Didactic Fragments
The Taxonomy of Mental Health Court Eligibility

To be eligible for the MHC program participants must meet the State of Utah's definition for Serious and Persistent Mental Illness (SPMI) and have a diagnosis of Schizophrenia, Schizoaffective Disorder, and/or Bipolar Disorder (usually Bipolar I or Bipolar II, as Bipolar NOS does not reflect the same level of severity in functional impairment). However, diagnosis alone does not guarantee program acceptance. Criminal and mental health history, personality characteristics, substance use history, perceived suitability and potential for program success, as well as motivational history and apparent readiness for change are additional factors that will be taken into consideration.

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These additional considerations are much like a "totality of the circumstances test" in criminal jurisprudence, which looks to all the circumstances attending the alleged violation, rather than to any particular factor to the exclusion of all others. While some factors may recur more frequently than others, the relative importance of any one factor depends upon the particular facts of each case. Similarly, the mental health court will take into consideration a variety of factors that combine to form a totality of the circumstances relevant to the eligibility of the defendant. Although not all factors may carry the same weight, still diagnosis alone should not completely outweigh all other relevant circumstances. With this in mind, other considerations for eligibility may include:

- Criminal history:

  Criminal history includes not only criminal offenses alleged currently or committed historically, but also the longitudinal pattern of criminal conduct over time. The one-time offender may be quite different from someone who has an established pattern of criminal conduct and multiple offense convictions over a considerable span of time. The habitual offender may represent a poor candidate with whom to attempt to succeed in achieving the goal of a reduction in criminal recidivism.

- Nature of criminal charges:

  Both historically, and in the current circumstance, the nature of criminal offenses with respect to the issues of public safety, represent a critical factor of eligibility. Violent offenses, especially those that are aggravated, pose a higher factor of risk both to public safety and program viability, which may on balance necessitate program exclusion.

- Mental health treatment history:

  Referral candidates may or may not have previous mental health treatment histories or are currently participating in treatment. Both current and historical records if available are important sources of information about the defendant's motivation for treatment and their existing or past level of participation in mental health services. In some cases, mental health treatment has been avoided or resisted and has not been of interest until the circumstance of incarceration

- Substance abuse history:

  Substance abuse is sometimes a complicating factor in considerations of mental illness diagnosis as it can produce symptoms that mimic other mental illness conditions. Substance induced disorders can include psychosis, dementia, delirium, substance induced mood disorders, anxiety disorders, sleep disorders, etc., the differential diagnosis of which may be considerably complicated and time consuming. In addition to the production of symptoms that mirror mental illness, substance use and abuse may also easily exacerbate existing co-occurring mental disorders that otherwise may have been previously stabilized or in remission.

- Personality characteristics:

  Personality characteristics, depending on variety and severity can be especially problematic. Generally, personality in the diagnostic spectrum is conceptualized relative to either traits or disorders. Traits representing enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Personality Disorders.

  Although not consistently validated, the approach to Personality Disorders in the APA's diagnostic manual represents a categorical perspective as these disorders are grouped into three clusters according to descriptive similarities. Cluster A includes the Paranoid, Schizoid, and Schizotypal Personality Disorders. Individuals with these disorders often appear odd or eccentric. Cluster B includes the Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders often characterized by dramatic, emotional, or erratic behavior. Cluster C includes the Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders, where anxiety and fear often dominate the clinical picture.

  The essential feature of a Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in areas of cognition, affectivity, interpersonal functioning, or impulse control. This enduring pattern is quite inflexible and pervasive across a broad range of personal and social situations. Generally, personality disorders are ego syntonic, meaning that the individual does not experience their disordered pattern of experience and interaction as anything alien that would motivate efforts toward treatment as is the case with other

disorders. From the perception of the personality disordered individual, it is the environment and everyone else in it that needs correction.

For this reason, Personality Disorder is exceptionally difficult to manage and pervades into most areas of functioning such that it produces ongoing and revolving or cyclical conflicts that are equally enduring and problematic. Subsequently, where individuals may have a qualifying diagnosis for the mental health court program, but Personality Disorder is considered the primary diagnosis and the major focus of clinical treatment, such individuals must be scrutinized carefully for program acceptance.

- Family dynamics:

  The participant's relationship with immediate and extended family can either represent a network of strength and support or a malignancy characterized by repeated conflict and turmoil. To the degree that family members function as advocates for individual responsibility and encourage the participant's appropriate progression through the program, and do not foster overdependence, avoidance of accountability, or increase the potential for recidivism, such relationships will enhance the participant's possibility for long-term success. In some cases, participants may have significant family pathology, criminal histories, and dysfunctional patterns of socialization and relationship with the program participant such that the family may pose a serious detriment to the defendant's success.

- Patterns of association:

  Success in the mental health court program may necessitate a change in the defendant's lifestyle, which can include a change in friendship patterns and unhealthy associations. The power and influence of the defendant's peers can either be positive or negative depending on character and degree of maturity. A network of manipulative "friends" with criminal and substance abuse histories for example, will unduly place the defendant at greater risk of failure than associations that are based in relationships of trust and responsibility.

- Motivational demeanor:

  Motivation for change is a critical factor for sustaining success beyond the formal structure of the mental health court program. A transition from extrinsic motivation through frequent court appearances and potential sanctions for non-compliance, to an intrinsic interest in personal change and the adoption of alternative patterns of behavior is the desired outcome of the mental health court program. Defendants who are not sufficiently motivated internally are more likely to repeat errors of the past. Those who merely placate the court, and who are otherwise not invested in the program, will usually plateau in progress, continually demonstrate a resistance or passivity in their participation in treatment, procrastinate completion of court assignments, and more often than not, prematurely terminate from the program, effectively wasting the time and effort of everyone involved.

- Readiness for change:

  The concept of “readiness to change” is borrowed from the Transtheoretical Model of Behavior Change developed by James Prochaska, John Norcross and Carlo DiClemente. The Transtheoretical approach recognizes that successful self-change follows a controllable and predictable course along specific stages, recognizing that individuals who set goals they are not ready for will be more inclined toward failure. Similarly, choosing goals that have already been mastered, will ultimately delay progress. However, goals that are closely matched to the stage of change in which the individual is currently in will maximize one’s ability to change. Generally, behavior change proceeds from the point of contemplation, in which the individual is seriously thinking about altering self-defeating patterns of behavior. Defendants who are in a contemplation stage of change will typically be more successful in the mental health court program than individuals in a stage of pre-contemplation in which they give no serious thought to changing their behavior and prefer to project blame for their situation to others or circumstances beyond their control.