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What is This?
Homesteading a Pioneer Mental Health Court: A Judicial Perspective From the Last Frontier

Kathi R. Trawver¹ and Stephanie L. Rhoades²

Abstract

Although judges with interests in improving the criminal justice response to individuals with serious mental illness have long been principal leaders in the development and innovation of mental health courts (MHCs), little is known about the experiences of pioneering MHC judges. Through an edited written narrative, this article provides a history of one “first-generation” MHC through the lens of its founding judge. This chronicle of the Anchorage Mental Health Court’s 15-year history details its inception and evolving challenges, triumphs, sustainability, and philosophy. The history of the Anchorage Mental Health Court, in the context of evolving national changes in MHC practices, is presented to inform both current and developing MHCs.

Keywords

mental health court, mental health court judge, problem-solving courts

Pioneering a new kind of therapeutic justice, the first mental health courts (MHCs) emerged in the late 1990s as a problem-solving specialty criminal docket, intended to offer a treatment diversion response to the disproportionately large numbers of persons with mental health disorders recycling through the criminal justice system. According to Steadman and Redlich (2005), early MHCs were created to address a growing frustration with increasing criminal dockets slowed by “processing more

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persons with serious mental illness and seeing some of the same mentally ill persons continually reappearing before the criminal courts" (p. 2) in addition to the difficulties traditional criminal courts faced in addressing cases involving people with serious mental illness.

MHCs aimed to quickly identify, intervene with, and divert individuals with mental illness who were charged with a crime from the criminal justice system into community-based treatment. Eligible defendants were able to voluntarily opt in to an MHC and agree to participate in an individualized treatment plan in place of traditional adjudication processes and sentencing sanctions (Hasselbrack, 2001). Ideally, MHC participants would either have their criminal charges reduced or dismissed or receive a reduced sentence following successful program completion. Most broadly, MHCs were intended to reduce the recycling of people with mental illness through the criminal justice system and address jail overcrowding while protecting public safety (Steadman, Redlich, Griffin, Petrilà, & Monahan, 2005).

Goldkamp and Irons-Guynn (2000) described what are now considered to be four founding MHCs, located in Fort Lauderdale, Florida; Seattle, Washington; San Bernardino, California; and Anchorage, Alaska. These founding courts, along with others established early on, are now commonly referred to as “first-generation” MHCs (Griffin, Steadman, & Petrilà, 2002). Since then, MHCs have gained wide support and have continued to proliferate (Miller & Perelman, 2009). Current estimates suggest that there are more than 300 MHCs operating nationwide (Council of State Governments, 2012).

From the inception of the first MHCs, judges with personal and professional interests in improving the criminal justice response to individuals with serious mental illness have been key leaders in court development, expansion, and innovation. Few would dispute that without strong judicial leadership, many of today’s working MHCs would never have gotten off the ground. Although the history of MHCs has been previously covered from general legal, advocacy, and policy points of view, this history has yet to be described from the perspective of a founding judge. The MHC practice community is fortunate to have available the experience of still-active judges who pioneered the early development of these courts to inform newcomers to the field.

The purpose of this article is to provide a narrative history of the development of one pioneer, first-generation MHC, the Anchorage Mental Health Court (AMHC), through the lens of its founding judge. This article chronicles the experience and knowledge of judge Stephanie Rhoades, from the advent of the AMHC to the present, through her written and coedited responses to questions posed by coauthor Kathi Trawver, who was the first project manager of the AMHC. The resulting account offers the judge’s personal perspective on the local and broader public motivations for developing the AMHC, the organizational challenges to creating and sustaining it, and refinement of the court over time to better meet its stated mission. The article concludes by exploring the implications of this history to inform existing MHC programs as well as jurisdictions considering developing their own courts.
What were the major personal, local, and broader public motivations that influenced your decision to pursue an MHC?

I came upon the issue of criminalization of the mentally ill at the intersection of two experiences, one personal and the other professional. First, my youngest brother has mental health disorders, and I serve as his family case manager. Second, about 5 years into my judicial career of hearing primarily misdemeanor cases, I began to see a continued pattern of people with my brother’s characteristics recycling through the jail on nuisance crimes. I was shocked to learn that individuals with mental illness composed nearly half of Alaska corrections’ population. Many were homeless, unemployed and unemployable, indigent, chronically ill, not accepting or not receiving treatment in the community, and spending a lot of time in jail for very low-risk crimes. They could neither organize themselves nor track the way other people did. Moreover, they had no family or friends offering them the kind of help my brother received from me.

At that same time, policy makers in Alaska had begun to take notice of the problem of jail overcrowding and the large and disproportionate numbers of individuals with mental illness in jail and were beginning to look for solutions. Hearing of my interest, our chief justice appointed me to a statewide Criminal Justice Commission tasked with reducing jail overcrowding. I was made chair of that commission’s Decriminalization of the Mentally Ill Subcommittee.

Throughout the commission’s existence, the subcommittee analyzed issues driving criminalization and formulated statewide recommendations to improve our response. Chief among those recommendations was the creation of a pilot MHC as a primary strategy for decriminalization. At the end of its 3-year mission, the commission published a lengthy report of recommendations to reduce corrections overcrowding. Fortunately, when the special commission ended, the subcommittee “morphed” into an Anchorage-based MHC planning and implementation committee. We on the subcommittee knew that we did not want to see our vision of a MHC end up in a report on a shelf. The dedication of both policy-level and line-worker members of that subcommittee was what ultimately resulted in Alaska’s first MHC.

When we opened the court in 1998, all that we had to inform us were some jail diversion programs from the “lower 48” states. Only a few of those programs were court based, and they had little research behind them. As a result, we brainstormed an MHC without ever actually seeing a model. The National GAINS Center had been in existence for a while, but there were few other resources to guide the planning of a court diversion program. Broward and King County MHCs were getting a lot of press but were also just starting up and were about in the same place as we were in terms of technical or practical experience.

Before I knew about other MHCs, the inspiration I had for a model came from my own experiences. First, I saw a huge gap between community mental health and corrections mental health. While both providers treated the same patients, once community mental health patients entered jail, they were no longer under the community
provider's treatment. Treatment continuity was lost with each transition from the community to corrections and from corrections to community. Next, I knew that if my brother were to be arrested, he would need me to explain to the powers-that-be that he really needed help and not jail. He would need me to get him out and keep him from going back. I wanted a program to provide a surrogate “good sister” to offenders who did not have one. I concluded that a unique case manager resource could be that gap-spanning surrogate good sister. Finally, I wanted to make sure that offenders who chose treatment could return to court to show the prosecutor that they were no longer a public safety risk and thereby convince the prosecutor to offer a favorable plea bargain.

What kinds of supports were available to get the court started? Were there milestones in getting it set up? Were there setbacks along the way? Who supported the idea and implementation? Who did not?

At the time we were planning the AMHC, I was fortunate to have a deputy presiding judge who had worked as both a psychiatric hospital orderly and as a police officer before entering law school. He had seen the issues firsthand and supported an MHC. With his support, we received approval from our Supreme Court, and in fact, his interest led him to be the second judge to preside over AMHC hearings.

By the time we opened the doors, we had smoothed a lot of impediments to systems collaboration. Still, stakeholders came with differing missions. Nobody was oriented to a problem-solving court because at the time, Alaska did not even have a drug court, so no one had ever seen the model. Court system administrators were skeptical. High-volume regular court filings needed more judges for core functions, and allocating judge time to a docket that scheduled multiple hearings for a small group of people seemed like a waste to them.

Prosecutors were interested in “sexier” trial and adversarial work, not in being part of a therapeutic team. Some prosecutors ridiculed the court, nicknaming it “clapping court,” because one participant incentive was a round of applause. Both prosecutors and defense counsel resisted spending extra time in court on what amounted to multiple status hearings in a very small number of their assigned cases. Defense attorneys were interested in alternatives for their vulnerable clients but fearful of setting them up for lengthy participation in MHC when showing success in treatment to get a better legal deal could backfire in any number of ways.

My judicial colleagues also had mixed reactions. Some regarded what I was doing as a nonjudicial function, while others were glad to be able to refer cases involving people whose behaviors bogged down their hearings. Community behavioral health policy makers and providers were very interested in an MHC that was more humane for persons with mental disorders and adaptive to their disabilities. All told, everyone had a different view and I felt like I was trying to turn the Titanic...
by advocating for a MHC. Regardless of the differing views, it was hard to argue that nothing different should be done.

Somehow, I convinced court system administration to support the idea and apply for a Bureau of Justice assistance grant to fund our pilot MHC. Fortunately, when that application was denied, the Alaska Mental Health Trust Authority—which had representatives on the previously mentioned subcommittee and which had strongly supported development of a MHC—provided pilot funding to hire our first case coordinator and project manager. So began the AMHC.

**What were the early days of the MHC like? What were the legal, bureaucratic, financial, public relations, and other challenges that were faced?**

For both me and the project manager, the early days of the AMHC amounted to on-the-job training about what an MHC’s mission and model should be to produce desired outcomes. We relied some on drug court literature as well as on National GAINS Center publications and technical assistance to guide us.

Our initial target population was limited to people with psychotic disorders, since they were eligible for treatment through community mental health, and we wanted to facilitate swift linkage to treatment. We accepted only misdemeanor cases because my limited jurisdiction did not extend to felony cases, and it was admittedly easier to stay below the public safety radar by targeting lesser crimes for a new court process.

However, it became clear that those with only psychotic disorders were not a large percentage of the persons with mental disorders in our jails. In response, we quickly expanded our target population to include those with any mental disorder. We felt that to truly decriminalize, we had to target as many as possible, so we quickly began to accept people with developmental disabilities, mental illness, traumatic and organic brain injuries, and/or fetal alcohol spectrum disorder, all with co-occurring substance use disorders. For all participants, we required the mental disorder to have some nexus to their involvement with the justice system but not necessarily to the crime that brought them before the court.

Initially, we were naïvely confident that the MHC would significantly reduce the numbers of persons with mental disorders in our jails. Our most recent study of the AMHC showed reductions in legal recidivism and psychiatric hospital stays, but it did not show tremendous reduction in the percentage of people with mental disorders in jails or cost savings. We can by no means say that we have decriminalized our community through the MHC alone. So, I have been asking myself: What is the role of MHCs almost 15 years later?

At the beginning, we were all under the misimpression that criminalization could be solely explained by hospitals closures, lack of community mental health funding to adequately serve clients’ needs, and high civil-commitment criteria compared to low probable-cause criteria for arrest. If that was the case, then the MHC model was to
intercept criminalized persons, divert them to treatment that fully addressed their needs, motivate treatment adherence, and voila, you would have performed decriminalization. We quickly came to realize that it was not that simple.

In our court, the Alaska Department of Corrections and the Division of Behavioral Health are the direct employers of our case coordinators. We have faced some interesting challenges in reaching consensus on the necessary qualities and skills we require of our case coordinators. We all agree that MHC participants require intensive case management, outreach, and relationship building. However, agreeing on whether it is more important to have personnel who are fulfilled by performing these roles or to have highly educated mental health professionals capable of assigning diagnoses and compiling treatment plan components and less interested in participant engagement has been a challenge. My view has been that case coordinators must be knowledgeable and savvy linkers with strong advocacy skills and the ability to create and maintain a firm and fair alliance with each participant so that the participant knows that he or she will be both supported and held accountable for abiding by the law and participation in treatment.

Memoranda of agreement with community agencies have always been valuable, but they have become essential in assuring service priority and collaboration beyond the verbal agreements made by stakeholders when the court began. This is especially true as we do not purchase services and therefore rely on community agencies to accept and serve participants in a time frame commensurate with their legal exposure. One other effective strategy that we have used was to secure flexible funding that we could make available to court participants on an as-needed basis to prevent them from returning to jail due to lack of housing or their inability to pay for medications and other necessities.

Our most extreme challenges arose after 2003 when the Alaska Department of Health and Social Services, determined to make major cuts to the behavioral health system, refinanced community services almost exclusively through Medicaid reimbursements. This resulted in a significantly reduced service capacity for non-Medicaid reimbursable services most needed by justice-involved persons with mental disorders, such as more assertive outreach and engagement as well as intensive case management. These issues continue to challenge us today.

What has changed most since the beginning?
The AMHC has operated similarly to other MHCs, in many respects. Since MHCs are collaborations between the court, corrections, prosecutors, defense attorneys, and a myriad of community behavioral health partners, they benefit or suffer when positive or negative changes occur within any collaborating agencies. Our most decisive victory came when our pilot grant funding was transferred to state general funding; we felt we had achieved a new level of stability and sustainability.

We are now reviewing our mission and outcomes and are convinced that we need to further evolve our approach to better impact decriminalization. Decriminalization is an
easy-to-meet goal for some but not for the majority. One of my favorite participants illustrates why. His name is Adam (a pseudonym). Adam has schizophrenia, which he treats with copious quantities of alcohol. Adam was repeatedly charged with trespassing. When he came into MHC, he was happy to have someone get him housing and to work with the mental health center. He took his meds, he got good reports, and we gave him a gift card to a local food store as an incentive. The next thing I knew, Adam had used the gift card to buy alcohol, had come home drunk and disorderly, and got kicked out of the housing we had arranged for him. He also stole from the gift card donor store. Adam sheepishly appeared before me the next day charged with theft. So, here he was, being recriminalized and having burned a couple of important bridges the court had made with his housing provider and the gift card donor in the process. It was then that it dawned on me that maybe Adam was being criminalized not because of his mental illness but because maybe he was a criminal with mental illness. Because once Adam started thinking clearly, he was clearly thinking like a criminal. On top of that, Adam had a raging addiction. I concluded that our simple assessment and treatment-planning model was not fully serving our decriminalization goal.

Years later, we are in the process of refining our mission to be more accurate about what we can expect to accomplish and to reflect what we now know, both from our experience and from empirical research. We are learning to differentiate among participants and identify those who are at higher risk of experiencing things in life that promote criminal involvement in anybody. Those factors are called criminogenic risks. I have come to believe that unless we assess and address those additional risk factors for the Adams of the world, they will return again and again. However, rearrest of an MHC participant is not necessarily a bad thing. We recognize that the trajectory of recovery from serious mental and substance-use disorders is in the neighborhood of years rather than the few months we will work with them. Because of this, we accept participants back into MHC if they reoffend and can use MHC services.

To improve our prediction of risk and intervention planning as well as to reduce criminogenic risks that underlie recidivism, we have begun using a structured assessment tool called the Level of Service–Case Management Inventory (LS-CMI). The LS-CMI measures participants’ criminogenic risk factors and prioritizes treatment needs for each individual. The tool helps us to make the referrals best calculated to reduce the risk of recidivism, even for our most challenging participants. Once we have completed the assessment, we can use motivational approaches to help participants succeed in identified need areas as well as in treatment.

Incorporating the LS-CMI into the MHC was daunting. No system is overly interested in providing services to people who may be labeled as high risk. Our clinically trained mental health professionals balked at the extra time it took to administer the LS-CMI. They didn’t think it was helpful in developing a treatment plan and were concerned that it might be harder to link participants that an instrument has labeled as high risk. Prosecutors sometimes liked to glom onto a high criminogenic risk score to exclude MHC participants, even though the LS-CMI measures the risk of recidivism, not violence.
We are working through these things now. My feelings remain strong, though, that courts must plan in those areas that are likely to reduce recidivism, or we are not fully meeting our decriminalization challenge. Judges and prosecutors assess and manage high-risk offenders on a daily basis in the regular court and at a much higher volume. Recidivism risk should not be a reason for exclusion from an MHC that has more resources available to monitor and manage risk. In fact, the LS-CMI helps prioritize those participants who need the most intensive interventions and supervision so we can assign our resources more intentionally. I am currently purveying my view about the importance of using this tool to my court team and will report back on that progress if asked.

The more difficult issue presented in assessing criminogenic risk factors is that many are static and our participants experience more of them. You can’t change a person’s criminal history, and no intervention can reduce that history as a risk factor. Other factors are generally not subject to change through treatment interventions as well, particularly with the population we see most often. For instance, higher education and stable employment are not going to be a big part of the life mix for many people with serious mental disorders. Finances consist of very limited government benefits, meaning that poverty will always contribute to a person’s risk. Similarly, family and other personal relationships are often already challenged.

Nonetheless, rather than abandoning participants assessed as high risk to recidivate and enforcing a zero-tolerance attitude when setting terms of participation in the MHC, we embrace a harm reduction approach that aims to reduce the harmful consequences of risky behaviors. For example, we can’t change a person’s past criminal history, but the promise of MHC for all participants is a better legal resolution in their case, which can include dismissal, which in turn can reduce the potential harm of an additional conviction. To respond to other factors, we make sure that interventions are planned so that a participant can achieve the most education he or she can attain within his or her capabilities or provide linkage to supported employment when competitive employment is not possible. If education or employment is not viable, we make certain that the participant has applied for and obtained the maximum benefits available for self-support. Finally, we link participants with the safest and most supportive housing needed while respecting their desire for independent living and assure that substance abuse is routinely screened for and treated and that meaningful prosocial activities in life are scheduled.

When MHCs first developed, most accepted only low-level misdemeanor cases, such as trespassing, shoplifting, and disorderly conduct. Often these crimes were behaviors that were the direct result of untreated mental illness and were often what some refer to as status crimes. Now, many MHCs accept misdemeanor and felony cases, and some are felony-only MHCs. This movement reflects a growing consensus; in the continuum of diversion, the highest and best use of MHCs is for the most complex and high-needs individuals. Those individuals charged with nuisance crimes should ideally be offered earlier community-based diversion rather than court-based interventions.
How are the challenges of developing an MHC different today than the early years? What of the early experience remains valuable today?

Fortunately, the experience of planning and implementing a MHC is less challenging today in that there are many resources and materials that have been compiled as guides. For example, the Criminal Justice–Mental Health Consensus Project, the Judge’s Leadership Initiative, the National GAINS Center, SAMHSA (Substance Abuse and Mental Health Services Administration), and the Center for Court Innovation have all provided a wealth of publications to walk a new judge and stakeholder group through developing an MHC. There are now MHC conference tracks at the annual National Association of Drug Court Professionals conference and a specific conference dedicated to the subject of MHCs. These are all incredible resources that were unavailable in the early years.

Still, many challenges remain. Whereas drug courts have a specific program model with two decades of research, each MHC must locate from among a variety of disciplines the research and technical assistance to build the most appropriate model in light of that community’s political and criminal justice climate, taking into consideration the policy, legislative, budget, and fiscal issues of all collaborators along with public sentiment and, of course, available community resources. The planning and implementation of an MHC still requires a leader and convener with the motivation, time, and capability of collecting and synthesizing multidisciplinary literature to guide practices while also understanding the many global and local pressures that influence the type of MHC model that any given community will accept. Often the judge is that person, and I fear that few are willing to assume this weighty mantle.

In the course of the past 15 years, what aspects of MHC have been most effective in keeping participants engaged and adherent to treatment conditions? What has been most satisfying for you as a judge?

The factors that appear most important to engagement and adherence are the relationships developed by the case coordinators and the judge with the participant directly. Case coordinators provide intensive day-to-day case management in addition to that provided by community mental health and assure warm transfers for participants into treatment at the time of linkage.

Many of our participants have to be sold on a treatment system they distrust by a judge they just met and case coordinators who look a lot like all the other treatment providers they learned not to trust. They view treatment not just as unwelcoming but as a system with its jaws wide open for them to walk into. In many respects, they are right. Case coordinators and the judge have to facilitate and negotiate a mutually engaging relationship between each participant and our community treatment providers. Some of
our participants were persona non grata in the treatment community. A lot of them are previous clients considered to be unmotivated or treatment resistant.

In our MHC, case coordinators are not just the boundary spanners and linkage folk; they also monitor and report treatment progress to the court. MHC monitoring takes the heat off of community treatment providers to be the “bad guys” and instead allows the therapeutic relationship to flourish. Our case coordinators are oriented and tasked with being helpers who are both fair and firm.

The relationship between the judge and the participant has always been a cornerstone of MHC practice. It is therapeutic and motivating and we think that it has positive outcomes for participants in and of itself. The judge-participant relationship relies on catching participants in success and not failure. Regularly scheduled hearings before the judge, rather than only when a participant is nonadherent, allows the judge to learn about participants and their strengths, motivations, and challenges. So many participants have low self-esteem and are insecure in their ability to change their behavior. The judge walks the path alongside the participant, reflecting back to the participant even small successes so that he or she can gain the confidence to maintain a commitment to treatment and to change.

The benefits to the judge-participant relationship are mutual. The most professional satisfaction that I—and other therapeutic court judges—have ever experienced has been in our work in therapeutic courts. Alaska is a very large state that functions like a small town. I run into former court participants and their families all over Alaska regularly. I never feel more like I am making a public service contribution in my public-sector job then when I see former participants doing well in our communities.

As an MHC judge, what advice would you give other jurisdictions that are considering developing an MHC? What do you consider most important for developing courts?

When I began an MHC, it was considered a primary decriminalization strategy. This view was likely the result of overconfidence in a single strategy, but it was not a reasonable view; unless MHCs become involuntary (which I am not suggesting), they will serve only a very limited number of people.

MHCs involve a tremendous number of resources. I advise communities contemplating a MHC to begin planning using the sequential intercept model to evaluate whether an MHC will serve the highest need and will be the most effective strategy to implement. It is possible that communities that could achieve similar—or better—outcomes than an MHC and may offer greater efficiency and benefits by planning and implementing prearrest or jail diversion strategies, especially for participants who need not move as far into the criminal justice system to benefit from diversion.

With respect to already established courts, as one collaborative strategy, I urge MHCs to be community resources that provide expertise and promote a broader array
of other criminal justice–mental health collaborations and strategies. Our project manager and I have membership in various policy work groups in the areas of reentry, disabilities justice, and emergency services. MHCs are microclimates of all the system failures that contribute to criminalization, and they should make themselves learning grounds for honing effective communication, leadership, advocacy, partnership, and institution-building skills for system improvement, wherever they exist in our communities. MHCs are also extremely effective demonstration and learning sites to teach everyone in a community about the issues faced by individuals with serious mental illness. For instance, our hearings are public criminal court hearings, and university students in nursing, psychology, criminal justice, and other disciplines attend hearings to observe in-play examples of the complicated dynamics participants experience with behavioral health and criminal justice systems. Additionally, the treatment community can learn through the MHC how to address forensic needs, such as criminogenic risk factors and co-occurring disorders in cognitively challenged justice-involved people, as we may be the most capable of articulating and advocating for those very specific and needed services.

Other advice I frequently relate to MHCs concerns the use of incentives and sanctions in MHCs. MHCs should never operate off a sanctions grid. Understanding the underlying reasons for negative behaviors of people with mental disorders can be elusive. It can be difficult for a judge to know when a participant is volitionally nonadherent or whether his or her mental status is affecting behavior. What motivates behavioral change for them is also complex and highly individualized. Although some studies indicate that the use of jail as a sanction has little deleterious effect, in my view, the use of jail as a sanction is far more likely to disrupt medication continuity and to place the individual at higher risk of suicide or victimization than it would any other type of offender. The antitherapeutic effect of using jail as a sanction must be carefully weighed, and in a misdemeanor court, most of the time, the trade-off is too great to warrant the sanction. In addition, a much higher ratio of incentives to sanctions should be used with MHC participants. Recently I have undertaken to see that there are tangible incentives for court participants, as I am certain I previously undervalued their role in motivating participants.

Finally, I give advice in terms of sustainability. Some recent research suggests that MHCs do not make a measurable difference in terms of reducing the overall numbers of people with mental disorders in corrections. I am not sure what that means for us. We clearly make a difference, but national decriminalization may not be our contribution to society. What we do know is that studies show that MHC participants show reduced recidivism and sometimes less use of expensive emergency services. How do MHCs do that? I'm not really sure and neither is the current research. There is no definite MHC model, only descriptions of individual court processes and their outcomes. There is little research to inform a model. All we have are programs and practices. We make it up as we go along. Everyone has a theory about what works about MHCs; no one has a definitive answer. I have become comfortable with that so long as the way we make it up is by establishing a clear and ethical mission to which we are clean and
true and by continually seeking, analyzing, and implementing the best knowledge and practices available to be most effective in carrying out our MHC’s mission. I require our team to focus on the specific and individual issues presented in each and every case and in each and every hearing each and every day, always returning to our mission as the beacon from which all else should flow. So that is some of the tradition and lore of the planning, implementation, and evolution of a first-generation MHC.

Discussion
This article describes the startup and progression to current practices of one pioneer MHC from the perspective of its founding judge. The judge recounts a series of unique factors that affected the planning and implementation of the AMHC model, including funding and competing community views of the utility and wisdom of establishing an MHC. She further details how the court has changed in the course of the past 15 years to include an expanded target population, increased focus on assessment of criminogenic risks and targeted interventions, team member adoption of both a strengths and a harm reduction perspective toward participant change, and a commitment to serve complex, high-needs individuals.

Judge Rhoades details the aforementioned changes within the context of a few key national shifts in MHC practices. First, when MHCs first began, many jurisdictions naively endorsed the model as the answer to criminalization without equal consideration of less restrictive alternatives. Later, when Munetz and Griffin (2006) introduced the sequential intercept model, the MHC community of practice began to conceptualize the court-based response as one potential interception point along a continuum of several diversion opportunities.

Next, since the startup of the AMHC, a “second generation” of MHCs has developed (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). When founding MHCs began operation, most programs accepted only participants who were seriously mentally ill (i.e., schizo-spectrum disorder, bipolar, and/or major depression) and charged with nonviolent misdemeanor crimes committed as a direct result of their mental health disorder (Stefan & Winick, 2005). Second-generation MHCs developed later and are more likely to accept felony charges, use a postadjudication model, impose jail as a sanction for nonadherence, and use criminal justice professionals (e.g., probation officers) versus mental health professionals to supervise court participants than are first-generation courts (Redlich et al., 2005). In fact, a 2006 survey of 90 MHCs showed that 14% of the surveyed courts had begun to accept felony cases as well (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). More recently, a number of MHCs have been identified that exclusively accept only felony cases (Castellano & Trawver, 2011), which may arguably constitute an emergence of “third-generation” MHCs.

Third, there is a developing consensus between the judge’s experiences and the MHC practice community’s developing philosophy that MHCs should be reserved for those defendants who are assessed as being at the highest risk of recidivism. New
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thinking and increased focus on the factors that are thought to contribute to criminalization of individuals has clearly expanded from the original belief that crime resulted directly from untreated mental illness.

The final key point made by the judge is the fact that early MHCs developed without any real expectation of accountability. Even today, expectations of self-assessment are program specific, and few courts have resources to conduct meaningful program evaluation. Although research and technical assistance provided by organizations such as the Council of State Government, the GAINS Center, and others have expanded the MHC community-of-practice knowledge base, there is still a great deal more to be studied and learned about these courts and their effectiveness, especially as new generations of courts evolve. The future of MHCs based on empirically supported practices, and not just good hunches and intentions, will be furthered by defining what MHCs are actually doing and in rigorously researching their effectiveness. With approximately 300 functioning MHCs across the United States today—and new courts developing each year—the time is right for pursuing just such an agenda in the hope of building ethically sound, evidence-based, and fiscally responsible MHCs across the country.

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Notes

1. The Substance Abuse and Mental Health Services’ National GAINS Center is operated by Policy Research Associates, Inc. Its primary focus is expanding access to community-based services for adults with co-occurring mental and substance disorders in contact with the justice system through consultation and technical assistance. See http://gainscenter.samhsa.gov/.

2. For more information, see the Alaska Mental Health Trust Authority website at http://www.mhtrust.org/.


4. Criminogenic (i.e., crime-causing) factors have been shown to increase one’s risk of reoffending. These eight risk factors include (a) antisocial personality pattern, (b) antisocial cognitions, (c) antisocial associates, (d) lack of leisure involvement, (e) a history of antisocial behaviors (e.g., criminal history), (f) family or marital problems, (g) low work or school performance, and (h) substance abuse (Andrews & Bonta, 2003; Andrews, Bonta, & Wormith, 2006).

5. The Level of Service–Case Management Inventory (Andrews, Bonta, & Wormith, 2004) is a standardized risk and need assessment and treatment-planning system for adolescent and adult offenders.
6. See Chase and Hora (2006). This article presents the results of a survey of more than 300 judges comparing the satisfaction of those who presided in problem-solving courts with those who presided only in traditional courts.

7. The sequential intercept model was conceptualized by Munetz and Griffin (2006). This model identifies the multiple points of potential intercept (i.e., prebooking, postbooking, court based, postrelease, probation) that diversion programs can target to offer jail diversion interventions.

References


**Bios**

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