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Mitchell Hamline Law Review

Volume 42 | Issue 2 Article 1

2016

Hennepin County Criminal Mental Health Court: Experiences in a Large Metropolitan Mental Health Court

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Meyer, Kerry (2016) "Hennepin County Criminal Mental Health Court: Experiences in a Large Metropolitan Mental Health Court," *Mitchell Hamline Law Review*: Vol. 42: Iss. 2, Article 1.
Available at: http://open.mitchellhamline.edu/mhlr/vol42/iss2/1

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HENNEPIN COUNTY CRIMINAL MENTAL HEALTH COURT: EXPERIENCES IN A LARGE METROPOLITAN MENTAL HEALTH COURT

Hon. Kerry Meyer†

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Published by Mitchell Hamline Open Access, 2016

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I. INTRODUCTION

Many defendants in the criminal justice system have mental illness diagnoses, developmental disabilities, or a history of serious traumatic brain injuries (TBI), and many of them also have a co-occurring substance use disorder.[1] For many of them, specific treatment to address those issues can prevent them from committing new criminal offenses and reduce the amount of emergency psychiatric or hospital services they use in the future. The criminal justice system can be part of this solution. In Hennepin County, Minnesota, we have established a criminal mental health court that brings together criminal justice, social service, and psychiatric professionals to create and monitor individual treatment plans for qualified defendants. The mental health court works with hundreds of people each year and has seen dramatic positive changes in these defendants' behavior.

II. EXPANDING DRUG COURTS TO OTHER AREAS: PROBLEM-SOLVING TREATMENT COURTS

The first drug court began in Miami-Dade, Florida in 1989.[2] It was the era of "The War on Drugs," and the penalties for all drug crimes had increased.[3] Criminal justice professionals saw that sending addicts to prison was not decreasing the volume of drugs in their community or drug crimes charged in their courthouse.[4] They decided to take an innovative approach to criminal justice for people suffering from addiction—chemically dependent defendants would receive immediate, extended treatment and regularly report to their judge and probation officer, instead of

1. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SUBSTANCE USE & MENTAL ILLNESS IN U.S. ADULTS (18+) 1 (2013) (concluding that one in five adults had a mental illness in the past year, one in twelve had a substance use disorder in the past year, and 7.7 million adults had both).

2. MIAMI-DADE COUNTY DRUG CT., http://www.miamidrugcourt.com (last visited Mar. 17, 2016).

3. JEFFREY TAUBER, THE DRUG COURT JUDICIAL BENCHBOOK 11 (Douglas B. Marlowe & William G. Meyer eds., 2011) [hereinafter BENCHBOOK], http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf.

4. *See id.* at 1.

remaining in custody.[5] That approach worked to stem the tide of defendants coming into the court on drug possession crimes.[6] The success was noted and replicated in many jurisdictions. Now twenty-five years later, the drug court concept has spread to over 2900 problem-solving courts across the country.[7] Drug courts are also in place in at least fourteen countries.[8]

The problem-solving court model of supervision is what most lay people probably expect when they think of what it means to be on probation: probation officers supervising a small enough number of defendants that they have time to regularly meet with them in person and make sure that they follow court orders; treatment programs long enough to usher in change; treatment providers in close contact with probation officers and the judge; defendants facing a judge frequently to provide progress reports; and judges reinforcing positive changes and making swift responses to violations.

Hennepin County is served by the Fourth Judicial District of Minnesota. Corresponding to the largest population of any judicial district in the state, it has the largest number of court cases filed each year, totaling approximately forty percent of all cases filed in Minnesota.[9] That reality is reflected in the number of criminal cases handled in Hennepin County—approximately 40,000 cases per year.[10] Consequently, the need for innovative approaches to criminal justice is apparent.

In the late 1990s, the promising results in Miami's drug court led a handful of judges in Hennepin County to begin a creative approach to drug cases.[11] The Hennepin County Drug Court is

5. *Id.* at 12–13.

6. *Drug Courts Work*, NAT'L ASS'N DRUG CT. PROFS., http://www.nadcp.org/node/201 (last visited Mar. 20, 2016).

7. 2 NAT'L ASS'N OF DRUG COURT PROF'LS, ADULT DRUG COURT BEST PRACTICE STANDARDS 6 (2015) [hereinafter DRUG COURT BEST PRACTICE STANDARDS II].

8. *Id.*

9. *Fourth Judicial District*, MINN. JUD. BRANCH, http://www.mncourts.gov/Find-Courts/Fourth-Judicial-District.aspx (last visited Mar. 20, 2016).

10. Nearly 40,000 adult criminal cases were resolved in Hennepin County in 2013 and 2014. Memorandum from Fourth Judicial Dist. Research Dep't to author (July 2015) (on file with author) (synthesizing data from the Minnesota Court Information System).

11. Committee Minutes, Fourth Judicial Dist. Exec. Comm. (Feb. 25, 1998) (on file with author).

unique, innovative, and massive.[12] It eventually underwent a complete remodel in 2007 after working with national researcher, Dr. Douglas Marlowe, to develop the Risk and Needs Triage Tool now commonly used in drug courts across the country.[13]

Hennepin County judges and their criminal justice partners saw need for specialized treatment court responses for other populations. A Criminal Mental Health Court (MHC) started in 2003,[14] 2007 saw the beginning of the Driving While Impaired (DWI) Court,[15] and a special court just for veterans began in 2010.[16] This group of courts is often called problem-solving, treatment, or specialty courts. Sometimes these courts are referred to collectively as drug courts.

Hennepin County also has special court calendars for women facing prostitution charges and chronically homeless individuals in Minneapolis who are facing livability crime charges. These six court programs are handled by two judges in Hennepin County.[17] I have been fortunate enough to be one of those judges for nearly three years. Being part of a collaborative team comprised of criminal justice, treatment, and psychological professionals has not only improved my professional skills, but has enhanced my personal life as well.

In each of these court programs, the team meets before the court calendar to "staff" the cases.[18] The judge and attorneys are present while probation officers and treatment professionals update the team about what the participants have been doing since

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12. The original Hennepin County Drug Court was a program for defendants charged with a felony-level controlled substance crime in the county. They were moved into treatment as soon as possible, but the individual outcomes were negatively affected by the overwhelming volume.

13. Committee Minutes, Fourth Judicial Dist. Exec. Comm. (Nov. 22, 2006) (on file with author).

14. Committee Minutes, Fourth Judicial Dist. Exec. Comm. (Aug. 4, 2003) (on file with author); Memorandum from Judge Richard Hopper to members of the Hennepin Cty. Dist. Court Exec. Comm. (July 21, 2003) (on file with author).

15. Committee Minutes, Fourth Judicial Dist. Exec. Comm. (Dec. 13, 2006) (on file with author).

16. Committee Minutes, Fourth Judicial Dist. Exec. Comm. (Jan. 27, 2010) (on file with author).

17. *Hennepin Criminal & Traffic Division*, MINN. JUD. BRANCH, http://www.mncourts.gov/Find-Courts/Hennepin/HennepinCriminalTrafficCourt.aspx#tab03OtherCourts (last visited Mar. 20, 2016).

18. HENNEPIN CTY. MENTAL HEALTH COURT, POLICY AND PROCEDURES MANUAL 11 (2015) [hereinafter MHC POLICY AND PROCEDURES MANUAL].

their last court appearances.[19] This staffing time before the public calendar allows the attorneys, probation officer, judge, and other interested professionals to argue or agree on responses to behavior. Ultimately, it is the judge's decision whether and how to sanction,[20] but the team's input is invaluable.[21] While the attorneys and probation officers still make a record in the courtroom, problem-solving courts are less adversarial than a traditional criminal court because the professionals ultimately have a united goal of assisting the participants in making positive changes to improve their lives.[22] This goal is best achieved by the participant understanding why a sanction has been imposed.[23] If the participant feels like the judge "ruled against him," he may develop resistance to following the court's orders.

Problem-solving courts in Hennepin County utilize somewhat diverse approaches in that two courts focus primarily on addiction and others include participants with a wider variety of presenting issues. Drug and DWI Courts are the primary addiction courts. These courts are structured specifically to help defendants achieve sobriety and live in recovery.[24] Although every defendant has a unique path to recovery, that path generally involves chemical dependency treatment with a period of aftercare and community sober support. The Drug and DWI Courts focus on that path for every participant in each program.[25] Recovery only comes from addressing the underlying causes, and so these courts also have mental health professionals who serve on teams for participants who need that type of support to deal with the pain they previously masked with chemical use.[26]

MHC participants have greater variety in the paths they follow to stability. Not all of them come to the court addicted, although

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19. *Id.*

20. 1 NAT'L ASS'N OF DRUG COURT PROF'LS, ADULT DRUG COURT BEST PRACTICE STANDARDS 21 (2013) [hereinafter DRUG COURT BEST PRACTICE STANDARDS I], http://www.allrise.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf.

21. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 11.

22. DRUG COURT BEST PRACTICE STANDARDS I, *supra* note 20, at 27–28.

23. *Id.* at 27.

24. *See, e.g.,* Fourth Judicial Dist. Adult DWI Court Team, Adult DWI Court Program Policies & Procedures Manual 7 (2015) (on file with author).

25. *See, e.g.*, *id.* at 7–8.

26. *See, e.g.*, *id.* at 2–3.

many of them do.[27] Even if participants suffer from chemical dependency in addition to mental illness, there are many variables that influence defendants and their treatment plan in the court program.

We accept a number of different diagnoses into the MHC.[28] Different mental illnesses and brain disorders have different symptoms. In addition to possibly having co-occurring chemical dependency, many defendants who enter the MHC have multiple mental health diagnoses.[29] The combinations vary widely.[30] Many also suffer from serious physical health challenges.[31] There is a large variety of presentations among defendants in the court program, which means their treatment plans must be varied and flexible.

Those defendants also bring diverse attitudes toward psychiatric medication and psychotherapy.[32] Attitudes can reflect a feeling of stigma[33]—many people still have the belief that mental illness is shameful and should be secret.[34] Thus, requesting help to relieve symptoms can be difficult.[35] Others view mental illness as a

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27. U.S. DEP'T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS (2013), http://www.samhsa.gov/data/sites/default/files /NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf (explaining that 7.7 million of the 43.8 million adults in the United States with a mental illness also have a substance use disorder diagnosis); *see also* Fourth Judicial District Research Department MHC Database [hereinafter MHC Database] (on file with author).

28. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 8.

29. MHC Database, *supra* note 27.

30. *Id.*

31. *See* NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS., MORTALITY AND MORBIDITY IN PEOPLE WITH SERIOUS MENTAL ILLNESS, (Joe Parks et al. eds., 2006), https://www.yumpu.com/en/document/view/31396398/mortality-and-morbidity -final-report-81808 (explaining how physical complications may arise from long-term medication or other chemical use. It has been stated that people who live with mental illness die an average of twenty-five years earlier than the general population). For information on physical illnesses, see MHC Database, *supra* note 27.

32. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, MORBIDITY AND MORTALITY WEEKLY REPORT (2010), http://www.cdc.gov/mmwr/PDF/wk/mm5920.pdf.

33. *Id.*

34. Peter Byrne, *Stigma of Mental Illness and Ways of Diminishing It*, 6 ADVANCES PSYCHIATRIC TREATMENT 65, 65 (2000).

35. Brandon Marshall, *The Way People Talk About Mental Health Is Crazy*, HUFFINGTON POST (Oct. 12, 2015, 11:59 AM), http://www.huffingtonpost.com /brandon-marshall/the-way-people-talk-about-mental-health_b_8258152.html;

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weakness and deny its presence in their families.[36] I have heard family members say their child has "learning disabilities" rather than a mental illness. There are prevalent attitudes disfavoring medications that affect personality—some people see medication as changing the essence of who the person is, and that attitude can be a major barrier at the outset of MHC participation.

For many defendants who enter the court, they will meet with a therapist for the very first time. A large number will also abstain from illegal mood-altering chemicals and allow prescribed medication a chance to work for the first time since childhood. Although the transition can be difficult, the results are often dramatic and life-changing.

III. THE ESSENTIAL ELEMENTS OF HENNEPIN COUNTY CRIMINAL MENTAL HEALTH COURT

The Bureau of Justice Assistance has developed ten essential elements of a mental health court.[37] These elements are essential to bring a court program the greatest chance of success for the participants who join. Hennepin County was intentional about employing these elements when creating the court and has remained dedicated to following them since the court began operations in 2003.[38]

The purpose of the MHC is "to increase public safety, facilitate participation in effective mental health and substance abuse treatment, improve the quality of life for people with mental illnesses charged with crimes, and make more effective use of limited criminal justice and mental health resources."[39] Our court's

Mental Health: Overcoming the Stigma of Mental Illness, MAYO CLINIC (May 17, 2014), http://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477.

36. *See* Byrne, *supra* note 34, at 65 (citing ERVING GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY (1963)); Dr. Graham Davey, *Mental Health and Stigma*, PSYCHOL. TODAY (Aug. 2, 2013), https://www.psychologytoday.com/blog/why-we-worry/201308/mental-health-stigma.

37. COUNCIL OF STATE GOV'TS JUSTICE CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESS: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT 11 (2008) [hereinafter TEN ESSENTIAL ELEMENTS], https://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-essential-elements.pdf.

38. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 4.

39. TEN ESSENTIAL ELEMENTS, *supra* note 37, at vii.

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stated mission is "to address the unmet mental health needs of defendants and to increase public safety."[40]

A. *Planning and Administration*[41]

Stakeholders in the Hennepin County MHC have represented a broad base of criminal justice practitioners, mental health providers, substance abuse treatment professionals, and interested community members from the planning stages to the current administering of the court.[42] The MHC was planned in detail before defendants began appearing on the specific court calendar.[43] There is a steering committee of various professionals that meets bi-monthly and decides policy for the court. Steering committee members represent the district court; Department of Community Corrections and Rehabilitation (DOCCR); Hennepin County Human Services and Public Health Department (HSPHD); city and county prosecutors; public and private defense attorneys; law enforcement, including jail supervisors; psychological services; prepetition screening; specialized housing representatives;[44] and will soon include a serious and persistent mental illness (SPMI) treatment provider.[45]

B. *Target Population*[46]

One consideration in mental health courts is public safety.[47] The eligibility criteria for defendants to become participants address public safety and consider the treatment options available to Hennepin and Ramsey County residents.[48] We examine the presenting crime or crimes of which the defendant is charged or convicted and consider the safety of the other participants in the

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40. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 7.

41. TEN ESSENTIAL ELEMENTS, *supra* note 37, at 1.

42. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 4.

43. HENNEPIN CTY. MENTAL HEALTH COURT, POLICY AND PROCEDURES MANUAL (2003).

44. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 4.

45. A solicitation for provider was being finalized as this article was being prepared with the stated purpose of having a treatment provider that specializes in serious and prolonged mental illness co-occurring with chemical dependency to bring expertise to the steering committee and court team.

46. TEN ESSENTIAL ELEMENTS, *supra* note 37, at 2.

47. *Id.*

48. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 8.

MHC, as well as whether we can adequately supervise the individual within available community placement options.[49] For example, we seriously consider whether we can work with a defendant charged or convicted of arson because there is a severe limit on the number of treatment and residential placements that will house people with a history of firesetting. In addition to housing challenges similar to firesetters, a person with a felony criminal sexual conduct conviction also presents a heightened danger of victimizing the current vulnerable participants in MHC in the same way.[50] Many participants have experienced trauma related to sexual victimization,[51] and exposing them to a known predator is not an acceptable risk. Not limited to sexual violence, the team always considers the vulnerability of the current population when deciding whether to offer a new defendant a place in the court.[52] The MHC courtroom has to be a safe place for the participants to talk openly, and the integrity of that safety is the responsibility of the professionals.

Our target population must also demonstrate a link between the mental illness and the criminal offense.[53] Certainly, not every person with a qualifying diagnosis is a criminal and not every person charged with a crime has a mental illness. Additionally, not every person living with a mental illness diagnosis or brain disorder who is charged with a crime needs significant mental health treatment or intense court supervision. The MHC needs to see that an improvement in mental illness symptoms will affect future criminal behavior before agreeing to work with a person.[54] Given the volume of participants in the MHC, the services have to be limited to where they are most likely to be effective.

C. *Timely Participant Identification and Linkage to Services*[55]

Defendants should be "identified, referred, and accepted into mental health courts, and then linked to community-based service

49. *Id.* at 9.
50. *See id.* at 8–9.
51. Hennepin County MHC Screening Reports [hereinafter Screening Reports] (on file with author).
52. *See* MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 9.
53. *See id.* at 8.
54. *See id.*
55. TEN ESSENTIAL ELEMENTS, *supra* note 37, at 3.

providers as quickly as possible."[56] In Hennepin County, we regularly review the admission process and have made significant changes over the past two years to ease the entry process for potential participants.[57] We get most of the participants through attorney referrals and Rule 20.01 competency evaluations.

If a court professional thinks that a defendant may not be competent to proceed because the person either lacks mental capacity or is suffering mental health symptoms so severe that they cannot understand or cooperate in the court process, a judge orders a competency evaluation.[58]

The competent group of these defendants often meets the basic criteria for MHC admission. Knowing that, in the summer of 2013, the Fourth Judicial District consolidated all Rule 20.01 returns to the MHC presiding judge.[59] A doctor from the district's psychological services office conducts an evaluation, includes DSM-5 diagnoses,[60] and offers an opinion on the defendant's competency. When I review a doctor's written evaluation of a defendant who is competent, one thing I look for is whether there

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56. *Id.*

57. Committee Minutes, Hennepin Cty. MHC Steering Comm. (2014–15) (on file with author).

58. MINN. R. CRIM. P. 20.01 (2015). A defendant is not competent if he is not able to "(a) rationally consult with counsel; or (b) understand the proceedings or participate in the defense due to mental illness or deficiency." *Id.* R. 20.01, subdiv. 2. This is authorized by the statute, which has not changed since its inception in 1971: "No person having a mental illness or cognitive impairment so as to be incapable of understanding the proceedings or making a defense shall be tried, sentenced, or punished for any crime. . . ." MINN. STAT. § 611.026 (2014).

59. This change corresponded with the author's assignment to MHC. She has been the only judge to consistently see all Rule 20.01 returns in Hennepin County to date. Interestingly, the number of Rule 20 motions during this time period dramatically increased. There were 396 people who appeared on Rule 20.01 hearings in 2014. LAWRENCE PANCIERA & KERRY MEYER, NUMBER OF RULE 20.01 EVALUATIONS ORDERED BY FISCAL YEAR (2015). There were 495 people evaluated in 2015. *Id.*

60. "The DSM contains information regarding every official psychiatric disorder. Each diagnostic listing contains detailed information regarding the specific criteria required for a diagnosis, as well as a thorough overview of that particular disorder." Cheryl Lane, *DSM 5 – Fifth Edition Of The Diagnostic And Statistical Manual Of Mental Disorders*, PSYWEB (Dec. 1, 2012), http://www.psyweb.com/content/main-pages/dsm-5-fifth-edition-of-the-diagnostic-and-statistical-manual-of-mental-disorders. *See generally* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5].

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is a diagnosis or condition that would make that defendant eligible for the MHC. If the defendant is competent and has a qualifying diagnosis, the case can begin the MHC screening process within a week, if the attorneys agree.

Because the same judge presides over competency evaluation return hearings, incompetent defendants can fluidly enter the civil commitment process, thereby accessing mental health programming promptly.[61]

We have also decreased the time lag between a non-Rule 20 evaluated defendant being referred from criminal court without a Rule 20 motion and making his first appearance in MHC.[62] A person can be added to the MHC calendar as quickly as the next day, which gives the defendant less time to forget about the court date. This allows a social worker on our team to meet with the defendant and assess whether there is an immediate need for crisis intervention. It also puts a personal face on the court for the potential participants and allows them to observe the court proceedings without having to commit to participate immediately. This increases their comfort level and exposes them to the MHC

61. Prior to consolidation, getting a civil commitment petition filed after a finding of incompetence could take days and sometimes weeks, delaying the start of civil commitment proceedings and services. Currently, civil commitment petitions are regularly filed within hours of the criminal finding. We have also closed a gap in the process where we sometimes "lost" people between criminal and civil court by serving out-of-custody respondents with the civil commitment notice of hearing at the criminal appearance. With service completed, the civil hearing can happen much sooner and the person knows when they are supposed to appear next, resulting in fewer non-appearances in civil commitments. This also saves money because the notices do not have to be served separately.

Additionally, this consolidation has opened communication between criminal and civil mental health professionals with the support of the Criminal Justice Coordinating Committee Behavioral Health Subcommittee. Under the leadership of Co-chair Leah Kaiser of the HSPHD, we have pilot programs in place to provide needed mental health services to incompetent defendants in the community. The goal is to close the gap for people who are incompetent to proceed in criminal court but not committable in civil court, who historically receive no supported mental health services. *See* Andy Mannix, *The Uncommittables: How Offenders with Mental Illnesses Fall Through the Cracks of Minnesota's Criminal Justice System*, MINN. POST (July 20, 2015), http://www.minnpost.com/politics-policy/2015/07/uncommittables-how-offenders-mental-illnesses-fall-through-cracks-minnesota.

62. Prior to 2014, a case was scheduled two to three weeks in advance, and the defendant was expected to call a screener to schedule an appointment, show up for that appointment, and come to MHC for the first time.

experience before they participate in a detailed screening appointment with a probation officer or social worker.[63]

D. Terms of Participation[64]

The terms of participation for a defendant should be clear; promote public safety; help engage the participant with treatment; be individualized, especially in regards to public safety risk; and provide positive legal outcomes.[65] The first part of this, setting clear terms, may sound simple, but it is perhaps the most difficult in practice. Not everyone who enters our program needs medication (e.g., defendants diagnosed with developmental delay or TBI), chemical dependency treatment, housing, therapy, or education, but some defendants need all of those.[66] Even needing chemical dependency treatment has many variables depending on the participant's co-occurring disorder and drug of choice. A person with a TBI who is addicted to marijuana needs a different treatment approach than a person living with bipolar symptoms who is an opiate user turned heroin addict—both need treatment.[67] Whether the defendant has a stable residence affects whether treatment will include lodging. This is not a one-size-fits-all treatment plan program.[68] Every case plan is individualized, and treatment needs often change while people are engaged in the program, so we do not always know the exact terms of program completion when a person starts.[69] But we try to be clear with each participant about what needs to be done to graduate, and we must be able and willing to articulate why something changes or a condition is added. Sometimes I can only look as far forward as the next court appearance.

The legal outcome is also not the same for every participant who comes into the Hennepin County MHC.[70] Participation in the MHC usually starts with less time in custody or fewer days of

63. Probation officers screen felony cases and social workers screen non-felony cases. The screens involve answering very personal questions related to mental health history, chemical use, and exposure to traumatic events.

64. TEN ESSENTIAL ELEMENTS, *supra* note 37, at 4.

65. *Id.*

66. MHC Database, *supra* note 27.

67. BENCHBOOK, *supra* note 3, at 86.

68. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 13.

69. *Id.*

70. *Id.* at 7.

community service required at sentencing for people who agree to work the program, and often results in a lesser criminal conviction than originally charged. Like a primary addiction court program, the point is to begin treatment as soon as possible rather than delay it by requiring an in-custody period. A judge may depart from a presumptive prison commitment if the defendant has an SPMI and the judge orders completion of an appropriate supervised alternative living program that has a mental health treatment component.[71] This allows attorneys and judges to send defendants to the MHC program even if the defendants were facing a prison sentence.

Although we often do not require punishment up front, our responses to violations include community service or limited incarceration when deemed appropriate.[72] Participants who fail to complete the program can serve all of the time originally stayed on the case.

E. *Informed Choice*[73]

Defendants are assisted in understanding the program requirements in a variety of ways in our MHC. The base for assuring participants can understand the requirements is their relationship with the professionals. In addition to one judge,[74] who has a preferred back-up judge also trained in the problem-solving court model, the team members are consistent.[75] Legal counsel is available at every hearing; the Hennepin County Public Defender's Office dedicates a managing attorney for the felony calendar and a contract public defender for the misdemeanor calendar each

71. MINN. STAT. § 609.1055 (2014).
72. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 13.
73. *Id.* at 5.
74. *Id.*
75. *Id.* at 4. Studies show that cost savings and recidivism rates are adversely affected when the judge spends less than two years on the court assignment. SHANNON CAREY ET AL., EXPLORING THE KEY COMPONENTS OF DRUG COURTS: A COMPARATIVE STUDY OF 18 ADULT DRUG COURTS ON PRACTICES, OUTCOMES AND COSTS 9 (2008), http://www.ncjrs.gov/pdffiles1/nij/grants/223853.pdf; DRUG COURT BEST PRACTICE STANDARDS I, *supra* note 20, at 1. Similar reductions in effectiveness have been found when any team member leaves. DRUG COURT BEST PRACTICE STANDARDS II, *supra* note 7, at 47; Douglas Marlowe, Chief of Sci., Law, & Policy, Nat'l Ass'n of Drug Court Prof'ls, Presentation at the Statewide Drug Court Conference in Minnesota (June 2, 2015).

week.[76] They fill in for each other and there is a dedicated back-up attorney from their office as well. In unsettled felony cases, the assigned assistant public defender that originally referred the case to MHC personally comes to the calendar for the plea and sentencing. This consistency in legal representation is very important for the participants. The defense attorneys know the range of responses used by the judge and are privy to the discussions at staffing meetings with the other professionals. The defense attorney can communicate legal ramifications of choosing not to complete an ordered program if a participant is wavering. In addition to the small attorney team, each participant works with just one of the seven probation officers.[77] The team of probation officers covers for each other during vacations and are all present during staffing meetings when each participant is discussed. Again, the continuity helps the participant receive a consistent message from the professionals on the team, which increases understanding of the expectations. The very existence of these stable relationships is important to help the participant hear their requirements. To have trust with the person talking is important to everyone, but especially to a person who has suffered trauma at the hands of others or whose mental health symptoms make them relatively suspicious of people.[78]

Because some of the mental illnesses that participants experience have fluid symptoms, the MHC team is always checking in with participants to assure they understand the expectations. This is done at treatment,[79] during one-on-one probation meetings,[80] discussions with the attorney,[81] and judicial review hearings.[82] Competency is always assessed by members of the team,

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76. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 5.

77. *Id.* at 6. DOCCR currently dedicates seven probation officers who work directly with the clients and a corrections unit supervisor to the team. Five hold full-time supervision caseloads and the other two share screening duties and supervise smaller caseloads. An additional probation officer was assigned in January 2015 (and is included in these numbers) due to the consistently high number of participants.

78. Paranoia, delusions, or other symptoms that prompt distrust can be present in schizo affective disorder, schizophrenia, and borderline personality disorder, for example. *See* DSM-5, *supra* note 60, at 99, 105, 663–64.

79. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 13.

80. *Id.* at 11.

81. *Id.* at 5.

82. *Id.* at 11.

and when anyone is sincerely concerned that a participant does not understand the expectations, the judge will order a competency evaluation.[83] We recently had a woman in our program that, after two full years in the program and pretty steady progress, suddenly stopped caring for her diabetes and started violating a number of specific court orders. She has a lifelong history of trauma and diagnoses of schizophrenia, paranoid type; post-traumatic stress disorder; and a TBI.[84] We directed her to see the team nurse daily to make sure she took her insulin as needed, but after a short reprieve, issues with compliance started again when she suddenly became distrustful of, and hostile toward, her probation officer and suspicious of her attorney. I ordered a competency evaluation and the psychologist opined she was not competent at that time because her mental illness symptoms had become quite severe. She was civilly committed to a local hospital soon after.

Competency concerns have also arisen with participants who suffer from dementia because we see their cognitive function decline. When a participant does not have family support, no longer remembers the MHC team, or is unable to care for himself, we turn to competency and the civil system to provide for the ongoing care needs.

As discussed above, specific programming can change as a person moves through the court program.[85] Sometimes when a chemical addiction is put into remission, a new mental health concern is uncovered and must be addressed.[86] While we favor mental illness and chemical dependency (MICD; also known as dual diagnosis or co-occurring) programs for simultaneous treatment,[87] not all mental illness symptoms can be treated by all treatment providers.[88] When treatment goals change, the participant is included in the discussion to focus the treatment in a new direction. That buy-in is often essential to success, allowing us to avoid a potential period of resistance and interim failure.

83. *See* MINN. R. CRIM. P. 20.01. (2015).
84. Screening Reports, *supra* note 51.
85. BENCHBOOK, *supra* note 3, at 87.
86. *See id.* at 89.
87. *See id.* at 87.
88. *See id.*

F. *Treatment Supports and Services*[89]

We are able to connect participants to a wide variety of comprehensive and individualized treatment supports through a large number of providers in the community.[90] This is the most obvious benefit of being in a large metropolitan area. We only accept participants who live in Hennepin or Ramsey County because our team members know the programs available in those areas.[91] Most of the court's participants receive publicly funded services; funding which is dispensed at the county level.[92] One of the social workers on our team is a specialist in programs available in Hennepin County.[93] His knowledge is invaluable to getting a wide range of appropriate services in place for our participants. Our other social worker is exceptionally skilled at explaining community wrap-around resources and making referrals at first meetings with potential participants.[94]

We also have incredible resources unique to the Hennepin County MHC. The team that developed the MHC was truly visionary and created a physical location for many of the

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89. TEN ESSENTIAL ELEMENTS, *supra* note 37, at 6.

90. *Id.*

91. An additional reason for taking Ramsey County residents is that their cases committed in Hennepin County will be supervised by a Hennepin County probation officer in or out of MHC. Residents of any of the other eighty-five Minnesota counties will have probation supervised where they live. We want to provide the best service model possible for the people supervised in Hennepin County.

92. MHC Database, *supra* note 27.

93. *See* MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 5–6.

94. *See id.* at 5, 9. Services are provided by ARMHS or Assertive Community Treatment (ACT) Teams.

> [ACT] is an intensive, comprehensive, non-residential rehabilitative mental health service . . . team model. Services are consistent with Adult Rehabilitative Mental Health Services, except ACT services are: [p]rovided by multidisciplinary, qualified staff who have the capacity to provide most mental health services necessary to meet the recipient's needs, using a total team approach; [d]irected to recipients with a serious mental illness who require intensive services; and [o]ffered on a time-unlimited basis and are available . . . 24 hours per day, 7 days per week, 365 days per year.

Assertive Community Treatment (ACT), MINN. DEP'T HUMAN SERVS., http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058151 (last updated Oct. 22, 2013).

participants' needs outside the courthouse.[95] It is called Providing Resources and Increasing Services for the Mentally Ill (PRISM).[96] There is a nurse who stores and dispenses medication and talks to the participants as often as five days a week in the same space as some of our probation officers.[97] This allows us to know if there is a change in behavior or physical presentation very quickly and we can address those changes before the participant enters a crisis period. Having a medication dispensary also helps assure medications are not stolen from our most vulnerable participants. Additionally we have a therapist who is wonderful at working with people who have never talked with a therapist before.[98] Many of the people who join the court are reluctant to share information with others and it can take a while for them to develop trust. One young man told me after seeing the therapist a few times, "I do not like meeting with [her], I always cry." I knew from that statement they were working on the right stuff in their meetings, and although it was painful for him at the time, he would eventually find some peace if he continued with therapy. There are many participants who have a history of missing appointments, and community providers cannot be as patient with failures to appear as our dedicated therapist. We also have a psychiatrist present in the courthouse one day per week. She helps us with diagnoses, emergency prescriptions, history of treatment and psychiatric hospitalizations, and review of pharmacy records.[99] Knowing the legal chemicals a person takes is very important to understand behavioral issues and educate the person about medication interactions.[100] Review of prior hospital contact helps us understand limits on appointment-making and treatment options for some of the participants. For example, some people come to us with a restriction that they cannot make appointments at a given clinic but can do same-day walk-ins to fill cancellations.[101] We know the

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95. *See* MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 6.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *See* COUNCIL ON FAMILY HEALTH, DRUG INTERACTIONS: WHAT YOU SHOULD KNOW 2 (2004), http://www.fda.gov/downloads/Drugs/ResourcesForYou/UCM163355.pdf ("Drug interactions may make your drug less effective, cause unexpected side effects or increase the action of a particular drug. Some drug interactions can even be harmful to you.").

101. Screening Reports, *supra* note 51.

participant can still use the provider, which gives us a starting platform, and over time, if the participant cooperates with our program, he will likely earn back appointment-making privileges.

We are always learning about new programs that are available. We invite providers to observe our court and present information about their programs to the probation officers and social workers on the team. Many of our team members actively participate in efforts outside the MHC to improve and increase services for people with mental illness in Hennepin County. For example, members of the court team and the steering committee have joined the Hennepin County Medical Center (HCMC) to learn about triage and diversion programs being used successfully in other parts of the country. Two team members were also on a statewide legislative work group to explore legislative initiatives related to defendants living with mental illness.[102] Hennepin County is exploring an alternative to jail for people who have police contact because of a serious mental illness episode.[103] That alternative would be a short-term safe place with services available to stabilize mental health.[104] Ideally, the location would also have outpatient programming, to help defendants who are incompetent but do not need hospitalization, as well as available housing.[105] Members from the MHC are in the working group that is drafting the proposals. Until that facility is created, we are starting to pilot a competency restoration program (CRP) in a local intensive residential treatment services (IRTS) facility to avoid potential collateral consequences of a commitment[106] and get the criminal case

102. *See* MINN. DEP'T OF HUMAN SERVS., OFFENDERS WITH MENTAL ILLNESSES 7–9 (2015), http://www.mn.gov/dhs/images/Offenders_with_Mental_Illness.pdf. (listing the working group's recommendations for improving the treatment of people with mental illnesses in the criminal justice system).

103. The Criminal Justice Coordinating Council (CJCC) Behavioral Health Subcommittee is tasked with exploring the county's options.

104. For example, Orange County (in Orlando, Florida) has a central receiving center and Harris County (in Houston, Texas) has a neuropsychiatric center. Both receive people who are in mental health crises and referred by police officers. They replace the jails and hospitals for intake of this population.

105. Hennepin County started a pilot local competency restoration program at a Minneapolis intensive residential treatment service facility on September 15, 2015. The criminal and civil commitment systems are working together to get services to people who voluntarily agree to the mental health and educational services after they are found incompetent while the civil commitment is pending.

106. Civil commitments are public, can result in loss of civil liberties, and require specific treatment.

resolved quickly, which serves public safety.[107] We also have members at the table when county resources are allocated for people with mental illness.[108]

G. Confidentiality[109]

Although team members share with each other a lot of confidential information about the participants, participants' health and legal forms are protected in the court, social services, and probation systems.[110] We are careful about details that are discussed in open court, so that private data is not shared on the record.

H. Court Team[111]

The MHC team has a wide variety of professionals who attend all staffing meetings and collaborate to develop treatment responses.[112] We meet as a team for ninety minutes before every court session.[113] We update each other about what has happened with the participants since their last court appearance.[114] The combination of criminal justice professionals, social workers, and input from the treatment and service providers produces a well-rounded view of each participant and gives the judge educated guidance on whether and how to sanction behavioral violations.[115] Because the MHC likes to praise positive choices and continued progress in court, staff members guide the team in selecting who and what to commend.[116]

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107. As soon as the person is competent, he or she is returned to criminal court to resolve the case and presumably be on probation, often in the MHC.

108. Members of our steering committee are viewed as experts in each of the county departments and are called by their directors to provide input or actual testimony for the county board.

109. TEN ESSENTIAL ELEMENTS, *supra* note 37, at 7.

110. *Id.*

111. *See id.* at 8.

112. *Id.*

113. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 8 ("The mental health court team works collaboratively to help participants achieve treatment goals by bringing together staff from the agencies with a direct role in the participants' entrance into, and progress through, the court program.").

114. *Id.* at 11.

115. *See id.*

116. *See id.* at 12–13 .

In addition to the weekly court calendars, the team is also represented on the steering committee and has input on the court process.[117] Most changes to the process have been initiated from suggestions by team members. The team also receives on-going training related to issues facing both the participants and ourselves.[118] We are well aware of compassion fatigue, and after attending a specialized training on the subject,[119] we practice techniques to help prevent burn-out in our members.

I. Monitor Adherence to the Court Requirements[120]

The court team collaboratively monitors participants' adherence to court conditions as discussed above.[121] It also employs individualized responses to positive changes and negative behaviors.[122] Although, as presiding judge, I have to make final decisions about responses to behavior, the input of the variety of professionals on the team is invaluable in helping me feel that the response is the most effective for that individual.[123] Although a basic tenet of an addiction court (i.e., DWI or Drug Court) is predictability of response through advance notice,[124] in the MHC, almost everything is individualized, so the responses are rarely routine. It does have standard responses for missing ordered urinalysis (UA) testing,[125] but even though the number of hours participants who miss a UA will "serve" is known, how they will complete those hours varies depending on physical ability and comfort with strangers.[126] Additionally, participants know that if

117. *See id.* at 4.

118. For example, team members attended trauma-informed care training on October 22, 2015, and multiple TBI trainings in the summer of 2013, as well as statewide drug court training that covered a range of topics in June 2013 and May 2015.

119. Cheryl Kolb-Untinen, the Community Services Manager with Cornerstone, trained the MHC team on November 14, 2013.

120. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 10.

121. *See supra* Section III.I.

122. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 12–13.

123. *See id.*

124. DRUG COURT BEST PRACTICE STANDARDS I, *supra* note 20, at 29.

125. The consequence for a participant's first missed UA is four hours of community service, the second is eight hours of community service, and additional missed UAs are usually sanctioned with sentence to service (STS), rather than community service.

126. There are organized work groups that go out on eight-hour shifts

they fail to complete treatment, there will be a response from the court, but the nature of that response varies depending on when and why the failure occurred.[127] That response can also depend on how the participant communicated with the probation officers after leaving treatment—an immediate phone call explaining the reason for leaving is different from hiding until arrested on a warrant.

We use UA testing which, in addition to showing illegal chemicals and alcohol, also identifies whether prescribed medication is present.[128] Substances tested from the samples are individualized based on historical chemical usage and test results for each participant while they are in the MHC.[129]

The probation officer talks directly to the treatment providers, not about what the client says in treatment, but to make sure the client is attending treatment regularly and participating as expected.[130] The same is true for housing programs—we want to preempt terminations from programming, and our professionals can help explain expectations to smooth out adherence problems.[131] If that does not work and a participant is terminated from an outside program, that person will often appear in court on the next calendar in custody. We have an immediate response and make a new plan to get back on track and avoid a new criminal charge or psychiatric hospitalization.[132]

J. Sustainability[133]

The steering committee includes a research analyst.[134] The analyst helps collect and analyze data to demonstrate the impact of

organized through DOCCR called STS. STS requires a level of physical ability that some of our participants do not possess, so instead, those court participants are able to do community service at a non-profit of their choice. Likewise, people who cannot work with strangers or for eight hours at a time, usually due to physical limitations, are ordered to do community service instead of STS. We work with a program that makes jewelry and blankets for a non-profit to sell. I order women, who we would like to see socialize more, to do that specific program. Sometimes, however, the violation is so severe that a short jail stay is ordered.

127. DRUG COURT BEST PRACTICE STANDARDS I, *supra* note 20, at 26–33.

128. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 11–12.

129. Each substance tested adds expense to the process. We do "full panels" periodically, but primarily focus on the participant's drug or drugs of choice.

130. MHC Database, *supra* note 27.

131. *Id.*

132. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 12–13.

133. TEN ESSENTIAL ELEMENTS, *supra* note 37, at 10.

the court program, assess the court's performance, and institutionalize the court processes.[135] The Fourth Judicial District Research Department developed databases for the problem-solving courts in 2014.[136] The probation officers, social workers, and court coordinators provide information that is entered into the database. We are able to get timely information about each of our courts including the MHC. This database will aid the process of conducting formal assessments of the court.

Funding is also an important part of sustainability.[137] We enjoy ongoing financial support from the Department of Human Services (DHS)[138] and ongoing support of all stakeholder departments to devote adequate personnel to the team. Participation in county and state initiatives by individual team members also cultivates and expands generalized support for the court.[139] Many state legislators have visited the MHC to see what is available for defendants with mental illnesses[140] and members of our team presented to a joint Minnesota legislative committee about the court in 2014.[141] Spreading knowledge about this court and how it saves resources in other areas, such as hospitalization costs, helps support the program.

IV. SPECIFICS OF HENNEPIN COUNTY MHC PROGRAM

A. *Qualifying Criteria*

We do not work with every criminal defendant who has experienced mental illness. We only accept specific diagnoses, discussed in the paragraphs below.

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134. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 4. Dr. Matthew Johnson has held this position since early 2014.

135. MHC Database, *supra* note 27.

136. *Id.*

137. TEN ESSENTIAL ELEMENTS, *supra* note 37, at 10.

138. A grant renewed annually since 2011.

139. *See supra* Section III.H.

140. Although not memorialized, the MHC regularly hosts visitors from the legislature.

141. Specifically, members of the MHC team presented at the September 16–17, 2014, CLE hosted by the Minnesota State House Judiciary Finance and Policy Committee. The CLE was entitled, Specialty Courts in Minnesota: Function and Impact.

Serious and prolonged mental illness diagnoses are the most frequent basis for acceptance into the court.[142] We accept defendants who are diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, and borderline personality disorder.[143] These are all treatable conditions when working with mental health professionals.[144] Additional or other diagnoses do not preclude acceptance. This population tends to exhibit co-occurring disorders and most defendants attend at least one MICD treatment program while they are in the MHC.[145] The key for them is to consistently take prescribed medication and refrain from non-prescribed chemical use.[146] Many of these individuals do not like the side effects of the medication they tried years ago, which is why they take street drugs instead. I try to impress my reasoning on them: that prescriptions provide consistent chemicals that are actually in the pills, as opposed to the uncertainty and variety of chemicals in the substances bought on the street. We also talk about advances in medication since the last time they tried prescriptions. The people who agree to join the MHC are willing to try medications (often new types since they last worked with a doctor) and decide anew if the side effects are bearable. I understand the struggle because I see the side effects every week as adjustments are made. Some people cannot stay awake during court even though we start at 10:00 a.m. They often apologize and explain the medication makes it difficult to get up and stay awake. I have seen people gain or lose

142. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 8; MHC Database, *supra* note 27.

143. *Id.*

144. *See, e.g.*, *Bipolar Disorder*, NAT'L INST. MENTAL HEALTH, http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml (last visited Mar. 19, 2016); Borderline Personality Disorder, NAT'L INST. MENTAL HEALTH, http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml (last visited Mar. 19, 2016); Depression, NAT'L INST. MENTAL HEALTH, http://www.nimh.nih.gov/health/topics/depression/index.shtml (last visited Mar. 19, 2016); Schizoaffective Disorder Treatment and Drugs, Mayo Clinic (Jan. 24, 2014), http://www.mayoclinic.org/diseases-conditions/schizoaffective-disorder/basics/treatment/con-20029221; Schizophrenia, NAT'L INST. MENTAL HEALTH, http://www.nimh.nih.gov/health/publications/schizophrenia-booklet-12-2015/index.shtml (last visited Mar. 19, 2016).

145. MHC Database, *supra* note 27.

146. *See generally* MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at apps. A–C (providing a sample release of records and information form, conditional release order, and participant agreement).

dramatic amounts of weight in short time periods. I continue to encourage working with psychiatrists, however, because I have seen those same people achieve emotional regulation, get to a steady weight, present a bright disposition, and experience a productive life when they progress through the adjustment period. This is a much better result than self-medicating with illegal drugs or simply living with the untreated illness and the instability that ensues—the instability that led them to be charged with crimes in the first place.[147]

We also work with people who have experienced a significant decrease in functioning following a TBI.[148] This is a very difficult population to work with because TBIs affect people differently.[149] The participants are in a new state of being following the brain disorder and can be easily frustrated by the changes. Our success rate varies with this population. We worked with one man for many months that simply had no impulse control related to a certain woman. He articulated a desire to follow the rules, and we attempted many strategies to try to keep him away from her, but ultimately we could not find a way to divert him from repeating the same action short of physical separation through his incarceration. In another case, however, a man came into the MHC with a TBI and cocaine addiction. He attended a specialized TBI/chemical dependency treatment program at a local treatment center and achieved long-term sobriety while he gained needed insight into the changes in his brain functioning.

The final diagnosis we accept is developmental disability.[150] While the individuals admitted with developmental disability must be competent to participate, many still learn slowly and struggle on traditional probation. They tend to be vulnerable and are often taken advantage of by others. Many of the developmentally delayed participants present as defendants who cashed counterfeit checks[151] they got from strangers, or they agreed to do something to be nice to a person who only wanted to profit from them through a crime with much less personal exposure. The frequent contact and dialog with the probation officer and the judge helps protect our

147. BENCHBOOK, *supra* note 3, at 213.

148. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 8.

149. David Lenrow, TRAUMATIC BRAIN INJURY, http://www.traumaticbraininjury.com/ (last visited Mar. 20, 2016).

150. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 8.

151. MHC Database, *supra* note 27.

Meyer: Hennepin County Criminal Mental Health Court: Experiences in a La

participants from similar situations and assure their compliance with court orders.[152] It is usually a slow process, but we have seen great results in changing behavior and circumstances of the participants with developmental disabilities.

In addition to having an included diagnosis, that condition must significantly impact the defendant's life and be related to the criminal charge in order for the defendant to be offered a spot in the MHC.[153] For example, the defendant may be experiencing untreated bipolar disorder and during a transition in mood, may threaten a family member or emergency responder called to help. Likewise, a similarly situated defendant may engage in serious self-harm. Left untreated, the illness will continue to put the defendant in similar situations. On the other hand, if the diagnosis has no current impact, there is nothing for our court program to do. Once a person is taking appropriate medication, working regularly with a prescribing psychiatrist, perhaps seeing a therapist, and has housing and employment, they are already where we want to see them at graduation.[154] There would be no point to adding frequent probation meetings and court reviews if we do not want to change any behavior.

B. Community Cross-Section

The backgrounds of the participants in the MHC vary greatly.[155] We see a lot of young people experiencing their first significant mental illness episodes. When a range of symptoms is coupled with the person leaving his or her parents' home, the person can be left baffled and debilitated.[156] We worked with a young man from an affluent western suburb who, after graduating

152. We also have a rule that our participants cannot work as police informants while they are in the court program. This is to help end confusion about whether they can engage in the illegal activity at any time because a police officer said they could while working with the officer. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 12.

153. *Id.* at 8.

154. *Id.* at 13.

155. MHC Database, *supra* note 27.

156. "Mental illnesses usually strike individuals in the prime of their lives, often during adolescence and young adulthood." NAT'L ALLIANCE ON MENTAL ILLNESS MINN., WHAT IS MENTAL ILLNESS: MENTAL ILLNESS FACTS 2, http://www.namihelps.org/assets/PDFs/fact-sheets/General/What-is-Mental-Illness.pdf (last visited Mar. 16, 2016).

Published by Mitchell Hamline Open Access, 2016

from a private high school, was attending a local university when he experienced his first psychotic episode. He lashed out at his roommate in a frightening way. The roommate was naturally concerned for his own safety, but he also wanted help for his friend.[157] We were able to provide that help, and he successfully completed our program and returned to his studies.

We also work with several refugees from war-torn countries, primarily in Africa,[158] who suffered physical and psychological torture so horrific that they will not talk about it, but their bodies bear the permanent signs that attest to their suffering. Participants who agree to work with us and eventually talk about it describe watching their parents murdered, being personally injured by shrapnel and bombs, and being separated from family for years in refugee camps. One of our current participants was forced to serve as a soldier at age seven. He was given drugs throughout his youth by the older soldiers that clearly affected his brain development and outlook on life.[159] Another woman from an Asian country was kidnapped from her birth family at age six and sold to an adoption agency. Her U.S. adoption failed and she ended up in the foster care system. Now as an adult she has many challenges related to that trauma and failed attachment attempts.[160]

We also see a fairly common thread of personal stories that involve being raised by parents with untreated mental illness, serious drug addiction, or both.[161] They simply never had a capable and caring adult in their lives. They have never had a person sincerely tell them they did a good job. They had no positive role model for their now-adult relationships. What they had were volatile, unpredictable adults, modeling instability and creating constant vigilance and mistrust. Developing trust with participants in the MHC with this type of background takes incredible patience and often very uncomfortable growth for the individuals. Watching the process is incredible, however, and well worth the bumps along the road for people who stick around through the growing pains. Ultimately, this makes participants not just more law abiding and stable, but better parents and grandparents. The changes result in multigenerational improvement, and that is truly priceless.

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157. Screening Reports, *supra* note 51.
158. *Id.*; MHC Database, *supra* note 27.
159. Screening Reports, *supra* note 51.
160. *Id.*
161. *Id.*

As of August 1, 2015, Hennepin County MHC had 201 active participants. One hundred thirty-five of them had at least one current felony case. Fifty-nine percent of the total participants were men, but when felony defendants are excluded, the gender division is nearly equal. The percentage of women in the program is significantly higher than the entire criminal population, where women make up only 25% of the total.[162]

All people charged with a crime in Minnesota are asked to identify their race when they first appear in court.[163] Forty percent of MHC participants identify as white or Caucasian, while 37% self-identify as black or African American.[164] The next largest group is the 6% who identify as Native American.[165] There are also 10% who have not provided the race information.[166] The entire pool of criminal defendants identifies nearly 37% Caucasian, 41% African American, and 4.2% Native American, while 10% choose not to report a race.[167] As you can see, the MHC has a fairly representative racial cross-section of the criminal defendant population. It is important that problem-solving courts are available to historically disadvantaged populations,[168] and we are available to all populations in the MHC. The largest age group in MHC is twenty-five- to thirty-four-year-olds, but the next largest group is forty-five to fifty-four. We see an aging-out process similar to the entire criminal cohort with less than 15% of our participants being over the age of fifty-four.[169] The participants range each week from new adults to grandparents.

162. Report from Dr. Matthew Johnson to author (July 2015) [hereinafter MNCIS Reports] (on file with author) (collecting data from the Minnesota Court Information System).

163. "In 2001, Minnesota began collecting self-reported race data in every criminal and juvenile case at first appearance." Alan Page, *Bias in the Courts?*, Minn. Jud. Branch (July 17, 2003), http://www.mncourts.gov/About-The-Courts/NewsAndAnnouncements/ItemDetail.aspx?id=216.

164. Report from Allison Holbrook to author (July 1, 2015) [hereinafter Holbrook Report] (on file with author) (providing statistics on MHC participants).

165. *Id.*

166. *Id.*

167. *Id.*

168. DRUG COURT BEST PRACTICE STANDARDS I, *supra* note 20, at 11–19.

169. *Id.*

The types of crimes involved in MHC are also varied,[170] although theft is the leading charge at every criminal level. Other prevalent felony charges include drug possession, property damage, non-residential burglary, assault against police officers and medical personnel, and terroristic threats. The most frequent non-felony cases—in addition to theft—involve charges of trespass, assault, disorderly conduct, and DWI. As stated above, the safety of the other participants and placement/programming options factor into eligibility decisions, but we will consider all types of criminal charges sent to us.[171]

C. Outcomes and Available Data

There has not been a formal stand-alone study of the Hennepin County MHC since 2006.[172] The program was included in the 2010 MacArthur Mental Health Court Study[173] and the 2009 National Center for State Courts Report on Mental Health Courts.[174] In 2013, the MHC team changed the way we collect data, and in 2014, the district court added an internal database specifically for the problem-solving courts.[175] The goal is to make reporting on the courts easier by constantly collecting the needed data for use at the time of an evaluation.

From January 2013 through July 2015, 408 people ended their involvement in the program[176]: 213 were successful completions, but 189 left without completing the program. Six people died while in the program. Clearly, that is not a very high graduation rate. But the 213 who finished the program showed significant positive changes in their behavior. They were also connected with ongoing mental health care in their community, demonstrated months of continuous sobriety, and had their physical health needs

170. *See* MNCIS Reports, *supra* note 162.

171. *See* MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 8–9.

172. *See* DEBORAH A. ECKBERG, FOURTH JUDICIAL DIST., EVALUATION OF THE HENNEPIN COUNTY MENTAL HEALTH COURT (2006), http://www.mncourts.gov/mncourtsgov/media/assets/documents/4/reports/MHC_eval_(2006).pdf.

173. *See* Henry J. Steadman et al., *Effect of Mental Health Courts on Arrests and Jail Days: A Multisite Study*, 68 ARCHIVES GEN. PSYCHIATRY 167, 167 (2011).

174. NICOLE L. WATERS ET AL., NAT'L CTR. FOR STATE COURTS, MENTAL HEALTH COURT CULTURE: LEAVING YOUR HAT AT THE DOOR (2009), http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/209.

175. MHC Database, *supra* note 27.

176. Holbrook Report, *supra* note 164.

addressed.[177] When they entered the program, 20% of the defendants did not have insurance and less than 2% were uninsured when they left.[178]

It is one of the team's goals to reduce the amount of time participants spend in expensive psychiatric hospital beds. If they receive steady care for their mental illness symptoms, then they are less likely to enter a mental health crisis and need hospitalization. Even when traumatic events occur, they will have balance and coping skills that will prevent the need for institutional crisis intervention. This is a difficult thing for a criminal justice system to measure, however. The Health Insurance Portability and Accountability Act (HIPAA) protects the dissemination of medical information, but the result is that it generally prevents sharing of that data by the entities that keep it.[179] We are able to collect that information on our participants through signed releases of information;[180] the more difficult question is how to collect that information on a comparison group. We may be left with a less desirable evaluation in this area comparing the participants against only themselves before and after entering the court. A better evaluation would compare the number of hospital bed nights for participants in the MHC (before and after court involvement) with defendants who come to court and do not receive the MHC programming, often referred to in the studies as treatment as usual. The Fourth Judicial District Court Research Department continues to explore ways to collect needed data to produce a robust evaluation of the court program.

D. What Have We Learned?

The MHC team has worked with the mental health systems in Hennepin and Ramsey Counties for many years. We have learned to take a holistic approach to solving the problems presented to and by the participants. We are also in a unique position to learn about and work with the variety of programs available for people

177. MHC Database, *supra* note 27.

178. MNCIS Reports, *supra* note 163 (calculating percentages based on 408 defendants that left, regardless of their success).

179. Pub. L. No. 104-191, 110 Stat. 1936 (1996). *See generally* 45 C.F.R. § 164.502 (2013) ("A covered entity or business associate may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.").

180. *See* MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at app. A.

with mental illness. We have seen the strengths of many programs and have learned how to facilitate access those programs. We know what has worked best for other people suffering from SPMIs, TBIs, and intellectual disability. As a result of the team's experience, we can steer participants to the programs most likely to lead to behavioral health change based on their individual needs.[181]

We have also seen what does not work and are able to be part of the systemic accountability. If a program is not providing the services advertised, we have contact with professionals who can make changes. For example, there are supervisors from HSPHD on our steering committee who can demand information and affect funding for programs that do not provide needed services promised to our clients.[182]

We have learned to be client-centered rather than client-directed. Our team members know what works, and we often have to overcome the resistance of the participants to push them past their comfort zone to get appropriate services in place. While we are careful not to be patronizing, we are in a parental-type role and rely on the trust we build with the participants to encourage them to try new treatment approaches. Many of the participants are pleasantly surprised by the changes they experience in their lives when they try the services we suggest.

We have learned about the great work being done by Community Outreach for Psychiatric Emergencies[183] for people in crisis and we call them to the courthouse when needed. We know several incredible local ACT Team providers[184] and try to match our new participants with an appropriate agency right away.[185] Independent Living Skills workers are employed as discussed below. We also involve county social services as appropriate, and will get general case managers involved to assist the team in getting

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181. *See* BENCHBOOK, *supra* note 3, at 87.

182. Rule 31 funding for treatment providers who take participants not covered by insurance is allocated by HSPHD in Hennepin County.

183. Community Outreach for Psychiatric Emergencies is available when a severe disturbance of mood or thinking threatens a person's safety or the safety of others, and its professionals are available to manage the immediate crisis and provide a clinical assessment.

184. ACT Teams are available throughout Minnesota. *Assertive Community Treatment (ACT) Teams in Minnesota*, MINN. DEP'T HUM. SERVS. (Aug. 9, 2010), http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_142448.pdf.

185. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 5.

appropriate services for participants who qualify.[186] One of our social workers is familiar with a wide array of available government services and facilitates contact for individual participants with those agencies.[187] We also make contacts for participants who appear to qualify for social security benefits or who want to appeal a denial.

From long-term exposure, the professionals on the MHC team have become cross-trained in many areas. For example, I have learned more about what is involved in being a good probation officer in my first two years of my current assignment than I did in the prior twenty years I spent in the same criminal justice system. The consistent contact with social workers has also taught me much about how to employ a social-work approach in my work. Likewise, we learn from each other. As a result of developed expertise, team members are able to identify needs and get the appropriate services in place quickly for a variety of defendants who benefit from those resources. We use the staffing time to discuss every case so that we can give collective advice to the professional working most closely with that defendant.[188] Ultimately, the resource support results in positive behavioral health changes and a decrease in mental illness symptoms.

V. WHAT ELSE CAN BE DONE?

A. *Housing, Housing, Housing*

Our team is unanimous in our opinion that housing stability leads to life stability. Being able to feel safe, have a place to leave possessions, and know you have a place to sleep at night is the foundation of a stable life. Initial housing is difficult to obtain, especially for people who have been unstable in the past and may have lost prior rentals for failure to pay rent that was due. Additionally, the participants in the court program have criminal records. In the current economy, when there are few rental vacancies,[189] landlords are less willing to rent to people with criminal records or a history of not paying rent. While the

186. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 5.

187. *See id.*

188. *See id.* at 11.

189. Matt Sepic, *Construction Booming, but Apartments Hard to Find*, MINN. PUB. RADIO NEWS (Mar. 23, 2015), http://www.mprnews.org/story/2015/03/23/construction-boom-low-vacancy-rate.

participants are in our program, they are treating their symptoms and making the majority, if not all, of their appointments. This gives them a higher likelihood of being able to keep stable housing, even if that has not been true for them in the past. Part of our challenge is to find an opportunity for the participants to demonstrate their positive changes and allow them to develop a better track record.

Some of our participants are not able to thoroughly care for themselves. They require specialized, supportive housing with treatment for their mental illness. They can work with ILS workers to develop skills needed to live alone (e.g., shopping, cooking, safety, transportation, and health management).[190] But until those skills are acquired, they need to be in supportive housing.

A subset of the court's cohort is eligible for IRTS. DHS defines IRTS placements as "time-limited mental health services provided in a residential setting. Recipients of IRTS are in need of more restrictive settings (versus community settings) and at risk of significant functional deterioration if they do not receive these services."[191] After extensive work over five years, Hennepin County has recently created thirty-two new IRTS beds.[192] While these placements are perfect for some people, when DHS writes "time-limited," it means ninety days. This can be a great start for some of our participants, but the need to locate permanent housing continues even while they are in an IRTS placement.

Some of our participants are unable to keep undesirable people out of their homes.[193] They are vulnerable to family members and drug dealers who need a place to crash or deal drugs.[194] A supportive house with locked doors and rules about who can visit is helpful in teaching limit setting. There are not enough

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190. *Independent Living Skills*, ALLINA HEALTH, http://www.allinahealth.org/Courage-Kenny-Rehabilitation-Institute/Programs-and-services/Community-services/Independent-Living-Skills/ (last visited Mar. 20, 2016).

191. *Intensive Residential Treatment Services*, MINN. DEP'T HUM. SERVS., http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058155 (last updated Dec. 23, 2013).

192. This was a five-year process from application to opening the beds. Many people not involved in the criminal justice system have been placed on lengthy waiting lists, and these new beds alleviate the back-log and allow some space for our clients who need supportive housing.

193. Screening Reports, *supra* note 51.

194. *Id.*

of these types of housing complexes available for this vulnerable population, and we struggle to find this type of housing for all of our participants who would do better in this setting.

Some of the participants who are able to care for themselves have strong feelings about not wanting to spend money on housing. They would prefer to be homeless and stay in shelters in order to control the money they receive. This is a mindset that takes a lot of work to change, and we are not always successful in developing trust around financial issues. Even for the people who will agree that a housing program will get a percentage of their monthly benefits, there is an insufficient volume of appropriate low-income housing available. In addition to the impediments listed above, some of our participants do not present well during rental tours at prospective apartments.[195] Again, an apartment owner in the current economy has choices about whom to have live in their property. Often our participants are not the first choice for renters, and getting a foot in the door, so to speak, can be difficult.

Also, there are often additional complications of minor children or a difficult romantic partner when finding housing for our participants.[196] The MHC team and community housing specialists are tireless in efforts to get safe and stable housing for the families involved in the court.[197]

Given how difficult it is to find housing, once participants find housing, we work hard to help them keep their homes. The probation officers meet regularly with landlords and program directors to ensure the homes are supportive and have programming in place. They also help the participants understand the rules. Even with these safeguards in place, not all of the participants are able to find or keep secure housing—there are simply not enough homes available, and even improved behavior is not enough when interacting with other people. People less involved in the system may believe that Section 8 housing is the answer for low-income families and believe that it is a good solution for those who can get the vouchers. The U.S. Department of Housing and Urban Development (HUD) released a study in July 2015 that confirmed that people with open-ended housing vouchers have more stability than people staying in limited-

195. Anxiety symptoms may appear during this type of stressful situation.
196. MHC Database, *supra* note 27; Screening Reports, *supra* note 51.
197. MHC POLICY AND PROCEDURES MANUAL, *supra* note 18, at 5.

duration housing.[198] But according to the Minneapolis Public Housing Authority website, "[t]he last opening of the waiting list took place in June 2008. Over 7,000 active applicants currently remain on the list."[199] That dire news is consistent with the information provided by the participants in the MHC.

B. Treatment Waiting

Although we are comparatively rich in treatment options in Minneapolis, our most specialized residential MICD treatment centers are usually full with waiting lists, often approaching six weeks. This leads to major dilemmas. The team must ask, "Where does a homeless drug addict with a serious and persistent mental illness safely wait for treatment?" Unfortunately, the answer is sometimes jail, where he or she will be sober and safe. This is a terrible option, but after multiple relapses resulting in detoxification center or hospital stays, sobriety is the immediate priority. We need more treatment with housing options for our participants to reduce the wait. In response to this need, Park Avenue Treatment Center has opened a specialized long-term SPMI track with a lodging option to complement the existing treatment centers in our area who serve this population.[200] This is exactly what we need, and it will relieve some of the stress of long waiting periods for that population. Difficulties remain in finding treatment options for our participants with TBI and DD, but there are fewer total participants with these presentations so the need is not as great.

We also need a safe and secure medium-term alternative to jail. There are models of jail alternatives being used around the country.[201] In Orlando, Florida there is a central receiving center that police officers can use as an alternative to jail for people they

198. *See* DANIEL GUBITS ET AL., U.S. DEP'T OF HOUS. & URBAN DEV., FAMILY OPTIONS STUDY: SHORT-TERM IMPACTS OF HOUSING AND SERVICES INTERVENTIONS FOR HOMELESS FAMILIES 69 (2015), www.huduser.org/portal/sites/default/files/pdf/FamilyOptionsStudy_final.pdf.

199. *How Can I Apply to the MPHA Section 8 HCV Waiting List?*, MINNEAPOLIS PUB. HOUSING AUTHORITY, http://www.mphaonline.org/section-8/applicants/how-to-apply/ (last visited Mar. 20, 2016).

200. *See Co-occurring Disorders,* PARK AVENUE CTR., http://www.parkavenuecenter.com/COD-mild.html (last visited Mar. 20, 2016).

201. *See, e.g.*, ORANGE CTY. HEALTH SERV. STAFF, ORANGE COUNTY CENTRAL RECEIVING CENTER: 2013–2014 ANNUAL REPORT 6–7 (2014).

come into contact with that appear to be in a mental illness crisis.[202] The officer can choose to drop them at the receiving center rather than taking them to jail or a hospital. The people are then moved to secure beds while they stabilize from crisis. They move from there to appropriate treatment programs and, eventually, to long-term supportive housing that is part of the program.[203] A group of criminal justice and social service professionals is exploring whether that model could be implemented locally and expanded to include people who have been charged with crimes but are waiting for MICD treatment placement.[204]

C. *Post-treatment Housing*

After primary treatment, it is often counterproductive to return a person to the environment where he used drugs before treatment. The best results come from people who follow treatment with sober housing and specific aftercare programming.[205] A woman recently told me in court that, when she was finishing treatment, she begged for a transitional housing plan. She knew she needed a safe place to live and a safe place for her child to visit. She said the counselors kept telling her they would deal with her housing situation later. An incident occurred and she graduated early—housing was not in place. When she got back in contact with us several weeks later, she asked our team rhetorically, but in all sincerity, "Where could I go? Of course I went back to what I knew: drugs. . . . There is always a place to stay with drug dealers."

Most chemical dependency programs incorporate sober housing into transition from residential treatment.[206] We prefer that the sober housing for our participants employ staff that are trained to handle mental illness. Again, very few options are available and those that are available are short term so that the next groups of people who finish treatment also have a place to live while they complete aftercare.

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202. *Id.* at 7.

203. *Id.* at 95.

204. CJCC Behavioral Health Subcommittee.

205. *See Drug and Alcohol Treatment Aftercare: What Is Standard?*, ADDICTION BLOG. (Nov. 23, 2010), http://addictionblog.org/the-news/drug-and-alcohol-treatment-aftercare/.

206. *Sober Living Communities and Housing Options*, RECOVERY.ORG, http://www.recovery.org/topics/recovery-homes/ (last visited Mar. 20, 2016).

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D. Psychiatry and Therapy Appointments

The waiting time for a new patient to see a psychiatrist in Hennepin County is several weeks.[207] Often a new participant is scheduled ten to twelve weeks out to see a psychiatrist in a clinic approved by their insurance.[208] This leads to people using the hospital facility to see a psychiatrist and getting short-term medication without scheduling a follow-up to assure compliance with medication and dosage review.[209] Those are imperative requirements for new medication.[210] It appears, from my experience, that there are not enough psychiatrists practicing in the Twin Cities available to work with the court's population.

The clinics that have resources are understandably trying to run a business. They set appointments and see patients at a time set in advance. The SPMI population often has difficulty keeping appointments, especially early in their treatment program.[211] If they do not have supportive people that help them get organized, they are often unable to get where they need to be when they are expected to be there. We have the same difficulty in the MHC where 30% of the people referred fail to appear at the appointment they make with our screener.[212] We have to employ extreme flexibility with scheduling and chances to make appointments. Some clinics give people up to three chances to miss appointments, and then they either prohibit them from making future appointments or switch them to same-day care only. So, if there is an opening the day they call, then they can be seen, but they cannot make an appointment for tomorrow or next week. Although same-day-only appointments restrict access, they still leave some room for people struggling to get help. Having similar

207. A participant recently confirmed what probation officers have been telling me—that there is a three to four month wait for a new patient to get an initial appointment with a psychiatrist in Hennepin County.

208. MHC Database, *supra* note 27.

209. Acute psychiatry services are available at HCMC and the RCMHC will see patients in an emergency in Ramsey County.

210. *Mental Health Medications*, NAT'L INST. MENTAL HEALTH, http://www.nimh.nih.gov/health/topics/mental-health-medications/mental-health-medications.shtml (last visited Mar. 20, 2016) ("After taking the medication for a short time, tell your doctor how you feel, if you are having side effects, and any concerns you have about the medicine.").

211. Screening Reports, *supra* note 51.

212. Holbrook Report, *supra* note 164.

options for psychiatrists and therapists at all clinics would help this population get the help they need.

E. Crisis Intervention Training

There is specialized training available for police officers called Crisis Intervention Training (CIT).[213] Some law enforcement departments group their trained officers into Crisis Intervention Teams. There are many benefits to having police officers trained to recognize mental illness symptoms, the greatest of which is that it saves lives. Officers can stay safer when dealing with people in mental health crisis if they know what they are actually seeing.

In a perfect world, every police officer would be trained in crisis intervention. Not every officer is trained because the training is expensive, long, and not currently required by the Peace Officer Standards and Training Board. In 2014, the statewide Offenders with Mental Illness Workgroup recommended an expansion of CIT for seasoned officers.[214] HSPHD was recently awarded a grant to help cover the expense of training officers for Hennepin County police departments and the sheriff's office. This would relieve part of the monetary burden to the departments, which have to pay an officer to be on the street while another officer is in a week-long training.

VI. CONCLUSION

Problem-solving treatment courts are the best way to supervise criminal defendants in the community who present with high needs and a high risk to re-offend absent intervention.[215] The experiences in Hennepin County MHC support that statement. We created a supportive environment for defendants who live with SPMIs, TBIs, and developmental disabilities to engage in appropriate services while remaining directly accountable to a judge. Regular reviews allow for timely responses, which aid in behavior modification. Interaction with court professionals who

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213. *See generally What Is Crisis Intervention Team (CIT) Training?,* MINN. CIT OFFICER'S ASS'N (Nov. 9, 2011), http://mncit.org/what-is-crisis-intervention-team-cit-training/.

214. CMTY. SUPPORTS ADMIN., MINN. DEP'T OF HUM. SERVS., OFFENDERS WITH MENTAL ILLNESS 1, 7–8 (2014), http://www.mn.gov/dhs/images/Offenders_with_Mental_Illness.pdf.

215. BENCHBOOK, *supra* note 3, at 213.

show genuine care and concern, but never lose sight of public safety, helps motivate the participants to make positive changes.

The program has a variety of professionals who can provide direct services to participants while they establish long-term program contacts in the community. The professionals involved in MHC have developed expertise in finding appropriate programming and motivating participants to cooperate with those services.

We have worked with other county and private agencies to explore new interventions for incompetent defendants that address clinical needs and public safety. I predict this type of innovation will continue to develop in Hennepin County for an expanded population of people experiencing mental illnesses who have contact with the criminal justice system.