commit criminal acts, deterrent or punitive criminal sanctions, are neither effective, nor morally appropriate; (2) legal processes can be reshaped in ways that improve the psychological functioning and emotional well-being of mentally ill defendants; and (3) addressing the underlying mental illness that contributes to the criminal act increases public safety and decreases the likelihood of recidivism.[4] Through a collaborative, team-oriented approach, judges use a range of flexible responses, treatment programs, and close monitoring plans to reduce the risk of recidivism.[5]

Scholars often describe problem-solving court judges as activists.[6] This analysis is correct. Prior analysis has failed, however, to establish a framework for understanding how problem-solving court judges behave in ways that are different from our traditional conception of an activist judge who seeks to define and protect public values.[7] Mental health court judges do something more: they manage risk.

Risk is an intuitive and innate element in society.[8] It is the uncertainty about what the future will bring, not potential adverse events, which make life full of risk.[9] In response to this uncertainty, human beings, private organizations, and governments attempt to increase

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Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers: Special Report*, U.S. DEPT OF JUSTICE STATS., at 1 (July 1999). In particular, over one-fourth of the inmates with mental illnesses in local jails are incarcerated for a public order offense. *Id.* at 4.

4. *See* Bernstein & Seltzer, *supra* note 2, at 148. The rationale is that many individuals arrested for quality-of-life offenses suffer from mental illnesses and would not commit these offenses but for the mental illness. Also, mentally ill offenders often lack the mens rea component of culpability.

5. *Id.*

6. For a compelling argument that explains why problem-solving judges and, in particular, drug court judges are activists, see JAMES L. NOLAN, JR., REINVENTING JUSTICE: THE AMERICAN DRUG COURT MOVEMENT 94–99 (2001). "Instead, the drug court judge is, on a number of fronts, an activist judge." *Id.* at 94. For further discussion on problem-solving courts as activist, see Richard Boldt & Jana Singer, *Juristocracy in the Trenches: Problem-Solving Judges and Therapeutic Jurisprudence in Drug Treatment Courts and Unified Family Courts*, 65 MD. L. REV. 82, 83 (2006) (noting that problem-solving courts "have largely repudiated the classical virtues of restraint, disinterest, and modesty, replacing these features of the traditional judicial role with bold, engaged, action-oriented norms"); Joshua Matt, *Jurisprudence and Judicial Roles in Massachusetts Drug Courts*, 30 N. ENG. J. ON CRIM. & CIV. CONFINEMENT 151, 151–52 (2004) (noting that the primary evaluation of problem-solving judges is as activists).

7. Owen M. Fiss, Foreward, *The Forms of Justice*, 93 HARV. L. REV. 1 (1979) (noting that the judge's function is to give concrete meaning and application to public values through the process of adjudication).

8. *See* DAVID A. MOSS, WHEN ALL ELSE FAILS: GOVERNMENT AS THE ULTIMATE RISK MANAGER 1 (2002) ("[R]isk management constitutes a potent and pervasive form of public policy in the United States. Our economy would be unrecognizable in its absence. It is even possible that the economy would not function at all.").

9. *Id.* at 22.

certainty and stability while reducing risk. Scholars study risk management (that is, the ability to evaluate, reduce, and control risk) in a variety of areas, including public safety regulation, property insurance, products liability, criminal justice, accidents, commercial enterprise, financial management, and politics.[10] However, risk management has not been traditionally framed or analyzed as a function of the judiciary. This is the first Article of which the author is aware that exposes and expands the conceptual frame of reference for risk management to the judicial sphere.

The purpose of this Article is not to argue for or against judges taking on risk management functions.[11] Rather, this Article recognizes and understands how judges take on this important role in a particular type of specialty court. More importantly, this analysis moves scholarly attention away from the traditional debate of the judge's role as a "passive, neutral arbiter" versus "activist" and toward examination of how risk management approaches by judges play a growing role in the criminal court process.

Part II of this Article describes the "transinstitutionalization" of mentally ill individuals and traces how they went from state hospitals to state jails and prisons over the past fifty years.[12] It also explains how transinstitutionalization resulted in a revolving door phenomenon, whereby defendants cycled in and out of the criminal justice system for minor, quality-of-life offenses without receiving treatment for their illnesses.[13]

Part III explores risk management and the role of the risk manager.[14] In particular, risk management has three components: (1) identifying risk by conducting a risk assessment; (2) measuring and evaluating risk in order to implement a plan; and (3) handling risk through monitoring. The risk manager's objective is not to eliminate risk, but to control, manage, minimize, and reallocate it.[15] In order to

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10. *See generally* MOSS, *supra* note 8 (noting various ways risk is managed in society). For a comprehensive explanation of the various ways in which risk management has been studied and critiqued, see JIM BANNISTER, HOW TO MANAGE RISK (2d ed. 1997).

11. For a thorough discussion of the pros and cons of having mental health courts, see Susan Stefan & Bruce J. Winick, *A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 507 (2005).

12. *See infra* notes 23–72 and accompanying text.

13. *Id.*

14. *See infra* notes 73–118 and accompanying text.

15. *See generally* GUIDO CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 26 (1970) (noting "as axiomatic that the principal function of accident law is to reduce the sum of the costs of accidents and the costs of avoiding accidents"); Clayton P. Gillette & James E. Krier, *Risk, Courts, and Agencies*, 138 U. PA. L. REV. 1027, 1028 n.2 (1990) ("[T]he distribution of risk—demographically, spatially, and temporally—also has to be considered,

better understand how these roles are performed, Part III analyzes how psychiatrists manage the risk of patients with suicidal ideations. Next, Part IV explains what a mental health court is, how it functions, and how mental health judges perform their roles differently from a traditional judge.[16] In particular, judges facilitate a collaborative, team-oriented approach unique to each individual defendant.[17]

Part V argues that mental health court judges are "dynamic risk managers."[18] Rather than simply processing cases and perpetuating the revolving door, judges manage risk, attempt to resolve the underlying mental illness, and attempt to heal the defendant. Specifically, with the assistance of team members—including the public defender, prosecutor, and behavioral and mental health specialists—the judge performs the following three tasks: (1) he conducts a risk assessment in which he evaluates the defendant's potential to harm himself and the public; (2) he evaluates and implements a treatment plan designed to manage and reallocate the defendant's risk; and (3) he monitors the risk over a period of time, often requiring frequent return visits by the defendant.[19]

Part VI analyzes how dynamic risk management in mental health courts affects defendants.[20] When managing risk, mental health court judges function as hybrid social workers (diagnosing and implementing a plan) and probation officers (monitoring the offender to ensure compliance). When functioning in its ideal form, the collaborative, team-oriented approach of mental health courts shifts the focus of the criminal process toward healing and away from punishment.[21]

Part VII concludes that, although risk management techniques may have always been embedded in judges' roles, it is now becoming more overtly a part of the judicial routine. Thus, as Cardozo noted many years ago, mental health court judges are changing the "contour of the

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partly for reasons of justice and partly because distribution has a bearing on the measure of risk costs that one might hope to minimize."). Though risk and cost minimization are important ends of risk management, they are not the only ones.

16. *See infra* notes 119–174 and accompanying text.

17. *Id.*

18. *See infra* notes 175–199 and accompanying text.

19. *Id. See also* JUDGING IN A THERAPEUTIC KEY 122 (Bruce Winick & David Wexler eds., 2003).

20. *See infra* notes 200–233 and accompanying text.

21. *See* Malcolm M. Feeley & Jonathan Simon, *The New Penology: Notes on the Emerging Strategy of Corrections and its Implications*, 30 CRIMINOLOGY 449 (1992) (framing this new approach as the New Penology); Malcolm Feeley & Jonathan Simon, *Actuarial Justice: The Emerging New Criminal Law, in* THE FUTURES OF CRIMINOLOGY (David Nelkin ed., 1994); Jonathan Simon & Malcolm Feeley, *True Crime: The New Penology and Public Discourse on Crime, in* PUNISHMENT AND SOCIAL CONTROL: ESSAYS IN HONOR OF SHELDON MESSINGER 147 (Thomas G. Blomberg & Stanley Cohen eds., 1995).

landscape," casting aside "old maps," and "charting" new approaches to judges' roles.[22]

II. THE RISING POPULATION OF INCARCERATED MENTALLY ILL INDIVIDUALS AND THE REVOLVING DOOR

Before analyzing what risk management is and how mental health court judges employ risk management techniques, it is important to understand how and why such a large number of mentally ill individuals cycle in and out of the criminal justice system. This Part briefly traces the transinstitutionalization of the mentally ill, that is, how the mentally ill went from being confined in state hospitals to passing in and out of state jails and prisons over the past fifty years.[23] Section A discusses the growing mentally ill population in prisons.[24] Section B examines the reasons for transinstitutionalization.[25] Finally, Section C explores mental illness in prisons.[26]

A. The Growing Mentally Ill Population in Jails and Prisons

As incarceration rates increased over the last twenty-five years, the number of people with mental illnesses in the criminal justice system also steadily increased.[27] By 2005, "more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in state prisons, 78,800 in federal prisons, and 479,900 in local jails. These estimates represented 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates."[28] The number of mentally ill indi-

22. CARDOZO, *supra* note 1, at 178. *See infra* notes 234–235 and accompanying text.

23. *See Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernadino, and Anchorage*, U.S. DEPT. OF JUSTICE, BUREAU OF JUSTICE ASSISTANCE 1–3 (April 2000) (highlighting the plight of the mentally ill in jails and prisons) [hereinafter *Emerging Judicial Strategies*]. However, this Article limits its focus to the past fifty years.

24. *See infra* notes 27–34 and accompanying text.

25. *See infra* notes 35–49 and accompanying text.

26. *See infra* notes 50–72 and accompanying text.

27. *See* RAYMOND FOSDICK ET AL., CRIMINAL JUSTICE IN CLEVELAND (1922) (noting the rise of mentally ill persons in the prison system); Am. Bar Ass'n Criminal Justice Mental Health Standards (1989); Am. Bar Ass'n Criminal Justice Mental Health Standards (1989); *Emerging Judicial Strategies*, *supra* note 23, at 1–3.

28. Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates: Special Report*, U.S. DEPT. OF JUSTICE, BUREAU OF JUSTICE STATS. 1 (Sept. 2006, rev'd Dec., 2006). Prior studies noted that approximately 16% of people in state jails and prisons have a reported or diagnosed mental illness. *See* John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447, 452–53 (2005); Nicholas Freudenberg, *Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health*, 78 J. URBAN HEALTH 214, 217, 220 (2001); Ditton, *supra* note 3; HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 17 (2003) [hereinafter ILL-EQUIPPED].

viduals placed in American jails every year is approximately 700,000.[29] Compared with non-incarcerated individuals of similar age in the United States, prisoners are two-to-four times more likely to suffer from a psychotic illness or major depression and approximately ten times more likely to have an antisocial personality disorder.[30] The incidence of schizophrenia in state jails is two-to-three times higher than in the general population.[31] Additionally, the incidence of schizophrenia is three-to-five times higher in state prisons than in the general population.[32] These numbers demonstrate why jails and prisons have been referred to as the "new asylum."[33] These figures reflect the number of people who report their mental illness or are diagnosed as mentally ill by a jail or prison. There are many more incarcerated persons whose mental illness goes unreported and undiagnosed.[34]

B. The Pathway to Transinstitutionalization

There are multiple reasons for the high number of mentally ill individuals in carceral institutions, but two reasons remain at the forefront: the long-term effects of de-institutionalization and law enforcement strategies that target drug and low-level, quality-of-life offenses. According to Greg Berman and Derek Denckla, "[d]e-institutionalization is a term that describes a systematic shift in resources for treating people with mental illness—from large, residential, state-run psychiatric hospitals to community-based treatment."[35] The availability of psychiatric medications has increased tremendously since the 1950s. This led doctors to treat many mentally ill individuals on an outpatient basis.[36] In the 1960s and 1970s, civil libertarians and legis-

29. *See* Freudenberg, *supra* note 28, at 220; Jacobi, *supra* note 28, at 452–53.

30. *See* Seena Fazel & John Danesh, *Serious Mental Disorder in 23,000 Prisoners: A Systemic Review of 62 Surveys*, 359 THE LANCET 545, 548 (2002).

31. *See* Jacobi, *supra* note 28, at 453.

32. *Id.* (citing NAT'L COMM'N ON CORRECTIONAL HEALTH CARE: THE HEALTH STATUS OF SOON-TO-BE RELEASED INMATES: A REPORT TO CONGRESS, VOL. 1, 25–26 (March 2002) [hereinafter NCCHC REPORT]); *see also* NCCHC REPORT, *supra*, 15–28 (Mar. 2002). In fact, the NCCHC reports that 2.3% to 3.9% of state prison inmates have schizophrenia or another psychotic disorder, between 13.1% and 18.6% have a major depressive disorder, and another 2.1% to 4.3% have a bipolar disorder. *Id.* at 25. "NAMI (formerly known as the National Alliance for the Mentally Ill) reported in 1999 that the number of inmates with mental illness in prison was three times that of the number of non-incarcerated people hospitalized with such illnesses." Joyce Kosak, Comment, *Mental Health Treatment and Mistreatment in Prisons*, 32 WM. MITCHELL L. REV. 389, 397 (2005).

33. Michael Weissberg, *Chained in the Emergency Department: The New Asylum for the Poor*, 42 HOSP. & COMM. PSY. 3, 317–19 (1991).

34. *See* Jacobi, *supra* note 28, at 453.

35. *See* Denckla & Berman *supra* note 2, at 2. *See also* PHIL BROWN, THE TRANSFER OF CARE: PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS AFTERMATH 76–86, 133–41 (1985).

36. Denckla & Berman, *supra* note 2, at 2.

lative reformers led a movement toward offering proper treatment in the least restrictive environment possible.[37] In particular, civil commitment statutes made it harder for judges to place a person with a mental illness in a psychiatric hospital against that person's will.[38] These laws diverted larger numbers of people with mental illness into the community. The goal of civil libertarians and legislative reformers was to replace confinement with coercive attempts within the community to create therapeutic interventions.

These reformers unintentionally restricted access to mental health systems. In particular, many states closed or downsized their psychiatric hospitals without funding community treatment centers.[39] Thus, although the mentally ill were living in the community, they often lacked proper treatment facilities, support programs, or medication. Berman and Denckla noted that "[i]n 1955, there were 560,000 individuals hospitalized with mental illness in the United States. By 1999, there were less than 80,000."[40] Over the past thirty years, while the number of mentally ill individuals in state psychiatric facilities decreased, the number of mentally ill individuals in prisons rose at a staggering rate.[41] The simultaneous increase in imprisonment of people with mental illnesses and decrease of mentally ill people in mental hospitals is referred to as transinstitutionalization.[42]

Transinstitutionalization coincided with stricter law enforcement strategies. Increasingly stringent law enforcement placed an emphasis on enforcing quality-of-life offenses, such as shoplifting, illegal street vending, prostitution, trespassing, loitering, and low-level drug possession.[43] This increased the probability that law enforcement would cor-

37. *Id. See also* Gary E. Whitmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 AM. J. OF ORTHOPSYCHIATRY 65–75 (1980) (noting a similar process); E. Fuller Torrey & Mary Zdanowicz, *Why Deinstitutionalization Turned Deadly*, WALL ST. J., Aug. 4, 1998, *available at* http://www.psychlaws.org/GeneralResources/Article2.htm.

38. *See* Denckla & Berman, *supra* note 2, at 2.

39. *Id.* at 3.

40. *Id.* (citation omitted).

41. "By contrast, since 1970, the U.S. jail and prison populations have increased fivefold to a total of about 1.6 million people." *Id.* (citation omitted).

42. *See* John A. Talbott, *Deinstitutionalization: Avoiding the Diseases of the Past*, 30 HOSP. & COMMUNITY PSYCHIATRY 621, 622–24 (1979), *reprinted in* 55 PSYCHIATRIC SERVICES 1112, 1112–15 (2004) (explaining the process of transinstitutionalization). Also, transinstitutionalization was enlarged by the dramatic rise in homeless populations during the 1970s, 1980s, and 1990s, which quite often consisted of a large mentally ill population. *See Emerging Judicial Strategies*, *supra* note 23, at 2.

43. *See Emerging Judicial Strategies*, *supra* note 23, at 2 (noting that the War on Drugs, strict enforcement of quality-of-life offenses, and the rise in homeless population caused police officers to arrest large numbers of mentally ill offenders); *see also* Judith S. Kaye, *Changing Courts in Changing Times: The Need for a Fresh Look at How Courts are Run*, 48 HASTINGS L. J. 851, 855–56 (1997) (noting that officers often arrest mentally ill individuals for quality-of-life of-

ral mentally ill individuals—especially homeless mentally ill individuals—into the criminal justice system for minor offenses.[44] One study noted that, during street encounters, police officers were almost twice as likely to arrest someone who appeared to have a mental illness.[45] Approximately half of incarcerated mentally ill individuals are arrested for non-violent offenses, such as trespassing and disorderly conduct.[46] Also, a large number of people arrested as a result of the war on drugs during the 1980s suffered from mental illnesses.[47]

Thus, over the course of the last forty years, mentally ill individuals went from being treated in mental hospitals to being warehoused in prisons. The libertarian view of community-based mental health treatment prevalent in the 1960s and 1970s gave way to a view of the mentally ill as dangerous and high risk in the 1980s and 1990s, particularly because the attempt to deinstitutionalize mental health treatment by using more community treatment centers never fully came to fruition. During the 1980s and 1990s, the media often shaped public perception of mentally ill individuals as dangerous by spotlighting random acts of violence in the community.[48] Those suffering from co-occurring disorders (for instance, drug addiction and mental illness) were typically viewed as even more dangerous.[49] Popular legislation favored civil commitment proceedings as a method of containing mentally ill defendants, even after they completed their sentences. The public's increasingly negative perception of mentally ill individuals coincided with increases in zero-tolerance policies and arrests for quality-of-life offenses. The result was jail and prison populations filled with mentally ill individuals.

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fenses, creating a revolving door of mentally ill patients cycling in and out of the criminal justice system).

44. *See Emerging Judicial Strategies*, *supra* note 23, at 2.

45. Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, NAT. INST. OF JUST. J. 12 (July 2000) (explaining a Chicago study of thousands of police encounters, which concluded that 47% of people with a mental illness were arrested, whereas only 28% of individuals without a mental illness were arrested for the same behavior).

46. Bernstein & Seltzer, *supra* note 2, at 145.

47. *Id.*

48. *See* Carol Fisler, *Building Trust and Managing Risk*, 11 PSYCHOL. PUB. POL'Y & L. 587, 589–90 (2005) (noting that fear of mentally ill individuals is often aggravated by media portrayals of occasional violent behavior by mentally ill people).

49. For an evaluation of the high volume of offenders suffering co-occurring disorders, see Karen M. Abram & Linda A. Teplin, *Co-Occurring Disorders Among Mentally Ill Jail Detainees: Implications for Public Policy*, 46 AM. PSYCHOLOGIST 1036 (1991).

C. *The Revolving Door*

Prisons offer mentally ill people insufficient treatment. A September 2006 report released by the Bureau of Justice concerning state and federal inmates with mental illnesses found the following: (1) state prisoners had the highest rate of mental health treatment since admission (34%), followed by federal prisoners (23%), and jail inmates (17%); (2) taking a prescribed medication for a mental health problem was the most common type of treatment mentally ill inmates received since admission to prison or jail; (3) approximately 27% of state prisoners, 19% of federal prisoners, and 15% of mentally ill jail inmates used prescribed medication for a mental problem since admission; and (4) only 5% of state prisoners, 3% of federal prisoners, and 2% of prisoners in local jails stayed overnight in a hospital for a mental problem, making an overnight stay in a hospital the least likely method of treatment.[50] The inadequate treatment of mental illness by prisons is due to a number of factors, including "lack of funding, inadequate staffing to meet the needs of the entire prison population, lack of training for the health care and security staff, and lack of procedures to identify and track the needs of prisoners."[51]

In July 2006, the care provided to mentally ill prisoners in California was so inadequate that Federal District Court Judge Lawrence Karlton ordered California to hire more than 550 new mental health care staff.[52] Similarly, a recent report in Oklahoma offered a disheartening view of the warehousing of the mentally ill in prisons:

> The most unstable inmates are housed in 'Fantasy Island,' the nickname for the acute-care unit. Surrounded by a 12 foot fence, it's a prison within a prison for 108. The walls, made of unbreakable glass, allow staff to see most of the unit at a glance. There is a four-point restraint table where uncontrollable inmates can be tied down until they're calm. With temperatures in the teens one day earlier this year, few inmates ventured outside. Many milled around a recreation area in the zombie-like gait of the heavily medicated. Others, visibly agitated, paced back and forth and stared through the glass. Those considered too unpredictable and uncontrollable ever to be free are locked behind thick doors with small windows.

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50. James & Glaze, *supra* note 28, at 9.

51. Kosak, *supra* note 32, at 400; ILL-EQUIPPED, *supra* note 28, at 94–127 (noting problems in treatment).

52. James Sterngold, *U.S. Judge Tells State to Hire Prison Mental Health Staff*, S.F. CHRON., Aug. 1, 2006, at B-3. Sterngold reported that the special master appointed by Judge Karlton indicated that the prison suicide rate was soaring because of poor mental health treatment. *Id.*

> Screams, moans, and chanting are normal. The noise level rises as the sun goes down and before the medication kicks in.[53]

Additionally the criminal justice system devotes insufficient attention to reintegrating mentally ill individuals into society upon completion of their sentences. Thus, those with mental illnesses do not leave prison or jail any more stable than when they entered. Their conditions often worsen and increase the likelihood of recidivism.

Because of the lack of treatment prisoners receive, it is not surprising that many offenders cycle in and out of the criminal justice system, as if the system were a revolving door.[54] Almost 50% of mentally ill prisoners in the federal system have three or more prior probations, incarcerations, or arrests, compared with 28% without mental illnesses.[55] Family members indicate the average number of arrests for relatives with mental illness is more than three.[56] As mental health court Judge Stephen Manley of Santa Clara County noted:

> I've worked with mental health clients for years and I know our traditional method is to ignore them. We either cycle them through quickly or we give them long sentences. There's a stigma with the mentally ill that they are more dangerous, which is not true. Some are, some are not. They are, however, far more difficult to work with. It makes absolutely no sense in my view to warehouse someone who is mentally ill and release them into the community with no services, when we know they will be rearrested again and go right back into jail.[57]

In short, mentally ill individuals cycle from the street, to court, to jail or prison, and back to the street, only to repeat this cycle.[58]

In traditional criminal court, cases involving mentally ill defendants are processed just like any other.[59] Because a significant number of low-level public order offenses involve the mentally ill, these cases are

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53. Gary Fields, *No Way Out: Trapped by Rules, the Mentally Ill Languish in Prison,* WALL ST. J., May 3, 2006, at 1A.

54. *See* Kaye, *supra* note 43, at 856 (describing the revolving door dilemma in the criminal justice system).

55. *See* Denckla & Berman, *supra* note 2, at 4.

56. *See id.*

57. Interview with Judge Stephen Manley, Mental Health Treatment Court, Santa Clara County, Ctr. for Court Innovation (Jan. 2005), *available at* http://courtinnovation.org/index.cfm?fuseaction=Document.viewDocument&documentID=618&documentTopicID=25&documentTypeID=8.

58. "[O]ur jails and prisons are so filled, riddled, with the mentally ill that you can start with almost any subset." Interview with Judge Morris, Satellite Broadcast of Mental Health Courts, Ctr. for Court Innovation (Nov. 14, 2002), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/transcripts.pdf.

59. *See* Denckla & Berman, *supra* note 2, at 6 (noting that mental health offenders are often processed the same way as other defendants).

typically resolved via plea bargain.[60] Judges often play a limited role, simply moving the case through the system.[61] This is consistent with the traditional adversarial model of the judge as neutral and passive.[62] Under this model, "judges are not supposed to have an involvement or interest in the controversies they adjudicate. Disengagement and dispassion supposedly enable judges to decide cases fairly and impartially."[63] In most criminal cases, including those involving mentally ill defendants, the judge is on the sidelines, while the prosecutor and the defense attorney plea bargain.[64] Consider the following evaluation of the criminal process:

> Many state court judges have reported that the pressure of processing hundreds of cases each day has transformed their courtrooms into 'plea bargain mills' which place the highest value on disposing of the maximum number of cases in the minimum amount of time. Additionally, they bemoan their lack of tools—both information and sentencing options—for responding to the complexities of drug addiction, mental illness and domestic violence cases. Chief Justice Kathleen Blatz of Minnesota neatly summarized the feelings of many judges: 'Judges are very frustrated. . . . The innovation that we're seeing now is a result of judges processing cases like a vegetable factory. Instead of cans of peas, you've got cases. You just move 'em, move 'em, move 'em. One of my colleagues on the bench said, 'You know, I feel like I work for McJustice: we sure aren't good for you, but we are fast.'[65]

The traditional criminal justice system fails to address the underlying problems that cause recidivism. To the extent that mentally ill defendants pose a risk to themselves or others, little emphasis is placed on decreasing or controlling the risk of recidivism.[66]

There are three principal effects of short sentence and quality-of-life offenses for mentally ill defendants: (1) the risk of recidivism for mentally ill defendants remains high upon release; (2) the likelihood that the condition will continue and possibly worsen during incarceration is high; and (3) the likelihood that the community will be safer is low, because these offenders are often released without receiving any treatment.

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60. *See id.*

61. *See id.*

62. Lon L. Fuller, *The Forms and Limits of Adjudication*, 92 HARV. L. REV. 353 (1978) (noting that the role of the judge is to act as a passive arbiter for actual disputes).

63. Judith Resnick, *Managerial Judges*, 96 HARV. L. REV. 374, 376 (1982).

64. JUDGING IN A THERAPEUTIC KEY, *supra* note 19, at 77.

65. *Id.*

66. *See* Judith S. Kaye, *Delivering Justice Today: A Problem-Solving Approach*, 22 YALE L. & POL'Y REV. 125, 129 (2004) (highlighting the lack of focus on outcomes under the traditional system).

In response to these problems, Congress enacted America's Law Enforcement and Mental Health Project Act in 2000 ("Act").[67] The goal of the Act is to improve access to mental health services for juvenile and adult non-violent offenders and reduce the incarceration and recidivism rates of mentally ill individuals.[68] By linking mental health services and support, the Act sought to prevent arrests of mentally ill people.[69] Specifically, the Act authorized federal funds for states and counties to develop mental health courts and diversion programs.[70] Congressional findings issued in the Mentally Ill Offender and Crime Reduction Act of 2004 indicated that most mentally ill prisoners successfully respond to intervention that integrates treatment, rehabilitation, and support services.[71]

Because mental health courts have only existed since 2000, there is little research on their processes and cases.[72] As this Article shows, however, mental health court judges are not acting as impartial arbiters, but as dynamic risk managers. Before this Article fully explores this new framework for reconceptualizing the judge's role, it is important to understand the fundamentals of risk management.

III. THE FUNDAMENTALS OF RISK MANAGEMENT

This Part explores risk management and the risk manager's role. In particular, it explains that, in order to manage, minimize, and reallocate risk, risk managers perform three main functions: (1) assessing risk; (2) evaluating and measuring risk; and (3) controlling risk.[73] In order to show risk management functions in practice, this Part examines how psychiatrists manage the risk of patients with suicidal ideations.[74] This approach is similar to that taken by judges in mental health courts and, therefore, provides a logical reference point.[75]

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

68. *Id.*

69. *Id.*

70. *Id.*

71. Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. No. 108-414 § 2(6), 118 Stat. 2327 (2004).

72. *See* Allison D. Redlich et al., *The Second Generation of Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 527, 527 (2005) ("Empirical data, both evaluative and outcome, remain sparse despite [mental health courts] growth.").

73. *See infra* notes 76–118 and accompanying text.

74. *Id.*

75. Although there are multiple approaches to managing the risk of suicidal patients, this Part highlights a routine approach.

A. What is Risk Management?

In its most basic form, risk management is any activity designed to either reduce or reallocate risk.[76] It is an attempt to increase certainty and, therefore, stability by reducing risk.[77] Risk management is typically viewed as a compilation of techniques employed in flexible and coordinated ways.[78] More precisely, "[i]t is essentially a *multi-disciplinary process* where different skills and disciplines are brought together in risk problem solving."[79] Typically, risk management becomes necessary when a company, organization, or person is concerned about a particular risk.[80] Managing risk for a company is an "all-embracing task."[81] Using a top-down approach, risk management teams are structured with a single risk manager who acts as a chief executive and, through his team, makes the ultimate management decisions for the company.[82]

B. How do Risk Managers Manage Risk?

Risk managers' jobs include recognizing risks, implementing plans to control risks, and monitoring risks so that their managing strategies are successful.[83] The ultimate goal is to identify and assess the risks and reduce the chances of negative consequences.[84] Evaluation and measurement consist of the risk manager using the assessment to estimate the probability and possible severity of the risk occurrence.[85] During this process, the manager attempts to develop a plan to mitigate the risk.[86] Finally, once a plan is in place, the manager attempts to control and monitor the risk.[87]

The specific risk management approach depends on the risk involved. Many organizations manage risk. The government manages

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76. MOSS, *supra* note 8, at 1.

77. Darwin B. Close, *Teaching Principles of Insurance and Risk by the Contract Method*, 41 J. OF RISK & INS. 719 (1974) (explaining the risk calculus involved in managing risk).

78. BANNISTER, *supra* note 10, at 2, 285.

79. *Id.* at 2 (emphasis added).

80. *See id.* (noting that the precise reason for risk management is often dependent on the company, but the ultimate goal is to reduce risk).

81. *Id.*

82. *Id.*

83. For a compendium of risk management strategies employed, including an analysis of risk management's major tasks, see BANNISTER, *supra* note 10, at 1–25, 277–92.

84. Joseph V. Rodricks, *Evaluating Disease Causation in Humans Exposed to Toxic Substances*, 14 J.L. & POL'Y 39, 54–55 n.40 (2006). "[R]isk assessors' goal is to reduce risks to acceptably low levels, the technical definition of safe levels." *Id.* at 54.

85. *See* Bannister, *supra* note 10, at 1–22.

86. *Id.*

87. *Id.*

public risks, such as nuclear power plants, dangerous products, and public health risks like pollution.[88] Families manage private risks, such as finances.[89] Although the specific risks are different, the management approach is often the same.[90]

For example, a corporate risk manager's first task is to identify and assess the risk by preparing a risk profile.[91] A risk profile analyzes a company's risk position in order to identify the possible financial, legal, and political exposures.[92] Next, during the evaluation stage, the risk manager formulates a series of key risk management objectives and conducts an audit of present risk management capability.[93] For example, if a car manufacturer is worried about a safety hazard, it might implement a recall plan in order to avoid a loss. Finally, during the control stage, the risk manager defines the responsibilities of the management team members, trains those involved in risk management, and establishes a system for monitoring the effectiveness of the risk management plan.[94]

C. *What Qualities do Successful Risk Managers Have?*

Successful risk managers possess several qualities, including patience, an open mind, a willingness to address problems, an understanding personality, the ability to be friendly but firm, and the ability to quickly learn and digest important information.[95] Risk management systems analysts note that these qualities typically manifest themselves in the form of superior understanding, practical ability, and communication skills.[96] Risk managers must balance these skills

88. *See generally* MOSS, *supra* note 8 (evaluating how different government entities manage risk).

89. *Id.*

90. *Id. See generally* BANNISTER, *supra* note 10.

91. BANNISTER, *supra* note 10, at 286 (analyzing the factors involved in managing risk for a company).

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.* at 23.

96. *Id.* at 21–23 (detailing the "value added" qualities successful risk managers have). Consider one commentator's analysis of what these attributes mean in the context of risk management:

> Superior understanding is likely to come from more careful analysis and particular multidisciplinary or many-sided analysis. Often it replaces a dogmatic one-sided view by a more perceptive examination of why risks are not seen in advance. It may be due to over-familiarity or lack of broader vision. The missing factor is often, but not always, an understanding of human behavior.
>
> Superior practical ability will come from various sources. It can be either through study, or from looking at the problem in various circumstances and from various view-

with realistic potential costs and benefits.[97] Regardless of whether one manages a public or private risk, risk managers rely heavily on meticulous, patient investigation and research in order to understand the risk and why it exists.[98]

D. Risk Management of Patients with Suicidal Ideations

This Part evaluates the manner in which clinical psychiatrists manage the risk of suicidal patients who warrant inpatient treatment. Typically, "[s]uicidal behaviors are behaviors that are correlated with a range of psychiatric, psychological, biological, social, and cognitive disorders and dysfunctions."[99] Suicidal patients often suffer from Axis I-IV mental disorders.[100] Thus, analyzing how doctors manage suicidal patients provides a useful comparison point for evaluating mental health courts.[101]

In *Risk Management with Suicidal Patients*, the authors analyzed how clinicians manage risk when treating suicidal patients.[102] Managing this risk is challenging, because suicidal behavior is often not only based on mental illness, but is coupled with "impulsive, irrational, unpredictable, situationally based, reactive, reactionary, or opportunistic" behavior.[103] As a result, the clinician's goal is to reasonably

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points. It might result from wider or more varied experience and especially from lots of practice in different circumstances.

Superior communication skills are likely to result from the ability to feel about the problem like the person being taught, the effective use of example and illustration and lively and interesting presentation.

Id. at 21–22.

97. BANNISTER, *supra* note 10, at 22.

98. *See id.* (chronicling the diverse approaches private risk managers must employ); MOSS, *supra* note 8 (explaining the diverse tasks public risk managers must complete in order to be successful).

99. Morton M. Silverman et al., *Inpatient Standards of Care and the Suicidal Patient: Part II, An Integration with Clinical Risk Management*, *in* RISK MANAGEMENT WITH SUICIDAL PATIENTS 94 (Bruce Bongar et al. eds., 1998).

100. Andrew Edmund Slaby, *Outpatient Management of Suicidal Patients*, *in* RISK MANAGEMENT WITH SUICIDAL PATIENTS 34–36 (Bruce Bongar et al. eds., 1998) (noting that suicidal persons often suffer from depression, chemical imbalance, and schizophrenia). The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association provides criteria and a classification system for diagnosing mentally ill individuals into Axis levels. Axis I consists of clinical disorders, such as schizophrenia, major depression, substance-related disorders, and anxiety disorders; Axis II disorders consist of mental retardation and personality disorders; Axis III consists of general medical conditions; and Axis IV consists of psychological and environmental problems. *See* The Diagnostic and Statistical Manual of Mental Disorders, *available at* http://dsmivtr.org (last visited July 25, 2007).

101. In some respects, persons with suicidal thoughts reflect the most serious dimension of mental illness, because they are on the brink of taking their own lives.

102. Silverman, *supra* note 99, at 106.

103. *See id.*

reduce the risk of suicidal behavior.[104] When administering inpatient treatment, the doctor makes an assessment, implements a treatment plan, and monitors patients.[105] "At every point in the clinical assessment, treatment and management of a suicidal inpatient, the clinician is faced with risk management decisions, beginning with the initial decision to hospitalize the patient."[106]

Clinicians working in inpatient settings with suicidal patients use four principles to guide their risk management efforts: "(1) attention to therapeutic alliance; (2) regular assessment of the patient's competencies and capabilities for cooperation and collaboration with the treatment plan; (3) consultation with other clinicians and specialists; and (4) documentation of significant information and decisions in the patient's record."[107] Treatment involves the collaboration of the treatment team—the clinician, hospital staff, and hospital administration.

1. Assessment

In addition to thorough evaluations of suicidal patients, clinical assessment is based on prior experience, knowledge, and training.[108] In order to classify mentally ill individuals into Axis levels, doctors must master and correctly apply the criteria derived from the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.[109] Clinicians perform assessments by relying on clinical experience, facts, observations, and secondary information.[110] Clinicians thoroughly review patients' histories and determine whether they present a suicide risk.[111] Because treating suicidal patients is highly individualized and the circumstances behind suicidal ideations are unique to the individual, clinicians do not rely heavily on actuarial assessments. After evaluating subjective and objective criteria, clinicians assess risks based on "the foreseeability of the patient's course of behavior or disorder. The clinical decision itself is a mediating variable, having both its own set of consequences (which are not always foreseeable or predictable) and a consequent effect on the pa-

104. *See id.*

105. *See id.* at 89.

106. *Id.*

107. *See id.* at 105.

108. Silverman, *supra* note 99, at 106.

109. Wendy L. Packman & Eric A. Harris, *Legal Issues and Risk Management in Suicidal Patients*, *in* RISK MANAGEMENT WITH SUICIDAL PATIENTS 166–67 (Bruce Bongar et al. eds., 1998).

110. *See* Silverman, *supra* note 99, at 88.

111. *See* Packman & Harris, *supra* note 109, at 166. The fact that the patient is in the hospital as opposed to receiving outpatient care means the risk factors are higher.

tient's behavior and prognosis."[112] The clinician's role is dynamic, because treatment decisions are constantly reviewed, adjusted, and recalibrated depending on the increase or decrease in the risk posed by a suicidal patient.[113]

2. *Implementing Treatment*

In the implementation of a treatment plan, patient care decisions are routinely discussed with stakeholders, such as consultants and hospital staff, the patient's support network (family and friends), and the patient. The implementation of a treatment plan is based on "relative risk"—a statistical term traditionally used by epidemiologists to determine the degree to which an individual is at risk to express a particular disorder or dysfunction relative to another person.[114] In the context of suicidal patients, relative risk is the end product of evaluating factors such as prior history of suicidal behavior, the presence or absence of a major psychiatric disorder, positive or negative response to psychotropic medication, the degree of social support and therapeutic alliance established with primary health care providers, and level of behavioral interaction observed on the unit.[115] Clinicians evaluate the risk factors of a patient throughout the treatment process.[116]

3. *Monitoring*

Through hospital staff and other stakeholders, clinicians monitor patients' behaviors to determine if the risk of suicide has subsided or stabilized enough to decrease restrictions or issue a release. In the last step of the monitoring process, the hospital communicates that it trusts the patient enough to manage his own thoughts, feelings, and affairs.[117] The risk management goal in this setting is to effectuate a long-term and stable therapeutic result: "[r]estoring a patient's sense of well-being, self-esteem, self-confidence, and self-worth is a critical element of the therapeutic restoration achieved through an inpatient hospitalization."[118]

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112. Silverman, *supra* note 99, at 88–89.

113. *See id.* at 90 ("The care of a suicidal patient entails a constant review of the risk-benefit ratio associated with making clinical and administrative interventions.").

114. *See id.* at 93 (discussing relative risk in the context of risk management of suicidal patients).

115. *See id.* at 94.

116. *See* Packman & Harris, *supra* note 109, at 166 ("[S]uicide potential [should] be evaluated several times during treatment, including at the time of hospital admission, at the time of transfer to less restrictive wards, before home visits, and before discharge.").

117. *See* Silverman, *supra* note 99, at 99–100.

118. *Id.* at 99.

IV. MENTAL HEALTH COURTS

This Part focuses on what mental health courts are, how these courts function, and how judges perform their roles differently from traditional criminal court judges. Specifically, this Part demonstrates how mental health court judges facilitate and lead a collaborative, team-oriented approach unique to each defendant, focusing on identifying and assessing the defendant's risk, implementing a treatment plan, and monitoring the defendant's behavior.

A. What are Mental Health Courts?

Mental health courts are specialized, diversionary, and interventionist courts within the criminal justice system that seek to link mentally ill defendants with long-term treatment as an alternative to incarceration. These problem-solving courts address the underlying problems that often result in the incarceration of mentally ill offenders.[119] In addition to diverting criminal offenders from the normal criminal process, these courts attempt to improve "legitimate community participation of persons with mental illness who are brought before a criminal court through treatment, supervision, and social services."[120] This preventive model shifts focus from evaluating blameworthiness to changing the future behavior of defendants in order to avoid recidivism.[121] Mental health courts try to

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119. Judge Judith Kaye, a leading advocate of problem-solving courts, pointed out these courts' goals in succinct fashion:

> Their motivating vision is to recognize that crime is often a cycle, and their long-term goal is to end that cycle. Their primary method is to provide treatment and incentives for defendants to turn their lives around. These courts closely monitor defendants to assure compliance with court orders and treatment plans, and link defendants to outside resources—social services, health services, job training, and housing—that help offenders reclaim their future, thus potentially saving thousands of lives, and millions of dollars for state and local governments.

Judith S. Kaye, *Albany Law Review Symposium: Refinement or Reinvention, The State of Reform in New York: The Courts*, 69 ALB. L. REV. 831, 837–38 (2006).

120. Nancy Wolff & Wendy Pogorzelski, *Measuring the Effectiveness of Mental Health Courts: Challenges and Recommendations*, 11 PSYCHOL. PUB. POL'Y & L. 539, 541 (2005).

121. The following succinctly highlights the unique design of the mental health court:

> From a design perspective, the primary goal of mental health courts is to encourage treatment instead of incarceration when mental illness is expected to motivate criminal behavior. Shifting the focus of the courts from its traditional legal emphasis to issues of therapy follows the legal theory of therapeutic jurisprudence. Mental health courts, accordingly, change the nature of court proceedings by focusing on treatment and future improvements in a person's mental health and general quality of life rather than on the criminal charge and assessing the level of culpability and punishment. The guiding premise of mental health courts flows from the assumed connection between mental illness and criminal behavior.

Id. at 553, 555.

treat the mental illness that may have contributed to the criminal act.[122]

Some mental health courts only accept offenders diagnosed as having serious and persistent mental illness (SPMI, Axis I disorders), while other courts only require evidence of mental health problems, rather than a formal diagnosis.[123] Moreover, in addition to misdemeanors, some mental health courts now accept defendants charged with low-level felonies.[124] Participation in the mental health court system is voluntary.[125] Eligibility determinations are ultimately made by the judge after team members—prosecutor, defense attorney, and mental health and behavior treatment specialists—give feedback and evaluate whether the offender is a proper candidate for the pro-

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122. Bernstein & Seltzer, *supra* note 2, at 144–48. Persons with mental illness are more likely to be arrested, not because they necessarily commit more crimes, but because they are a likely target of profiling by the police. Although such targeting by law enforcement is unjustified, the ramifications of such profiling are beyond the scope of this Article. However, given that mentally ill people are more likely to be swooped into the criminal justice system, at least mental health courts offer an opportunity to divert offenders from the traditional criminal justice process and try to address their illness. Consider one judge's assessment of the issue:

> There's a population of the mentally ill that never commit criminal offenses. That's not the population we deal with. We're dealing specifically with the population of the mentally ill that have gotten involved with the criminal justice system because they have committed a crime. Before the advent of mental health courts, that group would have simply gone to jail or state prison, and then come back again because we furnished them no treatment or chance of success. What a mental health court does is actually decriminalize the mentally ill by setting up probation terms and mental health treatment, including medication compliance, that will help them succeed in being on probation and not picking up a new criminal offense and then getting out of the system. So, in fact, we have decriminalized the population.

Interview with Judge Becky Dugan, Satellite Broadcast of Mental Health Courts, Ctr. for Court Innovation (Nov. 14, 2002), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/transcript.pdf. Regardless of whether the mentally ill are profiled, scholars note that offenders with a mental illness frequently "commit violent crimes after release. Of repeat offenders, 53% of state inmates with a mental illness had a current or past sentence for a violent crime, compared to 45% of those inmates without a mental illness. The comparison among state jailed inmates is 46% to 32%, and among federal prisoners, it is 44% to 22%." Kosak, *supra* note 35, at 398–99; *see also* Ditton, *supra* note 3, at 5.

123. *See* Redlich, *supra* note 3, at 607 (noting the variety of approaches mental health courts take regarding the type of mental illness or problem permitted to qualify); *see generally Emerging Judicial Strategies*, *supra* note 23 (describing four different mental health courts' approaches toward what qualifies as a mental illness).

124. *See* Redlich, *supra* note 3, at 607.

125. There is great debate regarding whether one facing a conviction or who needs to plead guilty in order to be a part of the program is engaging in a "voluntary" decision. *See* Stefan & Winick, *supra* note 11, at 520–23. Although this is an important issue, it is beyond the scope of this Article. The author does point out that the alternative to entering the mental health court is to enter the normal criminal process, where the mentally ill are likely to remain untreated or undiagnosed.

gram.[126] Generally, participants enter the program three different ways: (1) under an agreement, whereby the prosecution agrees to defer prosecuting the case pending treatment (prejudgment plea); (2) a plea agreement is reached, but disposition or sentencing is deferred pending treatment; or (3) a plea occurs, and the mental health court treatment is a condition of probation.[127]

Bruce Winick, one of the leading advocates of therapeutic interventions in specialty courts, described the holistic approach taken by mental health courts as follows:

> All mental health courts represent a multiagency and systemwide response to the problem of untreated mental illness. The process is designed to motivate the individual to accept needed mental health treatment and to encourage and monitor treatment compliance. The judge and the members of the treatment team often play a social work function in linking the individual to treatment resources and facilitating their utilization and the individual's ongoing participation.[128]

In its ideal form, a mental health court is driven and coordinated by community resources, mental health services, public sentiment, and a criminal court system all working together.[129] These independent and interdependent factors all play a role in the court's growth and development.[130]

Although mental health courts are a recent development, distinctions are emerging between first (1998–2003) and second (2003–present) generation courts.[131] In particular, mental health courts have changed in four ways: (1) they are increasingly willing to accept felony cases in addition to misdemeanor cases (and sometimes violent felony cases as well); (2) the point of entry into mental health courts is increasingly post-plea as opposed to pre-plea; (3) courts increasingly

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126. *See* Lisa Shoaf, *A Case Study of the Akron Mental Health Court*, 32 CAP. U. L. REV. 975, 976–86 (2004); Wolff & Pogorzelski, *supra* note 120, at 541–42; *Emerging Judicial Strategies*, *supra* note 23, at 15–60.

127. Redlich, *supra* note 3, at 607–08. Under the last scenario, the jail sentence is often suspended pending successful completion of the treatment program. *Id.*; *see also Emerging Judicial Strategies*, *supra* note 23.

128. Stefan & Winick, *supra* note 11, at 52.

129. Wolff & Pogorzelski, *supra* note 120, at 541–42 (noting the multiagency and systemwide approach to mental health courts).

130. *See id.* at 542.

131. *See* Allison D. Redlich et al., *The Second Generation of Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 527 (2005) (conducting an evaluation of first and second generation mental health courts based on available empirical data).

use imprisonment as a sanction; and (4) community health personnel increasingly oversee adjudication.[132]

B. The Role of the Judge

1. The Judge's First Task: Identifying and Assessing Risk

Mental health courts attempt to improve psychiatric stability and public safety by decreasing the risk that a mentally ill defendant will commit a crime or harm himself.[133] With the help of the treatment team, the judge first assesses whether the offender qualifies for the program (that is, the individual has a mental illness for which treatment is appropriate) and whether the person presents a high risk of harm to himself or others if released into the community.

Courts use two traditional models that assess the risk of violence or future dangerousness among suspect populations. In the clinical prediction model, a clinical professional uses his skill and experience to predict future behavior.[134] The accuracy of clinical prediction has been called into question in recent years. John Monahan, one of the leading advocates for actuarial assessments of future dangerousness, reviewed the literature on clinical predictions of future dangerousness in civil commitment proceedings and concluded that clinicians were accurate only one out of three times.[135] Some of the main criticisms of

132. *Id.* at 535. Jail is increasingly used as a "wake up call" for medical detoxification, for repeated criminal offenses, and for repeated noncompliance.

133. "My job is to balance their needs against public safety and if they're not doing what they're supposed to be doing or if there's the possibility of jeopardizing the public safety, then I have no choice but to act." Interview with Judge Matthew J. D'Emic, Brooklyn Mental Health Court, Ctr. for Court Innovation (June 2004), *available at* http://www.courtinnovation.org/index.cfm?fuseaction=Document.viewDocument&documentID=554&documentTopicID=25&documentTypeID=8. Fears concerning mentally ill people are driven by perceived and actual concerns about mentally ill offenders. Media accounts and entertainment industry portrayals of mentally ill offenders as violent and dangerous have fueled perceived fears about mentally ill people. However, the leading research on violence and mental illness, sponsored by the MacArthur Foundation, indicated that, "in the absence of drug or alcohol abuse, people discharged from psychiatric hospitals are no more likely to be violent than those without mental illness." Fisler, *supra* note 48, at 588.

134. *See* Bruce J. Winick, *Applying the Law Therapeutically in Domestic Violence Cases*, 69 UMKC L. REV. 33, 47–49 (2000) (describing the clinical prediction model).

135. JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 47–49 (1978) (noting these findings); *but see* Douglas Mossman, *Assessing Predictions of Violence: Being Accurate About Accuracy*, 62 J. CONSULTING & CLINICAL PSYCHOL. 783, 788–90 (1994) (reanalyzing over fifty data sets and demonstrating that clinical predictions generally exceeded chance, but errors are inevitable and past behavior is the best prediction of future violent conduct.). It appears Monahan himself softened his position on clinical prediction. *Cf.* John Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM J. PSYCHIATRY 10, 11 (1984) (indicating that, based on new research that used more sophisticated methodology, predictions of dangerousness made by mental health professionals are accurate closer to 50% of the time); *see also* Christopher Slobogin, *The Civilization of the Criminal Law*, 58 VAND. L. REV.

risk assessment by clinical prediction models are that they are subjective, "dichotomous—the individual is determined to be either dangerous or not—and static—involving a onetime prediction based upon factors existing at the time the prediction is made."[136]

Assessment using an actuarial model is an increasingly prevalent alternate approach in decisions regarding parole release, prison custody, and sexually violent predators.[137] Relying less on clinical predictions and intuitive judgments, actuarial models identify risk factors and weigh them accordingly. Judges use empirically-derived criteria based upon research regarding the degree to which potential risk factors correlate with future violence.[138] Scholars often criticize violence prediction instruments as inflexible and "not . . . sufficiently reliable and accurate to justify . . . deprivations of liberty, at least without additional and more individualized evidence concerning the person."[139] In between these two models is a series of hybrid approaches that attempt to combine actuarial and clinical prediction.[140]

Mental health courts have a unique, clinically-based risk management model that is routinely updated and altered and relies on dynamic assessment.[141] Given the highly individualized nature of mental illness, many mental health courts favor a type of clinical model that has multiple checks as opposed to heavy reliance on actuarial factors. Typically, the treatment team conducts a psychiatric evaluation and psychosocial assessment of each offender.[142] Both the social worker and psychiatrist evaluate the offender and provide a comprehensive report to the judge, prosecutor, and defense attorney. These reports consist of the offender's social and psychiatric history, family, commu-

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121, 144–45 (2005) ("[Monahan] also noted that any estimates of predictive accuracy are likely to be skewed downward by the fact that the research on which they are based almost always uses samples of people who are immediately institutionalized after a positive prediction, thus making impossible observation of their actions had they been left alone, which is the true test of the prediction.").

136. *See* Winick, *supra* note 134, at 47.

137. *Id.* For further discussion, see generally DAVID L. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY (1997).

138. *See* Winick, *supra* note 134, at 47–49.

139. *Id.* at 50 n.87. For a critical evaluation of actuarial approaches, see GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 284–93 (2d ed. 1998).

140. For a review of the hybrid approaches, see Winick, *supra* note 134, at 50–52.

141. "The interactive procedures of dynamic risk management, court review, supervision and coordination of resources all fit together in new court review processes which [sic] utilizes the judge in a new way to achieve favorable outcomes and meet the expectations of the community for their judicial system." JUDGING IN A THERAPEUTIC KEY, *supra* note 19, at 122 (quoting mental health court Judge Randal Fritzler).

142. *See* Fisler, *supra* note 48, at 594–95 (describing in detail the assessment process for Brooklyn's Mental Health Court).

nity ties, treatment needs, and an assessment of the risk of future violence. Many treatment teams are also trained in "violence risk assessment schemes," which rely on actuarial factors.[143] Although research indicates that actuarial methods are superior to clinical methods in predicting violence,[144] many treatment teams do not rely upon actuarial assessment models because of the "numerous and complex mechanisms in place for managing risks" and because, until recently, only misdemeanor offenders were eligible for mental health courts.[145]

Unlike many traditional clinical prediction models, mental health courts routinely alter their treatment plans based on close monitoring and reevaluation of the offender's progress. It is not a one-time assessment by the judge.[146] As one judge noted, "[e]ach defendant has an individual criminal history but also an individual diagnostic profile and a different set of needs, and [the judge has] to be ethical in matching up a person's exposure in a criminal case and the price of that particular criminal action."[147] Thus, unlike traditional clinical models, this "dynamic, interactive scheme" allows judges to continually monitor and guide individuals through therapeutic rehabilitation.[148] Regularly scheduled review allows mental health courts to monitor the dynamic process and make changes "to a person's treatment, supervision and restrictions based upon dynamic factors that reflect increasing [or decreasing] dangerousness."[149]

2. *The Judge's Second Task: Implementing a Treatment Plan*

Risk managers typically move from risk identification and assessment to risk evaluation with the goal of implementing a plan.[150] In

143. *Id.* at 595 n.4.

144. *See supra* note 135 and accompanying text.

145. *Id.* Fisler noted that the complex mechanisms include close monitoring and a coordinated approach of the team members, including not just a psychiatrist, but a behavioral specialist, case manager, and others all working to intervene in a multi-systemic manner, not only to improve the individual's mental health, but also his overall life conditions. *See id.* at 595–96.

146. *See* JUDGING IN A THERAPEUTIC KEY, *supra* note 19, at 122; *see also* Fisler, *supra* note 48, at 595 n.4. Fisler noted that mental health courts de-emphasize actuarial assessment tools because of likely delay and because "any potential decrease in the court's ability to predict violence would be more than compensated for by the numerous and complex mechanisms in place" such as comprehensive coordination, planning, collaboration, flexible alteration of treatment, and monitoring "for managing risks presented by individual offenders." *Id.*

147. Interview with Judge Stephanie Rhoades, Anchorage Mental Health Court, Ctr. for Court Innovation (May 2006), *available at* http://www.courtinnovation.org/index.cfm?fuseaction=Document.viewDocument&documentID=722&documentTopicID=25&documentTypeID=8 [hereinafter Rhoades Interview].

148. *See* JUDGING IN A THERAPEUTIC KEY, *supra* note 19, at 122 (interview with mental health court Judge Randal B. Fritzler noting the dynamic interactive scheme).

149. *Id.*

150. *See supra* Part III.

the mental health court context, the judge's task, with the assistance of the treatment team, is to establish a highly individualized treatment plan for the offender.[151] The treatment plan maintains the following risk-benefit assessment goals at all times: (1) healing and achieving psychiatric stability; (2) reducing the likelihood of recidivism; and (3) protecting public safety.[152] The treatment plans are individualized and comprehensive: "[e]ach plan identifies mental health treatment, substance abuse treatment, case management, education, and employment services that address the offender's specific clinical needs as well as the public safety requirements articulated by the judge."[153]

Going from risk identification to treatment implementation in an effective manner is essential. According to one mental health court judge:

> If you don't have treatments to divert people to, then you really can't operate a successful program. A mental health court is in and of itself a therapeutic intervention but it's only one component of what needs to be an overall multidisciplinary approach, and if you have treatment that's inappropriate or not a good match, then it's set up for the person to fail.[154]

Judges often develop individualized treatment plans early in the court process. These plans require offenders to take their medication and attend therapy.[155] Other requirements center on normalizing defendants' daily behaviors and routines. Treatment plans include requirements such as "desisting criminal behaviors, attending scheduled court review hearings, meeting with vocational training officers, finding and maintaining employment, and following more idiosyncratic mandates (for example, physical exercise, keeping one's home clean, or moving from a certain location)."[156]

Mental health courts use a collaborative, nonadversarial team comprised of the judge, prosecutor, defense attorney, and mental and behavioral health specialists to establish direct links to the mental health

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151. "It requires that the treatment team adequately first assess and then fully accept the client's potential capacity so that we don't form expectations that exceed the person's capacity when they're maximally functioning." Interview with Dr. Keram, Satellite Broadcast of Mental Health Courts, Ctr. for Court Innovation (Nov. 14, 2002), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/transcript.pdf [hereinafter Keram Interview].

152. *See* Fisler, *supra* note 48, at 595 ("Each treatment plan is designed to maximize the likelihood that a particular offender will be engaged in treatment, achieve psychiatric stability, and avoid crime.").

153. *Id.* at 595.

154. Rhoades Interview, *supra* note 147.

155. *Id.* Offenders sometimes enter into behavioral contracts with the court.

156. Redlich, *supra* note 3, at 607.

system.[157] The judge and the treatment team are often trained and have experience working with mentally ill individuals.[158] In particular, community and health agencies linked to courts provide pathways to assist offenders by offering such services as day treatment programs, individual therapy, intensive psychiatric rehabilitation programs, psychosocial clubs, and assertive community treatment teams.[159] The judge attempts to address the underlying problems leading to criminal acts and structure plans that can improve offenders' social conditions:

> The treatment plan really rests on two foundations that have to be solid. One is having an accurate diagnostic assessment, because if you don't get the problem right, you're not going to get the treatment plan right. . . . The second foundation is that the person who's doing your assessment and the team that's doing the treating have experience to deal with the problem that's been identified. . . . Once you have a sense of what his diagnosis is or the diagnoses are, a treatment plan is going to involve lots and lots of different pieces. You need to treat the entire environment that this person lives in, making sure that they have a roof over their head in which they're not likely to become noncompliant.[160]

Because studies show that the risk of violence by people suffering from co-occurring disorders (for example, drug or alcohol abuse and mental illness) is dramatically higher, specialists attempt to treat both disorders concurrently.[161]

3. *The Judge's Third Task: Monitoring the Risk*

The judge's final task is to mandate and monitor community mental health treatment.[162] The intensity of monitoring often depends on the

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157. Shoaf, *supra* note 126, at 976–86; Redlich, *supra* note 3, at 607–08; Wolff & Pogorzelski, *supra* note 120, at 541–42.

158. The team is expected to be trained in "basic mental disorders, medications and side effects, what a psychiatric assessment is, what a neuro-psychiatric assessment is, what kind of treatment is available in your community, why individuals with one diagnosis get hooked up with one place and individuals with another diagnosis get hooked up with another place, and what the funding mechanisms are for these things." Rhoades Interview, *supra* note 147.

159. Fisler, *supra* note 48, at 596–97 (noting the variety of treatment alternatives and the fact that mental health courts often communicate with the treatment provider weekly and receive written reports monthly).

160. Keram Interview, *supra* note 151, at 6.

161. *See* Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES OF GEN. PSYCHIATRY 393–401 (noting that offenders suffering from co-occurring disorders are more likely to engage in violent behavior); Denckla & Berman, *supra* note 2, at 16.

162. Redlich, *supra* note 3, at 607–08 ("[A]ll MHCs mandate and monitor community mental health treatment.").

defendant's condition.[163] The goal is to ensure that defendants stay involved in community treatment by attending therapy sessions, taking medications, and following treatment plans. Thus, monitoring is always done with the goal of controlling risk. One mental health judge described the process as follows:

> The judge has to be on top of it. You have to see these people every week, and make sure that nothing bad happens. Someone from the court has to be in touch with their programs—to make sure that they're there, that they're doing what they're supposed to be doing, that they're taking their medications. Again, public safety is a huge part of this. The mental health court is labor-intensive, and the focus is to keep people in treatment and out of jail. These are people who are out in the community and you have to make sure that everybody's safe. It just takes time and effort.[164]

Treatment specialists, court monitors, and specialized probation officers work with treatment providers and keep judges informed.[165] Under this model of therapeutic jurisprudence, judges recognize small and large successes and often engage in a carrot-and-stick approach that involves public praise and shaming where appropriate.[166] The variety of responses include "[p]raise, certificates, admonitions, increased or decreased frequency of court appearances, and imposition or lifting of restrictions on activities."[167] More importantly, through frequent interaction, judges develop relationships with offenders. Consequently, judges' disappointment or anger can be powerful motivating forces.[168] Through continued interaction, judges are able to foster therapeutic alliances built on trust and mutual respect.[169]

Judges hold hearings weekly, bi-weekly, monthly, or even quarterly and typically include all team members.[170] To the extent offenders maintain stability, they can graduate from mental health courts. At that point, the charges are usually either dropped (pre-plea), or the

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163. *See id.* at 607.

164. Interview with Judge Matthew J. D'Emic, Brooklyn Mental Health Court, Ctr. for Court Innovation (June 2004), *available at* http://www.courtinnovation.org/index.cfm?fuseaction=Document.viewDocument&document=554&documentTopicID=25&documentTypeID=8.

165. *Id.*

166. The rewards and sanctions administered often vary from court to court. Examples of sanctions include the following: (1) increased frequency of hearings; (2) reprimands and admonishments; (3) threatened jail time; (4) actual jail time; or (5) termination from the program. Shoaf, *supra* note 126, at 976–86. Some rewards include praise from the judge and team members in court, changes in treatment requirements, and tangible gifts, such as gift certificates. *Id.*

167. Fisler, *supra* note 48, at 597.

168. *Id.*

169. *See* Winick, *supra* note 134, at 57–60 (describing the therapeutic impact judges can have on domestic violence offenders when mutual trust is built).

170. Redlich, *supra* note 3, at 608.

convictions are vacated or expunged (post-plea).[171] If an offender does not comply, he may be dismissed from the mental health court and returned to regular criminal court.[172] Given the instability of many participants, "nonadherence is common and expected."[173] As a result, mental health court judges must be patient, willing to issue graduated sanctions, and able to remain realistic in setting measurable and attainable goals.[174]

V. MENTAL HEALTH COURT JUDGES AS DYNAMIC RISK MANAGERS

Although not typically recognized as a judiciary function, risk management constitutes a fundamental method by which mental health court judges dynamically solve problems. Judge Randal B. Fritzler aptly encapsulated the phenomenon in one sentence: "The basic functions involved in dynamic risk management are not new to the court system but the application and focus [in mental health courts] is revolutionary."[175] Mental health court judges do not merely process cases or act as neutral arbiters. Mental health court judges manage risk. This Part explains why mental health court judges are dynamic risk managers, paying careful attention to how these judges understand and conceive of their own role and how mental health court judges' approaches parallel the traditional risk management approaches highlighted in Part III.[176]

A. Mental Health Court Judges: Dynamic Risk Managers

In partnership with mental health court teams, judges perform three tasks: (1) conduct risk assessments in which they evaluate defendants' potential harm to themselves or the public, (2) evaluate and implement treatment plans designed to minimize defendants' risk and heal them, and (3) monitor risks over a period of time, often requiring frequent return visits. One judge summarized the process as follows: "You've got to have very good assessments, treatment placements, and monitoring done by both mental health and drug and alcohol spe-

171. *Id.*; *see also* Patricia A. Griffin et al., *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVICES 1285 (2002).

172. Redlich, *supra* note 3, at 608.

173. *Id.*

174. *Id.* ("[I]t should be noted that perfect performance is not expected in [mental health courts]. As such, a hierarchy of sanctions is in place with jail usually as a later option when other penalties have failed. Thus, although most [mental health courts] have lenient policies regarding noncompliance, all courts have mechanisms in place to counter nonadherence to mandates.").

175. JUDGING IN A THERAPEUTIC KEY, *supra* note 19, at 121 (interview with Randal Fritzler).

176. *See supra* notes 73–118 and accompanying text.

cialists. . . . That's where the judge can be an agent of change."[177] Judges facilitate a flexible, collaborative, and team-oriented approach in order to tailor the intervention and treatment of defendants toward healing them and ending the revolving door phenomenon. Although mental health court judges occasionally rely on actuarial tools, particularly regarding the potential for violence, most make clinical judgments based on the opinions of expert team members. Unlike the traditional clinical model, judges behave dynamically by continually interacting with offenders and altering treatment plans to effectuate positive outcomes.

Mental health court judges' approaches are similar to that of risk managers. For example, risk managers view risk factors in context, rather than as isolated events and, therefore, try to effectuate a systematic change to protect and lower an institution's risk.[178] Risk managers conduct individualized interventions based on the need to deal with specific risk factors.[179] Risk managers constantly monitor risks until they are low enough that such regulation is unnecessary.[180] By engaging in a flexible, dynamic approach, risk managers constantly recalibrate risk and modify their plans.[181] Finally, a successful risk management program often reduces costs to the company or entity.[182]

Similarly, mental health court judges apply a prevention model that treats the crime and, more importantly, the mental illness in context and not as an isolated event or the result of individuals' irresponsible actions.[183] Mental health court judges apply a highly individualized clinical assessment that constantly evaluates risk factors and the offenders' conditions.[184] They monitor offenders through the treatment team and repeated appearances in court until graduation is appropriate.[185] Additionally, as successful risk management programs are more economical for corporate entities, graduation from mental

177. Interview with Judge Stephen Manley, Mental Health Treatment Court, Santa Clara County, Ctr. for Court Innovation (Jan. 2005), *available at* http://courtinnovation.org/index.cfm?fuseaction=Document.viewDocument&documentID=618&documentTopicID=25&documentTypeID=8.

178. *See supra* Part III.A-D.

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *See supra* Part IV.

184. *Id.*

185. *Id.*

health courts saves the state money in the long-term when compared to the cost of cycling offenders through jails or prisons.[186]

B. *Mental Health Court Judges Possess Risk Management Qualities*

When properly employing the therapeutic and problem-solving approach, mental health court judges possess the same qualities as successful risk managers: understanding, practical abilities and communication skills.[187] The judge's role in the mental health court is particularly illuminating, because the judge takes on many non-traditional duties. Consider one commentator's evaluation of the mental health court in Akron, Ohio:

> The judge is viewed by most of the mental health court team as the single most important character in the mental health court. Team members and other municipal court judges interviewed expressed that while the judge's position of authority certainly impacts what gets accomplished by the court, it is the judge's philosophy of therapeutic jurisprudence combined with her outgoing personality that truly makes the court a success. *An effective mental health court judge was described as one who needs to be able to look beyond the crime at the underlying issues, and who has to believe in the program and to have a willingness to learn, the capacity to be stern, yet compassionate, and the desire to do the job for little in return, other than personal satisfaction.* The role of the judge is different from the traditional, 'adversarial' figure common to most courtrooms. The judge's role is to determine, with the help of the treatment team, who is eligible for the program, and to oversee involvement in the program by requiring the client to appear in court on a frequent basis. While the judge does deliver sanctions (which vary in intensity depending on the infraction committed) for noncompliant behavior while a person is in the program, she also delivers rewards for good behavior and for successful completion of phases in the program.[188]

Mental health court judges must also exude the qualities of successful risk managers—an "open mind," a willingness to get "to the heart of

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186. Interview with Judge Stephen Manley, Satellite Broadcast of Mental Health Courts, Ctr. for Court Innovation, at 4–5 (Nov. 14, 2002), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/transcript.pdf ("By keeping these clients out of jail, by cutting down on the recidivism rate, by producing clients that are taking their medications and are staying in treatment, you are saving and avoiding cost to the county."); Slobogin, *supra* note 135, at 156 (noting that drug courts and other multi-systemic therapy models are far cheaper than putting individuals in jail or prison); *see* M. Susan Ridgely et al., *Justice, Treatment and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court* (2007), *available at* http://www.rand.org/pubs/technical_reports/TR439/ (recent RAND study indicating that mental health courts have the potential to save taxpayers money).

187. *See supra* Part III.C.

188. Shoaf, *supra* note 120, at 980–81 (emphasis added).

the problem," and "a mixture of firmness and fairness."[189] Part III discussed the importance of these skills for risk managers, but also emphasized that good risk managers are realistic about the risk-reduction goals they seek to achieve.[190] Similarly, mental health judges often begin with small goals for offenders, because they may be unstable.[191]

C. *The Parallels Between Managing the Risks of Mentally Ill Criminal Offenders and Suicidal Patients*

Mental health courts parallel modern hospital disease management.[192] For example, the therapeutic alliances involved in managing suicidal patients and mentally ill defendants are nearly identical. There are several correlations between mental health court judges and psychiatrists. Doctors' goals are to address patients' needs and de-

189. *See supra* Part III.C.

190. *Id.*

191. Mental Health Court Judge Patrick Morris noted that expectations for mentally ill patients are lower than drug offenders:

> Well, for those of you who have drug court experience, throw away the charts. This is a new and different population, and the definition must be broadened substantially. In drug court, we require employment. We require schooling. We require drug-free living. We require NAs. We require a sponsor. In mental health court, we start with medication compliance. The first thing out of the box is, they've got to be seeing their doctor regularly and taking their meds, and they will, of course, be free from street drugs and alcohol.
>
> But the other definitions of success that we've used in drug court do not necessarily apply here. A substantial number of these folks are so low functioning that you have to reduce your level of expectations. Many are illiterate, and when you say, 'Go to school,' you may mean simply 'Go [to] the county library and be engaged in a literacy program.' What you want to do is essentially find a way to occupy them constructively in the community. Re-engage them with their family if at all possible, or a semblance of family, so that they have a support group out there and a daily activity to go to that's meaningful and constructive. And it may be as simple as a volunteer position at a homeless shelter; it may be at a school; but you look for a variety of ways to simply help them reconstruct a life that has some meaning to it, and that's about all you can do with some of these clients.

Interview with Judge Patrick Morris, Satellite Broadcast of Mental Health Courts, Ctr. for Court Innovation (Nov. 14, 2002), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/transcript.pdf.

192. This argument is not unique to mental health courts. Bruce Winick similarly argued that a domestic violence court is similar to a risk manager that applies case management and risk management approaches in order to reduce the risk of violence. Winick, *supra* note 134, at 57. Winick noted that such an approach parallels a "modern hospital practicing disease management and other forms of case management to teach patients how to manage their own illnesses, to encourage preventive approaches by patients, to increase the likelihood that patients receive appropriate medical interventions, and to decrease the risk of medical malpractice." *Id.* at 57. *See also* Shirley A. Musich et al., *Costs and Benefits of Prevention and Disease Management*, 5 DISEASE MANAGEMENT HEALTH OUTCOMES 153 (Mar. 1999) (noting how case management has grown to be a tool to measure and alter outcomes for patients and prevent illness).

crease the risk that patients will harm themselves.[193] Mental health court judges attempt to address underlying social problems, while decreasing the risk of harm to offenders and the public. Similar to doctors, mental health judges prioritize effective responses and "restor[e] a patient's sense of well-being, self-esteem, self-confidence," and ability to live safely in the community.[194] Judges, much like clinicians, foster therapeutic alliances with offenders by building relationships with them.[195] Psychiatrists' assessments are performed by examining and interviewing offenders, using the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, and consulting with the rest of the clinical team.[196] Similarly, judges, through treatment teams, rely on psychological assessments, but also continue to review new information concerning offenders while adjusting assessments.[197] Unlike models that predict dangerousness by assessing the probability of an event reoccurring, the mental health court approach attempts to reduce, manage, and reallocate risky behavior.[198] Psychiatrists also attempt to reduce the risk that a person will commit suicide. Similar to psychiatrists, judges collaborate with stakeholders and team members to develop treatment plans. The treatment of suicidal patients involves the collaboration and coordination of the clinician, hospital staff, and hospital administration.[199] Finally, both doctors and judges monitor participants directly, but also rely upon team members to monitor the participants' progress. Thus,

193. *See supra* Part III.D.

194. *Id.*

195. *Id.* "[J]udges foster therapeutic alliances with defendants by using the same techniques—empathy, acceptance, warmth, and allowance of self-expression—that therapists use with their clients." Fisler, *supra* note 48, at 597.

196. *See supra* Part III.D. Risk management in this context involves a cooperative, dynamic, and flexible process of continual risk assessment and treatment:

> Clinical risk management and clinical judgment are based on current clinical data, past data, experience, basic knowledge, a working relationship with the patient, an awareness of the milieu in which the therapy is being conducted, the physical environment of the inpatient unit, the evolving psychiatric disorder that has contributed to the patient's suicidal state, the degree of social and familial support available to the patient, the psychological/cognitive level of the patient, and the behavioral assessment of the patient. All of these data must be understood in terms of an evolving system that is undergoing change due to the therapeutic process, the effects of medication, and the benefits of being in a therapeutic inpatient milieu.

Silverman, *supra* note 99, at 102.

197. Although judges do not have a tool as sophisticated as the Diagnostic and Statistical Manual of Mental Disorders at their disposal, they rely on mental health treatment specialists' assessments.

198. *See* R. Karl Hanson, *What Do We Know About Sex Offender Risk Assessment?*, 4 PSYCHOL. PUB. POL'Y & L. 50, 58–60 (1998) (distinguishing static and dynamic factors and their importance in predicting recidivism and the effectiveness of treatment interventions).

199. *See supra* Part III.D.

therapeutic goals blend well with the risk management approaches that mental health court judges use.

VI. How Dynamic Risk Management Affects the Criminal Process

This Part addresses how the idea of judges as dynamic risk managers fits within scholars' understanding of the current criminal process and the role of judges within that process.[200] Specifically, this Part argues that mental health court judges are morphing into a hybrid social worker and probation officer.[201] Moreover, this Part asserts that, when functioning in its ideal form, mental health courts fall outside the "new penology," which focuses on managing dangerous categories of people, because the focus in these courts is on individuals, not groups.[202] Thus, to the extent that mental health court judges focus on individualized assessment and treatment, there is potential for the criminal process to focus more on therapeutic healing and less on punishment.

A. *The Dynamic Risk Managing Judge: Half Social Worker, Half Probation Officer*

The risk management tools employed by judges transform their role into a hybrid between a social worker and probation officer. Mental health court judges act as chief administrators for social service networks with authority to make initial assessments and implement treatment plans. Judges also monitor offenders and offer rewards and sanctions.

1. The Social Worker Role

As dynamic risk managers who take on a social worker role, mental health court judges are able to institute a multi-systemic approach in an effort to heal offenders. Researchers have confirmed that this model is more successful than a punitive approach:

> In general, researchers have found that programs based on fear, punishment, or psychotherapy—the bread and butter of older rehabilitation programs—are much less likely to reduce recidivism than programs 'that are highly structured and behavioral or cognitive-behavioral, that are run in the community rather than an institution, that are run with integrity and enthusiasm, that target higher-risk rather than lower-risk offenders, and that are intensive in terms of

200. *See infra* notes 203–233 and accompanying text.

201. *Id.*

202. *See supra* note 21 and accompanying text.

> number of hours and overall length of program.' For instance, 'multisystemic therapy,' which involves intense family, school, and peer-based interventions over a four-month period, can reduce recidivism among violent juveniles by as much as 75% compared to matched control groups that receive no treatment or traditional treatment in prisons. The same type of intensive, ecological treatment works well with many adult offenders. Thus, drug treatment courts that closely monitor the offender's performance in the program, as well as the program itself, typically cut drug use recidivism in half.[203]

Mental health court judges take the unique opportunity afforded by these courts to employ a multi-systemic approach toward problem-solving.[204]

Similar to the judges who used the Eighth Amendment as a jurisdictional grant of authority to attempt to reform prison conditions across the United States (especially the plantation prison model in the south),[205] judges are using mental health courts as a jurisdictional grant of authority to implement therapeutic jurisprudence, because

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203. Slobogin, *supra* note 135, at 151–52; *see also* Don Andrews, *The Psychology of Criminal Conduct and Effective Treatment*, *in* WHAT WORKS: REDUCING REOFFENDING 35, 38–41 (James McGuire ed., 1995) (analyzing criminal justice research and concluding that punitive programs are less effective in reducing recidivism than treatment programs and that "effective correctional treatment involves attention to individual differences in risk, need, and responsivity and to the use of professional discretion"); Charles M. Borduin et al., *Multisystemic Treatment of Serious Juvenile Offenders: Long-Term Prevention of Criminality and Violence*, 63 J. CONSULTING & CLINICAL PSYCHOL. 569, 573 (1995) (recidivism rate three times lower for those participating in multi-systemic therapy than those participating in traditional individual treatment); Michael C. Dorf & Charles F. Sabel, *Drug Treatment Courts and Emergent Experimentalist Government*, 53 VAND. L. REV. 831, 834, 839 (2000) ("[D]rug courts are able to determine which programs can effectively monitor the progress of individual clients, and which clients are able to take advantage of capable programs . . . [by mandating] that service providers continually inform the court about the progress (or lack thereof) of each client [and] . . . monitoring the treatment providers themselves."). Mental health courts have not been around long enough to properly evaluate whether they reduce recidivism. However, drug courts, which follow a similar approach, have been successful. *See* Duren Banks & Denise C. Gottfredson, *The Effects of Drug Treatment and Supervision on Time to Rearrest Among Drug Treatment Court Participants*, 33 J. DRUG ISSUES 385, 397 (2003) (noting a 40% recidivism rate among drug court offenders and 61% rate among control groups); Eric Blumenson, *Recovering from Drugs and the Drug War: An Achievable Public Health Alternative*, 6 J. GENDER, RACE & JUST. 225, 235 (2002) (finding that drug treatment programs "reported a dramatic decrease in criminal activity among participants").

204. *See* GREG BERMAN & JOHN FEINBLATT, GOOD COURTS: THE CASE FOR PROBLEM-SOLVING JUSTICE 35 (2004) (noting that problem-solving courts allow judges, prosecutors and public defenders to redefine their goals while simultaneously managing the risks of public safety and protecting a defendant's rights).

205. In MALCOLM M. FEELEY & EDWARD L. RUBIN, JUDICIAL POLICYMAKING AND THE MODERN STATE: HOW THE COURTS REFORMED AMERICA'S PRISONS (1998), Feeley and Rubin chronicle the judiciary's attempt to reform prison conditions, particularly in southern states. In particular, the authors show, through case histories from a number of states, how federal judges used the Eighth Amendment's cruel and unusual language as a "grant of jurisdiction" in response to the lack of reform by federal, state, and local governments. *Id.* at 171.

the health care system, community care system, and prison system have failed to address the revolving door facing mentally ill defendants. Judge Ginger Lerner-Wren of the Broward County Mental Health Court summarized this view as follows:

> We view the Mental Health Court as a 'strategy' to bring fairness to the administration of justice for persons being arrested on minor offenses who suffer from major mental disability. We have seen time and time again true successes. Persons with major psychiatric disorders and/or mental disabilities can live and thrive in the community with individualized care, treatment and community support.[206]

By serving as active case managers, creative administrators, and community leaders, mental health courts judges undertake a social worker role[207] and apply a different value system than that normally found in the criminal process.[208]

2. *The Probation Officer Role*

Judges are not only acting as social workers, but also as probation officers charged with monitoring risk and regulating behavior.[209] Instead of delegating the post-plea process to probation officers, judges use their plenary authority to impose conditions and directly monitor defendants in accordance with a treatment plan. This alters the crimi-

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206. Denckla & Berman, *supra* note 2, at 17.

207. Judith S. Kaye & Susan K. Knipps, *Judicial Response to Domestic Violence: The Case for a Problem Solving Approach*, 27 W. ST. UNIV. L. REV. 1, 12 (1999) ("These are admittedly different from traditional conceptions of the judge's role as remote and passive adjudicator. Different, but not appropriate.").

208. Judge William G. Schma summed up the value alteration that a therapeutic approach brings to the legal system:

> As David Wexler, cofounder with Bruce Winick of the school of TJ [Therapeutic Jurisprudence] has pointed out, the adversarial nature of our system has legitimate and crucial value for critical thinking. However the legal system suffers for a culture of adversarial representation and relationships, in which argument rises to the level of a privileged status. This can obscure many important societal values that the legal system need not and should not ignore, such as outcome, social harmony and the ethic of care. TJ is receiving attention precisely because it requires that we recognize such values, balance them with others and make choices. . . . Judges must take the lead and assume responsibility for these issues.

JUDGING IN A THERAPEUTIC KEY, *supra* note 19, at 91–92 (quoting William G. Schma, Judging for the New Millennium, 37 CT. REV. 4 (2000)). Rather than simply having criminal offenders serve time in prison or jail and be released into society without any curative treatment, the mental health court movement reflects the public value that mentally ill offenders should not simply be sent into a revolving door and that these risks can and should be managed.

209. *See* Kaye & Knipps, *supra* note 207, at 11 ("[M]uch of the discretion that problem solving judges exercise occurs within a sphere that is unquestionably within the purview of the courts: how to put the resources that have been allocated to us to their best and more effective use. In other words, much of this so-called 'policymaking' is nothing more than sound court administration.").

nal process, because increased active monitoring from the bench results in increased accountability by defendants entering diversion programs, such as mental health courts.[210] Judges are not passing offenders to probation officers. As Berman and Feinblatt noted in their survey of problem-solving courts:

> [U]nfortunately, probation departments have, by and large, turned out to be faulty vehicles—underresourced and overwhelmed with staggering caseloads, many probation departments have found it difficult to identify innovative interventions, to develop meaningful connections with community-based treatment providers, or to make informed decisions about which offenders require the most intensive supervision. The result has been that treatment sanctions have tended to lack teeth. Offenders have suffered few consequences unless they get arrested again.[211]

Judges, often through court psychologists, case managers, or probation officers, monitor whether defendants obtain treatment and engage in the healing process. Probation officers are now members of the team who offer feedback to the court, but do not ultimately make risk management decisions. Moreover, by requiring frequent court visits, judges are able to directly engage defendants and issue rewards or sanctions.[212] Consequently, both judges and offenders become more accountable.

B. Dynamic Risk Management Outside the Actuarial Model of Crime Management

One of the more influential statements on managing criminal categories was set forth by Malcolm Feeley and Jonathan Simon as an

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210. *See* BERMAN & FEINBLATT, *supra* note 204, at 56 (noting that problem-solving judges have subsumed the role of the probation officer and that "the resulting burden on judicial resources is not insignificant, but by requiring offenders to return to court regularly to report on their progress, problem-solving courts have markedly improved compliance"). Because the role of parole and probation officers has evolved over the past thirty-five years from that of a social worker to more of a law enforcer that parolees and probationers fear, problem-solving judges are now the institutional actors who are best positioned to balance the dual roles of social worker and enforcer, as well as ensuring that the offender remains engaged in the process. Shauhin A. Talesh, *Parole Officers and the Exclusionary Rule: Is There Any Deterrent Left?*, 31 CONN. L. REV. 1179 (1999) (describing not only how the role of parole officer has evolved into that of a law enforcer geared toward compliance and control, but how parolees increasingly fear their parole officer).

211. BERMAN & FEINBLATT, *supra* note 204, at 56.

212. For example, "a judge who orders an offender to attend drug treatment in Portland's conventional court usually has to rely on a probation officer to enforce attendance." *Id.* at 91. Furthermore, Berman and Feinblatt noted that "[t]he city's probation officers are so burdened with enormous caseloads that making contact with a probationer is infrequent at best, and contact with a treatment program is unlikely. Feedback to the sentencing judge almost never happens." *Id.* (also finding that "[o]n probation, it could take months or years before the offender gets picked up for violating a treatment mandate") (internal quotation marks omitted).

explication of "the new penology."[213] Feeley and Simon argued that, in the late twentieth century, a new model for managing dangerous persons emerged that relied heavily on statistical factors and actuarial methods of risk assessment.[214] This new penology focused on managing the risk of group populations and replaced the old model of individual moral culpability, clinical diagnosis, intervention, treatment, and retributive judgment.[215] As a result, notions of rehabilitation were replaced with managing career criminals and minimizing risk.[216] In contrast to the correctional continuum of the 1960s and 1970s, "this new custodial continuum does not design penal measures for the particular needs of the individual or the community. Rather, it sorts individuals into groups according to the degree of control warranted by their risk profiles."[217] Instead of relying on externally imposed social goals, such as public safety or inmate reintegration, criminal justice institutions in the new penology used internal system measures as evaluative performance indicators.[218] As one commentator noted in analyzing the new penology, "the optimism of the rehabilitative ideal that had played such an important role in 18th, 19th, and mid-20th century penology has been replaced by a pragmatic pessimism about the possibility of transformation."[219]

Simon and Feeley's actuarial paradigm accurately reflected a shift in penal theory and a disturbing trend in criminal justice systems' management of dangerous populations. Nonetheless, the risk management approach employed by mental health court judges largely falls outside the new penological model. In particular, mental health courts focus on each individual in an attempt to divert, therapeutically treat, and reintegrate them, while also minimizing future criminality and potential harm to others. The risk management approach is adjustable, individualized, and does not merely sort dangerous people into groups in order to incapacitate them. The variety of approaches judges use are all calibrated to the specific risk presented. Judges try to make decisions about proper interventions, monitoring, and supervision of each individual offender and focus on *healing* the specific

213. *See supra* note 21 and accompanying text.

214. Feeley & Simon, *The New Penology*, *supra* note 21, at 452.

215. *Id.*

216. *Id.* "It seeks to regulate levels of deviance, not intervene or respond to individual deviants or social malformations."

217. *Id.* at 459.

218. *Id.*

219. Winick, *supra* note 134, at 59 n.132 (analyzing Feeley & Simon's new penology model in the context of domestic violence courts).

individual.[220] Moreover, the assessment of dangerousness is not heavily dependent upon actuarial models, but instead relies on clinical predictions that are continuously updated and adjusted based on the defendant's decreasing or increasing level of risk.[221] When functioning properly,[222] mental health courts' approaches appear closer to the old medical model than the punitive model currently in place, because they focus on healing and intervention as opposed to incapacitation.[223]

To the extent that mental health courts accept more felony cases, future evaluation and research should be directed toward whether judicial, clinical prediction models based on collaboration with the treatment team can be assisted by actuarial tools in order to increase accuracy in the assessment process.[224] As outcome data on the success of these courts becomes available, scholars will be able to evaluate whether the clinical assessment model needs adjustment. Regardless, if mental health courts manage human risk, judges should—like corporate or public government risk managers—be armed with the best assessment and monitoring tools possible, such that they can effectuate their goals. Although actuarial instruments are not perfect, they could be used to assist judges and treatment teams.[225] Given the variety of symptoms among mentally ill offenders

220. *See id.* (arguing that domestic violence courts fall outside the new penology, because the focus is on the individual therapy and treatment as opposed to groups and actuarial category markers resulting in punishment).

221. It remains to be seen whether this trend will change if mental health courts continue to handle more felony cases.

222. The author recognizes that mental health courts are relatively new and, therefore, there is a limited amount of qualitative and quantitative data on these courts. If research were to uncover that risk management approaches by mental health court judges are aimed primarily at reducing alarming behaviors rather than comprehensive diversion and rehabilitation, then a credible argument could be made that the new penological paradigm is more applicable than this Article currently acknowledges.

223. Jonathan Simon has demonstrated how statutory preventive detention approaches for dealing with sex offenders reflect a shift from a medical model for dealing with sex offenders to a more direct system of managing risk through incapacitation. Jonathan Simon, *Managing the Monstrous: Sex Offenders and the New Penology*, 4 PSYCHOL. PUBL. POL'Y & L. 452 (1998).

224. *See* Fisler, *supra* note 48, at 594–95 (noting that mental health courts in New York that admit felony defendants are trained in violence actuarial assessments but do not rely much on them in practice).

225. *See* JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT: THE MACARTHUR STORY OF MENTAL DISORDER AND VIOLENCE 100–01 (2001) (noting the MacArthur Research Network research on actuarial risk assessment models and, in particular, the "iterative classification trees"—one of the more reliable models). The study noted that the tree can identify recidivism rates of 76% down to groups that have a 1% chance of recidivism. *Id.* Actuarial models could be useful during the initial evaluation stage by the treatment team.

and the need for individualized assessments, actuarial models should only be used to anchor judicial assessments, not to supplant them.[226]

C. *The Therapeutic Process is the Healing, Not the Punishment*

Recognizing how mental health courts fall outside the new penology shows that the criminal process can focus on healing an individual offender instead of categorizing a group of offenders, and punishing them. The process in mental health courts is focused on offenders' best interests rather than protecting formal rights. As one of the first mental health court judges noted, "[w]e are, for the first time in memory, not simply processing cases; we're doing the right thing in helping people solve base issues that bring them into the criminal justice system."[227]

This is a remarkably different approach from the traditional criminal process, which seeks to preserve protections for defendants "by fostering an ideal of perfectibility and a preoccupation with procedure. In the process it has created a system so complex and cumbersome that in the great bulk of minor criminal cases these protections and procedures serve limited functions at best."[228] Because the cost of invoking one's rights is often greater than the loss of the rights themselves, the majority of cases are resolved via plea bargaining.[229]

A judge's sense of justice under the traditional adversarial model is more compatible with speed and efficiency than with favorable outcomes.[230] As one judge noted:

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226. Moreover, future research should explore the extent to which judges and team members employ a de facto use of actuarial control based on observed patterns and probabilities of offenders over time. As more studies are released on these courts, scholars will be able to examine whether judges who obtain more experience with these offenders engage in *both* an actuarial *and* a case-based individualized model. Although this Article compares an ideal-type dichotomy model (actuarial versus clinical, individualized care), judges in practice may, to varying degrees, draw on actuarial-like models at some heuristic level.

227. Interview with Judge Patrick Morris, Satellite Broadcast of Mental Health Courts, Ctr. for Court Innovation (Nov. 14, 2002), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/transcripts.pdf.

228. MALCOLM M. FEELEY, THE PROCESS IS THE PUNISHMENT: HANDLING CASES IN A LOWER CRIMINAL COURT 297 (1979) (ethnography of criminal court, which chronicles how the process of invoking a defendant's rights within the criminal process proves to be greater than the rights themselves).

229. *Id.* at 277; *see also* BERMAN & FEINBLATT, *supra* note 204, at 19 ("[Plea bargaining] fundamentally alters the balance of power in the court system, moving crucial decision-making authority away from judges and jurors and placing it in the hands prosecutors. . . . The ultimate decision whether to bring a charge, moreover, or whether to accept a guilty plea . . . is left to the prosecutor's essentially unreviewable choice.").

230. BERMAN & FEINBLATT, *supra* note 204, at 19.

> In many of today's cases, the traditional approach yields unsatisfying results. The addict arrested for drug dealing is adjudicated, does time, then goes right back to dealing on the street. The battered wife obtains a protective order, goes home and is beaten again. Every legal right of the litigants is protected, all procedures followed, yet we aren't making a dent in the underlying problem. Not good for the parties involved. Not good for the community. Not good for the courts.[231]

Although mental health courts often relax formal procedures, the substantive process, when the court is functioning in its ideal form, (that is, identifying therapeutic opportunities for the client, locating housing for the client, making frequent court appearances, directing discussions with the judge, and using carrots and sticks) can result in healing. Thus, this model shifts the analysis from the punishment fitting the crime and the process ultimately being the punishment, to the process fitting the problem.[232] As mental health court Judge Randal Fritzler aptly stated, dynamic risk management is "revolutionary."[233]

VII. CONCLUSION

This Article has not advocated for or against mental health courts, but has recognized and explained how mental health court judges are dynamic risk managers. Understanding mental health court judges as dynamic risk managers not only alerts us to ways in which social control mechanisms are changing, but also offers an alternate model for how judges process defendants within the criminal justice system. Unlike traditional criminal courts, mental health courts process defendants using a risk management strategy capable of calibrating responses to specific events as they evolve over time.[234]

Problem-solving courts (including, but not limited to, mental health, family, drug, domestic violence, juvenile, juvenile mental health, homeless, and community courts) are emerging across the country as viable alternatives to the traditional criminal process. Mental health courts are one example of this new model, by which judges do not

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231. John B. Van de North, Jr., *Problem-Solving Judges—Meddlers or Innovators?*, 32 WM. MITCHELL L. REV. 949, 958 (2006) (quoting Judge Judith Kaye).

232. Although procedural rules are relaxed and there is still the coercive threat of jail or imprisonment if the client repeatedly shows no progress or commits an egregious violation, this "stick" is much further in the background of the process, often invoked only as a last resort.

233. JUDGING IN A THERAPEUTIC KEY, *supra* note 19, at 121 (interview with Randal Fritzler).

234. Although this approach offers potential for effectuating change in offenders, it also has the potential for inequitable outcomes (for example, some individuals may be more likely to be classified and treated as dangerous than others). This will be a continuing struggle that proponents, opponents, and scholars should cautiously monitor as problem-solving courts grow in number and type.

simply adjudicate cases, but tackle underlying social issues that led the offender to incarceration, while simultaneously diverting the offender out of traditional criminal court.[235] In addition to exploring how risk management routines are actually employed in mental health courts and whether therapeutic results are being realized, future empirical research should also explore whether this approach can be used to heal and reintegrate other types of defendants, even those perceived as dangerous. Thus, understanding judges as dynamic risk managers provides a framework for visualizing a new image of not only their role, but also a criminal process that focuses on therapeutic healing instead of punishment.

235. To the extent problem-solving courts are here to stay, states should begin to structure courts in ways that allow judges and their teams to engage in risk management functions. Bruce Winick, one of the advocates of problem-solving courts and therapeutic jurisprudence, has also called for a similar "re-structuring" of courts to facilitate these purposes. Winick, *supra* note 134, at 58.