Mental Health Counseling and Specialty Courts

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Specialty courts, such as mental health courts, drug courts, and veterans treatment courts, were developed with the intention of reducing recidivism and obtaining better outcomes for participants selected from the particular populations served by each court. Efforts to improve the public good have produced a reimagining of the justice system with a focus on therapeutic jurisprudence and restorative justice. Counselors contract with the courts to provide therapeutic services that assist the courts in supplementing the more traditional court functions of punishment, corrections, and public safety. Mental health clinicians can fulfill pivotal roles in these courts as advocates, educators, and clinical technicians. This paper provides an introduction into specialty courts for counselors considering provision of clinical services in these still-developing areas.

Keywords: **specialty courts, mental health courts, drug courts, veterans treatment courts, mental health counseling**

In 1963, the passage of the Community Mental Health Centers Act (Feldman, 2003) led to the closing of most state psychiatric hospitals and the provision for providing services at the community level. However, the same act had the unintentional result of transferring patients with severe mental illness from psychiatric hospitals into jails and prisons (Farmer et al., 2017; Hnatow, 2015; Shenson, Dubler, & Michaels, 1990; Torrey et al., 2014). More recently, the war on drugs has exacerbated the problem of overcrowding in penal and justice systems ill-equipped to provide therapeutic services for these individuals (Hafemeister & George, 2012; Harvard Law Review, 1998; Torrey, 1997; Walsh & Holt, 1999). This predicament has led to the Cook County jail in Illinois being labeled as the country's largest mental health institution (Hill, 2016).

In order to facilitate greater efficiency and effectiveness in the justice system for the populations encountered, specialty courts act to counter a system that historically has depersonalized individuals (Kleinfeld, 2016). Specialty courts identify common issues faced by particular populations and address the underlying causes of criminogenic behavior by focusing on the individual to produce better outcomes. Although mental health professionals fulfill pivotal roles in these courts, many counselors are unfamiliar with specialty courts. The purpose of this paper is to describe the specialty court movement and the roles of counselors within it.

The Justice System—Old and New

The justice system in America has traditionally been one of punitive action—to punish offenders and deter the tempted. Since the 1950s, America's policies targeting illicit drug use have resulted in a large population of low-level offenders serving long, mandatory-minimum sentences, often with inadequate support and resulting in repeated contact with the traditional criminal justice system (Haley, 2016; Kupers, 2015).

Between 1968 and 1978, the number of patients in state mental hospitals fell 64%, while the census in state prisons rose 65% (Steadman, Monahan, Duffee, & Hartstone, 1984). In 2012, the number of prisoners diagnosed with mental illness exceeded 352,000, more than 10 times the number in state

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psychiatric hospitals (Torrey et al., 2014). In the absence of evidence that incarceration without treatment is in their own best interest, or that of society (Isaac & Armat, 1990; Kondrat, Rowe, & Sosinski, 2012), such prisoners are a burden on the limited resources of prison systems in every state.

The specialty court movement arose to address the specific needs of the mentally ill, drug offenders, and other populations, and to effect a decrease in the underlying causes of criminal behavior and thereby reduce the number of people incarcerated in jails and prisons. Specialty courts take the traditionally adversarial roles of prosecution and defense and turn them into cooperative roles to foster a therapeutic environment for those individuals who would benefit (Kondo, 2001). Veterans treatment courts are a more recent addition to the specialty court movement, joining mental health courts, drug courts, gun courts, domestic violence courts, and other specialized courts (Baldwin, 2016). Veterans treatment courts treat underlying causes of crime and other challenges faced by veterans and service members.

The Center for Court Innovation developed three organizing principles for specialty courts (Boldt, 2014). The first principle is a problem-solving orientation that identifies and addresses underlying causes of criminality common to specific groups; the second principle is cooperation with community resources offering treatment and oversight; and the third principle is accountability (Boldt, 2014). These principles work within the context of the two major approaches of specialty courts: therapeutic jurisprudence and restorative justice.

Two Working Approaches in Specialty Courts

The specialty court movement is based on two overarching approaches: therapeutic jurisprudence, which seeks improved outcomes for the individual facing charges; and restorative justice, which seeks restitution for all stakeholders.

Therapeutic jurisprudence promotes a wellness paradigm using the court as a therapeutic tool. Therapeutic jurisprudence takes the approach that it is in the best interest of society to work cooperatively with all stakeholders to provide better outcomes in criminal justice. The model is a new paradigm based on a cooperative and non-adversarial approach of judges, prosecutors, defense attorneys, and community and mental health professionals (Haley, 2016).

Restorative justice is the idea that justice is served by restoration, both to the individuals and to the community affected by crime. In traditional court settings, restoration includes financial restitution by the offender (to the victims) in addition to incarceration (for the public good). The Centre for Justice & Reconciliation has defined restorative justice as a process to heal harms and bring about transformation for all parties (Centre for Justice & Reconciliation, 2017). This is necessary because crime is more than simply breaking the law. Crime also causes people harm and hurts relationships and the community. Thus, a just response needs to address the harms as well as the wrongdoing (Centre for Justice & Reconciliation, 2017). Restorative justice in specialty courts focuses on treatment options for an individual's issues, which promotes the restoration of the offender. Working with specialty courts allows mental health counselors to combine individual therapy with vocational counseling, oversight of community service for program participants, aftercare supervision, and mediation and arbitration with victims to emphasize accountability for the individual (Haley, 2016), impacting the restorative process for all stakeholders. Integrating the counselor's toolbox with all of these challenges requires skill and patience.

Clinical Integration With Specialty Courts

Specialty courts are challenging for all stakeholders. Judges must transition from performing as adjudicators of justice to facilitators of treatment, and the clinician serves both the court and the program participants by providing treatment services. Counselors educate and advocate for participants and are able to frame program objectives into long-term treatment outcomes and participant prognoses for judges and court officers (Kupers, 2015). The mental health counselor, as a therapeutic service provider, becomes a de facto expert who the court relies on to assist in the development and implementation of treatment goals (Hughes & Peak, 2012).

Specialty courts are full of legal terminology, and counselors working with the court can assist in conveying meaning clearly to program participants. A better-informed client will be more able to give informed consent and have more buy-in to the process. Facilitating education for participants increases the likelihood of successful completion of the program, which in turn translates to an improved quality of life and reduction in re-arrest rates (Haley, 2016).

Participants in specialty courts will bring many issues to treatment. Counselors may provide assessments for the presence of mental health disorders, substance use, and social service needs, and they may be called upon to facilitate other assessments on an as-needed basis.

Jurisdiction for participants is an area with a large amount of variety from program to program. For individuals that may be eligible for different programs, placing their case under the jurisdiction of one specialty court over another becomes a question of resources. For example, some mental health courts are able to address the substance use issues of participants, while others are not (Fisler, 2015).

Specialty courts operate under the model of managed care, in which the treatment modalities are brief and evidence-based, such as with cognitive behavioral therapy (Kupers, 2015). The Council of State Governments outlined best practices for the creation of mental health courts (Thompson, Osher, & Tomasini-Joshi, 2007), which included behavioral modification techniques and operant conditioning as a key educational element, and included instruction on proper use of negative and positive reinforcement techniques (Russell, 2015). Judges and court officers are able to use the Council of State Governments' model to structure their courts within the limitations of local resources and needs. Awareness of these needs and limitations allows the clinician to be more effective in influencing outcomes and program success for participants of specialty courts, of which three types are included in this discussion: drug courts, veterans treatment courts, and mental health courts.

Drug Courts

In 1989, a judge in Miami, Florida, started ordering drug users that came before the court into treatment in lieu of jail. Out of this was born the drug court, which has now become the model for specialty courts. The Miami court started as a response to the criminogenic life-cycle experienced by low-level offenders appearing before the court: substance use → crime → jail → release, then repeat (Fulkerson, 2009). The effect of the new paradigm on the cycle became: substance use → crime → treatment → support and supervision, leading to reduced recidivism (Haley, 2016). Since that time, drug courts have quickly spread across the nation. By 2001, there were more than 700 drug courts in the United States (Harrison & Scarpitti, 2002) and 1,600 as of 2010 (Haley, 2016).

Drug courts use supervision and monitoring to ensure compliance to program requirements. Counselors serve as agents of the court, verifying adherence through substance abuse treatment services, drug testing, talk therapy, and encouraging abstinence as a condition to successful completion. Counselors working with drug court participants face a rather straightforward challenge,

in which compliance to program requirements and overall program success can be quantified through drug testing and analysis of available data, including re-arrest rates. More complicated are issues facing participants in other specialty courts, such as the veterans treatment courts.

Veterans Treatment Courts

As of 2010, the United States had deployed approximately 1.9 million service members to serve in Afghanistan and Iraq (Rizzo et al., 2011). Conflicts from the Middle East have left the United States with over 40,000 wounded (Rizzo et al., 2011) and over 350,000 service members with traumatic brain injury (Baldwin, 2016). As the United States continues to conduct military operations around the world, the need exists to address the specific concerns of veterans returning to non-combat duties. Veterans treatment courts (VTCs) are now addressing, via the drug court model, various needs of this population (Slattery, Dugger, Lamb, & Williams, 2013). The first VTC was established in 2004 in Anchorage, Alaska, but the model from which most programs are built is the one established in Buffalo, New York, in 2007–2008 (Baldwin, 2016).

Issues the counselor may face with participants in VTCs include post-traumatic stress disorder, substance use, military sexual trauma, major depression, and neuropsychological problems (Eisen et al., 2012), as well as homelessness and unemployment issues (Baldwin, 2016). In addition to services available to participants in other specialty courts, VTCs are designed and built recognizing differing needs of supervision and support, including cooperation with the Veterans Administration (VA) and other service members (Russell, 2015). Connections the VTCs have through the VA make a difference for participants, who rely heavily on the VA for benefits. VA connections cannot easily be replaced or replicated and are scarce in many locales (Clark, McGuire, & Blue-Howells, 2014).

VTCs also differ from many other specialty courts in that they have a peer-mentoring component. Mentoring is the use of previous program participants and other service members in a peer-support role, similar to their use in 12-step programs as part of a successful drug treatment protocol. Mentoring is more important for this population because of the military's highly structured culture and the importance of respect for others with military experience (Clark et al., 2014; Russell, 2015).

Like other specialty courts, VTCs have some variance in those eligible for participation. VTCs often limit participation to those with certain mental health diagnoses or substance abuse issues and to those who are not charged with a felony or violent crime. Eligibility also may be restricted to only those deployed to a combat zone or only those who are eligible for VA benefits.

Funding for VTCs is different than that of other specialty courts, which rely on local sources of funding. VTCs get most of their funding through the VA (Russell, 2015), which operates through strict guidelines. In fact, VA guidelines currently limit the role of counselors, preferring instead services performed by psychiatrists and psychologists—a slightly different perspective than one seen in mental health courts.

Mental Health Courts

The first mental health court was introduced in the late 1990s in Broward County, Florida (Linhorst et al., 2009), and by 2010 there were over 200 operating in the United States (Fisler, 2015; Hughes & Peak, 2012). Individuals enter the court system through arrest, usually for minor offenses (Hnatow, 2015; Walsh & Holt, 1999). Mental health courts differ from drug courts in the wider variety of conditions that must be addressed and the greater degree of treatment individualization available for participants. More robust measurement of program success is required as well. In drug court, success can be measured by length of time spent in sobriety. In mental health court, the variety of

illnesses and conditions specific to the individual requires more advanced assessment and occurs in the arena of a team approach, with counselor, case manager, psychologist, and court administration involved in the process.

Again, there is variance in the design and operation of mental health courts. The Council of State Governments' document begins with the assumption that mental health courts are designed with the cooperation of a variety of individual stakeholders, all of whom may bring a wide range of goals with them (Fisler, 2015). The focus on public safety and court jurisdiction means eligibility criteria is again an issue. Most programs exclude individuals facing charges for felonies and violent crimes (Linhorst et al., 2009).

Counselors working with mental health courts have great influence on participant eligibility, as well as treatment options. Counselors work to inform participants of the risks of participation, potential benefits, their rights and responsibilities, requirements of successful program completion, and any ramifications of program failure. Again, counselors who are able to communicate clearly with participants can develop the rapport needed for buy-in and informed consent. With specialty court familiarity, counselors can address concerns and considerations.

Clinical Concerns and Considerations

Confidentiality and Privacy

Kupers (2015) advocated for the need to keep interventions confidential and private. Specialty court participants' hearings before a judge should be segregated from regular court proceedings and entered in the specialty court docket (the list of cases to be tried). This may mean that all participants be placed on dockets in a separate courtroom and, if possible, in separate locations. Public mingling with individuals awaiting their turn on the docket represents an all-too-real possibility of the loss of confidentiality and privacy.

Up-front disclosure of the limits of confidentiality will lead to a participant more able to give informed consent, a deeper rapport with clients, and greater diligence on the part of the counselor (Kupers, 2015). In an era of multidisciplinary teams, confidentiality requirements must be rigorous. As with regular notes, counselors' and case managers' personal notes need segregation from formal notes used in treatment. Case managers should keep specific treatment information separate from court files, and if an individual fails the program or withdraws, transfer documents used by the court should be created using general treatment information to ensure confidentiality (Linhorst et al., 2009).

Consistency of Programs

Consistency is an issue surrounding all areas of specialty court programs. One concern lies within law enforcement. The primary point of contact between an individual with mental illness and the justice system is often police or the county sheriff (Walsh & Holt, 1999). Having the ability to divert a person during daily operations, law enforcement benefits the most from training to identify and work with the mentally ill. In their survey of Virginia sheriffs, Walsh and Holt (1999) found that the majority of sheriffs received little or no instruction on working with individuals with mental illness.

More available training serves the public by providing more capable officers. Officers with experience and training in the diverse expression of mental illness and substance use are better able to recognize an individual in need or in crisis, with better outcomes (Ogloff et al., 2012). Overall, officers trained to deal more appropriately with detainees can reduce inappropriate incarceration, use of emergency services, recidivism, and cost to communities (Hnatow, 2015).

Consistency is necessary for fair and uniform needs assessments. Proper assessment is a cooperative process, requiring diligent coordination between counselors, case managers, and court officers. Regular meetings with stakeholders will promote assessment service needs, availability of services and costs, location and acquisition of funding, and specification of outcomes and outcome measurements (Walsh & Holt, 1999). With training and assessment addressed, counselors can direct more energy to advocacy needs.

Advocacy

Counselors have a duty to educate and advocate for the communities with which they interact and the American Counseling Association (2003) is fully in support of this ideal. On the surface, this may appear to be in opposition to the demands of working in the arena of specialty courts, but counselors are in an ideal situation to promote better outcomes for clients through advocacy efforts (Grob, 1995; Kupers, 2015).

By providing services to participants and advocating for programs, counselors working with specialty courts not only actively serve client needs, but also provide ethical and pragmatic examples of conduct for those considering service to these populations. Linhorst et al. (2009) also noted that counselor participation contributes to the development of best practices for the courts.

Conclusion

Specialty courts represent a new frontier for counselors. As mental health experts, counselors are the key to successful outcomes for participants (Linhorst et al., 2009). The need for cooperation and coordination by stakeholders with opposing goals and objectives and the increased scrutiny of treatment are challenges that await counselors with the courage to work with participant populations within specialty courts. The rewards of seeing change and improvement in participants' lives far outweigh the concerns of operating in these still-developing areas.

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