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# Mental health courts: The criminal justice response to the rise in mentally ill prisoners

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Mental Health Courts: The Criminal Justice Response to the Rise in Mentally Ill Prisoners

by

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Thesis

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In partial fulfillment of the requirements

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in

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## **Abstract**

In 2005, more than half of all prison and jail inmates had a mental health problem, and correctional institutions had replaced all other mental health facilities to become America's primary venue for the treatment of mental disorder. Further, the proportion of the correctional population that is mentally ill is increasing significantly faster than the correctional population itself. From 1998 to 2005, while the overall correctional population increased 20.8 percent, the mentally ill correctional population increased 27.3 percent. This thesis discusses the most recent literature that documents this increase, and presents reasons for it, including deinstitutionalization, the criminalization of the mentally ill, and behavioral problems in prison. Mental Health Courts (MHCs) were created in response to the increase in mentally ill offenders. A detailed overview of MHCs is provided, as is a discussion of their theoretical underpinnings, and what makes these courts effective. The thesis concludes with a summary, discussion of limitations, theoretical and policy implications, and recommendations for future research.

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## CHAPTER ONE: THE INCREASE IN MENTALLY ILL PRISONERS

Mental illness and those who suffer from such illnesses represent a significant issue for society and the criminal justice system. While the United States includes millions of mentally ill individuals who lead normal and productive lives, our jails and prisons are home to many mentally ill inmates who cycle in and out of the criminal justice system. The incarcerated mentally ill constitute a sub-population of prisoners that are a heavy burden on the police, the courts, and particularly, corrections, and are therefore deserving of special attention.

This chapter begins by discussing the measures used to determine the prevalence of mental illness in both non-incarcerated and incarcerated populations. It then presents data on the prevalence of mental illness among the non-incarcerated population, which serve as a reference point to help the reader understand the degree of mental illness in correctional populations. The chapter concludes by presenting data that demonstrate that the proportion of inmates with mental illness is increasing at a much faster rate than the general correctional population.

### *Mental Illness in the General U.S. Population*

There are several ways that the prevalence of mental illness is measured. The US Department of Health and Human Services (2012) measures prevalence in terms of the percentage of survey respondents who reported feelings or emotions suggestive of symptomology of mental illnesses (e.g. feelings of sadness and hopelessness). While the presence of symptoms does not indicate an actual psychiatric diagnosis, it is indicative of feelings typically associated with a specific mental illness.

The mentally ill represent a significant issue for both society and the criminal justice system. In 2013, an estimated 43.8 million adults age 18 and over, representing 18.5 percent of all adults, suffered with a mental illness. Ten million adults 18 and over suffered from a serious mental illness in the past year (National Survey on Drug Use and Health, 2014). The Diagnostic and Statistical Manual (DSM-V) defines mental illness as “a syndrome characterized by clinically significant disturbance in cognition, emotion regulation, or behavior...” Examples of mental illness include Anxiety, Obsessive Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder.

Serious mental illnesses are those that “resulted in functional impairment which substantially interferes with or limits one or more major life activities” (Federal Register, Volume 58, No. 96. Pp. 29422-29425 ). Examples of serious mental illness include Depression, Bipolar Disorder, and Schizophrenia. The major difference between serious mental illnesses and mental illnesses is the degree of interference that the illness creates in the individual’s life. The Summary Health Statistics for US Adults: National Health Review Survey (2012) asked respondents about how frequently they felt sad, hopeless, worthless, that everything was an effort, nervousness, and restlessness. A total of 234,921 people responded to the survey, and overall, 10 percent reported feelings of sadness all, most, or some of the time, 5 percent felt worthless, 6 percent felt hopeless, and 13 percent of respondents felt that everything was an effort all, some, or most of the time. Overall, 16 percent of respondents reported feeling nervous all, some, or most of the time, 16 percent reported feeling restless, and 3 percent reported serious psychological distress.

Kessler, Petukhova, Sampson, Zaslavsky, and Wittchen (2012) used DSM-IV criteria to determine whether a respondent had a mental illness. Six questions were used

to determine to what extent (0 to 4; 0 indicated they experienced such feelings none of the time, and 4 indicated feeling a prescribed way all of the time) the respondent felt a prescribed way. These numbers were summed, and translated onto a 0 to 24 scale, and scores of 13 or higher on this scale indicated psychological distress. Kessler et al (2012) reported the estimates of 12-month and the Lifetime Morbidity Risk (LMR) for respondents aged 13 and older. One interesting aspect of the report is that it includes LMR; the LMR tells us “not only about the proportion of the population that has so far experienced the disorder, but also about the additional proportion that is expected to experience the disorder at some time...”(Kessler, et. al. 2012; 170). The study found that the LMR for Major Depression was 29.9 percent, Generalized Anxiety Disorder; 9.0 percent, and Bipolar Disorder; 4.1 percent. The study also found that mood and depressive disorders (e.g. Major Depressive Disorder and Bipolar Disorder) are the most common in the United States.

How does the prevalence of mental illness in the general U.S. population compare to that of inmates in U.S. prisons and jails? Table 1 is compiled from data reported by James and Glaze (2006), and illustrates the percentages of individuals in the US general population (aged 18 and older) compared to state prison inmates and jail inmates who reported symptoms of mental illnesses in the previous twelve months, including Major Depression, Mania Disorder, and Psychotic Disorder. The most obvious finding in Table 1 is that a much greater proportion of inmates report symptoms of mental illness than do persons in the general population. Also note that jail inmates appear to experience more mental illness than do prison inmates. The totals reported in Table 1 indicate that while 10.6% of the general population reported symptoms of mental illness, nearly 50% of state

prison inmates and slightly over 60% of jail inmates reported symptoms of mental illness in the previous 12 months.

**Table 1: Symptoms of Mental Illness in General and Inmate Populations**

<b>Symptom</b>	<b>General Population</b>	<b>State Prison Inmates</b>	<b>Jail Inmates</b>
<b>Major Depression</b>	7.9%	23.5%	29.7%
<b>Mania Disorder</b>	1.8%	43.2%	54.5%
<b>Psychotic Disorder</b>	3.1%	15.4%	23.9%
<b>Totals</b>	10.6%	49.2%	60.5%

Source: James, Doris J. and Lauren E. Glaze. 2006. "Mental Health Problems of Prison and Jail Inmates". Bureau of Justice Statistics.

*Mental Illness in Correctional Populations*

There have been multiple attempts to gauge the extent of mental illness in correctional populations, but differences in the manner in which mental illness is measured or defined tends to complicate this estimate. Ditton (1999) uses two criteria to identify an inmate as mentally ill; (1) whether the inmate reported having a current mental or emotional condition, or, (2) the inmate reported an overnight stay in a mental hospital or treatment program, as well as reports of past hospitalization due to a mental health problem; this measure compensated for underreporting of mental illness among inmate respondents. Similarly, James and Glaze (2006) identified mentally ill inmates by (1) whether the inmate reported *a recent history of a mental health problem* or (2) *symptoms of a mental health problem* that have occurred in the past year, and there are differences in the numbers of inmates who reported having a recent history of mental

illness, and those who reported symptoms of a mental illness, or an overnight stay in a mental hospital. Although an inmate reported having symptoms of a mental illness, it does not necessarily mean they had received an official DSM diagnosis of mental illness. A recent history of a mental health problem was defined as a clinical diagnosis or treatment by a mental health professional, and mental illness symptoms were based on DSM-IV criteria.

Ditton (1999) reports prevalence figures over the course of several years (1996-1998) and finds that in 1996, 16.3 percent of jail inmates were identified as mentally ill, 10.5 percent reported having a mental or emotional condition, and 10.2 percent were admitted overnight to a mental hospital or treatment program. In 1997, 10.1 percent of state inmates reported a mental or emotional condition. Among this 10.1 percent, 16.2 percent had been admitted to a hospital overnight, 23.9 percent had taken a prescribed medication, 29.7 percent had received professional counseling or therapy, and 30.2 percent had received some other mental health services (Ditton, 1999).

In 1998, 179,200 state inmates were identified as mentally ill, 111,300 reported a mental or emotional condition, and 118,300 had been admitted to a mental hospital overnight. In the same year, 7,900 federal inmates had been identified as mentally ill, 5,200 reported a mental or emotional condition, and 5,000 had been admitted to a hospital overnight. The lowest numbers reported were for jail inmates, as 96,700 were mentally ill, 62,100 reported a mental or emotional condition, and 60,500 had been admitted to a hospital overnight (Ditton, 1999).

Human Rights Watch (2003) notes that in 1998, between 8 and 19 percent of inmates had a “significant psychiatric or functional disability” and that 15 to 20 percent

would “require some form of psychiatric intervention during their incarceration”. The American Psychiatric Association (2000) reported that one in five inmates was seriously mentally ill; and five percent were considered psychotic. The APA also found that between 2.3 and 3.9 percent of state prison inmates are estimated to have schizophrenia, and between 13.1 to 18.6 percent had major depression, while 2.1 to 4.3 percent suffered from Bipolar Disorder, and approximately 22.0 to 30.01 had an anxiety disorder.

Beck (2001) reported that in 2000 state prisons housed 191,000 mentally ill inmates, and one in every eight state prisoners were receiving some kind of mental health therapy or counseling services in mid-year 2000. That same year, ten percent were receiving psychotropic medications, and approximately 2 percent were in a 24- hour mental health unit. Among maximum- security prisons, the second most common form of mental health treatment was psychotropic medication (83 percent), followed by therapy and counseling at 84 percent (Beck, 2001). As of June, 2000, 9.8 percent of state prison inmates received psychotropic medication, while nearly half (45 percent) of inmates in prisons who declared their “primary function” as “mental health” received psychiatric medication (Beck, 2001).

The most recent BJS report on mental illness in correctional populations (James and Glaze, 2006) found that in mid-year 2005, 705,600 state inmates (56.2 percent of state prison inmates), 78,800 federal inmates (44.8 percent of federal inmates) and 479,000 jail inmates (64.2 percent of jail inmates) had “any mental health problem”, representing more than half of all prison and jail inmates. In addition, 49.2 percent of state prison inmates reported “symptoms of mental health disorder” compared to 39.8 percent of federal inmates and 60.5 percent of jail inmates. Observe that the percentage

of those reporting symptoms is much larger than those reporting a recent history of mental illness (see Table 2).

**Table 2: Recent History and Symptoms of Mental Health Problems**

	Percent of Inmates In		
	State Prison	Federal Prison	Local Jail
Any Mental health Problem (TOTAL)	56.2%	44.8%	64.2%
Recent History of Mental Health Problem (TOTAL)	24.3%	13.8%	20.6%
Told had disorder by mental health professional	9.4	5.4	10.9
Had overnight hospital stay	5.4	2.1	4.9
Used prescribed medication	18.0	10.3	14.4
Had professional mental health therapy	15.1	8.3	10.3
Symptoms of Mental Health Disorders (TOTAL)	49.2%	39.8%	60.5%
Major Depressive Disorder	23.5	16.0	29.7
Mania Disorder	43.2	35.1	54.5
Psychotic Disorder	15.4	10.2	23.9

Source: James and Glaze, 2006. Mental Health Problems of Prison and Jail Inmates". Bureau of Justice Statistics.

While the estimation of mental illness among prison and jail inmates is subject to multiple measures that generate variation, there seems little doubt that mental illness impacts a very significant proportion of the U.S. correctional population, and is much more common in prisons and jails than in the general U.S. population.

*Increase in Mental Illness in U.S. Correctional Populations*

As demonstrated above, mental illness represents a significant issue in both incarcerated and non-incarcerated populations in the United States, but is far more prevalent in correctional populations. But evidence also indicates that the percentage of inmates with mental illness is increasing more rapidly than the correctional population itself. Table 3 provides evidence of this increase from mid-year 1997 to mid-year 2005. Figures reflecting the increase in the total U.S. correctional population were taken from the Sourcebook of Criminal Justice Statistics, while figures for the mentally ill population were taken from Ditton (1999) and James and Glaze (2006). Ditton and James & Glaze used similar criteria to arrive at their respective estimates of mental illness in correctional populations.

**Table 3: Changes in Correctional Populations**

Population	1997	2005	Change	Percent Change
Total Correctional Population(a)	1,816,931	2,195,471	+378,540	20.8%
Mentally Ill Correctional Population	283,800 (b)	361,400 (c)	+77,600	27.3%

Source: (a) *Sourcebook of Criminal Justice Statistics Online*. University at Albany.Hindelang Criminal Justice Research Center. Retrieved January 27, 2014. (<http://www.albany.edu/sourcebook/pdf/t612011.pdf>)

(b) Ditton, Paula 1999. “Mental Health Treatment of Prison and Jail Inmates”. Bureau of Justice Statistics.

(c) James, Doris J. and Lauren E. Glaze. 2006. "Mental Health Problems of Prison and Jail Inmates". Bureau of Justice Statistics.

Observe that in Table 3, the total correctional population increased by 20.8%, while the mentally ill correctional population increased by 27.3% over the same time period. Independently, Wilson and Wood (2014) present findings that show an increase among inmates with "any mental health disorder" from 14.8% at year-end 2003 to 23.9% in 2010. Findings from Wilson and Wood and from Table 3 above support the notion that the mentally ill correctional population is increasing at a rapid pace. As noted by Wilson and Wood (2014), there are at least three possible explanations for the growth in mental illness in prisons--which may not be mutually exclusive. First, as electronic health records have become more widely used, the reported data are likely to be better and more comprehensive and may capture more cases over time. Second, prison mental health officials may be more willing to make mental health diagnoses for inmates with less severe symptomology. And third, the disproportionate incarceration of the mentally ill may be increasing over time due to an increase in the criminalization of mental illness and involvement of mentally ill persons in the criminal justice system. The following chapter will focus on factors believed to have impacted this latter explanation.

## CHAPTER TWO: EXPLAINING THE INCREASE

The previous chapter documented the increase in the mentally ill prisoner population; it used numerical data to show that over the years, more and more mentally ill inmates have appeared in prisons and jails nationwide. This chapter addresses the events, legislation, and other factors that led to the increase in prisoners with mental illness. It begins with Deinstitutionalization, and traces its history as well as the legislation that fueled it, and describes the consequences of deinstitutionalization and why the nation's jails and prisons are "full to the brim" with the mentally ill.

### *Deinstitutionalization*

There are several factors that led to the increase in mentally ill prisoners. The first and perhaps most prominent is deinstitutionalization, a movement in the 1970's that transferred thousands of people with mental illness from state mental hospitals to their respective communities. Deinstitutionalization's forerunner and social reformer, Dorothea Dix, toured prisons and jails in the 1800's and witnessed the maltreatment and poor living conditions of the mentally ill, and advocated for improved treatment, which resulted in the creation and proliferation of mental hospitals (Schneider, 1999). Although hospitals were a major improvement in Dix's time, they came to be viewed as more harmful than helpful, and it was this that motivated the landmark movement called deinstitutionalization.

Deinstitutionalization was based on the belief that community-based care was more humane, therapeutic, and cost-effective than hospital care, (Lamb and Bachrach, 2001). According to The Joint Commission on Mental Illness and Health, the objectives of Deinstitutionalization were to protect the mentally ill from the harms of

deinstitutionalization by limiting hospitalization and maintaining their health within the community as much as possible (Rose, 1979). President Jimmy Carter stated that the objective of deinstitutionalization was to maintain the “greatest degree of freedom, self-determination, autonomy, dignity and integrity...for the individual while he or she participates in treatment” (Erickson and Erickson, 2008: 31).

The prevailing view of mental hospitals at the time held that they were conducive to institutionalized behavior in patients and allegations of abuse and overcrowding were prominent (Aderlbigbe, 1997). Thus, hospitals were not the ideal treatment modality and a change had to be made. Aside from the spirit of concern for the welfare of the mentally ill, the introduction of psychiatric drugs, namely chlorpromazine and two antidepressants (Iproniazid and Imipramine) fueled the fire by allowing for more effective symptom management and assisted in decreasing the mental hospital census (Accordino, Porter, and Morse, 2001). The introduction of psychiatric drugs resulted in the decrease of mental hospital populations by allowing for effective symptom management, which allowed for release from hospitalization and the ability to manage mental illnesses within the community setting.

#### *Deinstitutionalization Legislation*

Legislation regarding mental health and the mentally ill contributed significantly to the deinstitutionalization movement. The National Mental Health Act passed in 1946 due to concern for soldiers returning from World War II with “battle fatigue” and how to treat them. It established the National Institute of Mental Health (NIMH), an organization empowered by the government to assist states in setting up their own mental health services, conduct research and provide funding (Cutler, Bevlacqua and McFarland,

2003). It was followed by the 1955 Mental Health Study Act that prompted the creation of the Joint Commission on Mental Illness and Mental Health, tasked with researching general mental as part of a “nationwide reevaluation of the human and economic problems of mental health” (National Institute of Mental Health).

In 1961 a report assessing the mental health conditions and resources nationwide was given to Congress and attracted the attention of former President John F. Kennedy, who requested and achieved the passage of The Community Mental Health Centers Act (CMHC) in 1963, which provided inpatient and outpatient treatment, crisis and emergency services, partial hospitalization and mental health resources in communities (Accordino et. al, 2001; Cutler et. al, 2003). President Jimmy Carter established the President’s Commission on Mental Health in 1977 to provide an overview of the mental health needs in the US and how to meet those needs. President Carter himself, in an address to Congress proposed the Mental Health Systems Act, its purpose was to “assure that the chronically mentally ill no longer face the cruel alternative of unnecessary institutionalization or inadequate care in the community” (The American Presidency Project).

#### *The Patients’ Rights Movement*

Another major occurrence during deinstitutionalization was the change in involuntary commitment criteria and legislation. Prior to these changes, involuntary commission to a hospital was a “simple and routine matter” and merely required that the individual be “mentally ill and appropriate” for commitment. The state of Wisconsin required that the individual be a “proper subject” for commitment as determined by the

treating psychiatrist, who could order commitment on the basis of irresponsible behavior alone, not a legitimate mental illness (Erickson, Vitacco, and Van Rybroek, 2005;364,).

A 1964 law passed in Washington, DC, declared that persons being involuntarily committed must meet two criteria: (1) They must have a mental illness, and (2) must pose an “imminent threat” to themselves and others, or (3) be shown to be gravely disabled, or unable to meet their basic survival needs (Testa and West, 2010). In 1976 Wisconsin passed its 1976 Mental Health Act which required “evidence of recent threats, attempts at suicide, or serious bodily harm...a substantial probability of physical harm to others as evidenced by a recent overt act of violent behavior...” and “impaired judgment evidenced by a pattern of recent acts or omissions that demonstrated a substantial probability of physical impairment or injury to self” (Erickson, et al. 2005; 8).

Standards for involuntary commitment became stricter due to legislation in 1980 and 1995. The new laws required the individual in question lack the ability to understand that they were mentally ill, and that they be unable to provide basic self-care (e.g. feeding and dressing). The aforementioned legislation, and similar pieces passed by other states, was intended to protect the liberties of the person being committed, as it was determined that their freedom and liberties were being encroached by forced commitment (Erickson, et. al, 2005). The Supreme Court has never clarified its position on whether involuntary commitment outweighs the need to prove dangerousness criteria (e.g. *O’Conner v. Davidson*) and has left such matters essentially in the hands of each state (Anfang and Applebaum, 2006).

The Patient Rights Movement created a decrease in hospital populations in two ways. The first was to make involuntary hospitalization much more difficult by requiring

a series of criteria to be met before the person could be hospitalized; if an individual did not meet all criteria satisfactorily, they could not be committed. Second, in combination with effective community treatment, the “revolving door” of commission, treatment, release, and relapse was closed; patients could not merely be fed back into the hospital system, therefore decreasing hospital populations. Lastly, patients were able to decide for themselves whether they needed to go to a hospital; they could not be forced. This put the prerogative of receiving treatment back into the patients’ hands and afforded them a measure of control over their lives and the hospitalization process.

### *The Consequences of Deinstitutionalization*

In 1955, 559,000 people of a national population of 165 million were institutionalized in state mental hospitals, and in December 1998, 57,151 were in state hospitals, compared to the national population of 275 million. In the 43 years from 1955 to 1998, state hospitalization rates dropped from 339 per 100,000 to 21 per 100,000 on any given day (Lamb and Bachrach, 2001). Inadequate funding was also an issue; the federal government did not provide ongoing funding for community mental health services while states cut their mental health budgets, resulting in serious underfunding and a lack of treatment and services for a vast number of people with mental illness (Human Rights Watch, 2003).

When hospitalization was needed, the mentally ill were treated acutely (e.g. stabilized) and discharged without adequate follow-up and treatment within their communities, which inevitably led to relapse and readmission, a process known as the “revolving door”.

### *The Homeless Mentally Ill*

Deinstitutionalization created a large mentally ill homeless population. A report by The Treatment Advocacy Center (2014) found that one-third of the homeless population is comprised of individuals who have serious untreated mental illnesses such as Schizophrenia or Bipolar Disorder. In fact, having a mental illness is one of the primary factors leading to homelessness (Sullivan, Burnam and Koegel, 2000).

A 2005 federal survey cited by Torrey, Entsminger, Geller, Stanley and Jaffe (2008) found that one third of the 500,000 homeless single men and women are seriously mentally ill, and a study of 81 American cities found an inverse relationship between having fewer psychiatric hospital beds and more homeless people (Torrey, et al. 2008).

Under stricter involuntary hospitalization laws, many who needed to be hospitalized were not admitted, and were left with little supervision or support; these individuals also lacked insight into their illnesses and did not take their medication and were unable to support themselves (Markowitz, 2006). The inability of the mentally ill to comply with treatment and to support themselves leads to a loss of competitive skills necessary to secure housing and employment (Nooe and Patterson, 2011) and often leads to homelessness.

Homelessness, a lack of competitive skills that could assist in gaining employment and housing, and untreated mental illness contribute to the criminalization of the mentally ill. Criminalization is a punitive reaction to people with mental illness and involves their inappropriate processing through the criminal justice system, rather than the mental health system (The Sentencing Project, 2002). Instead of receiving the treatment and assistance that they require, the mentally ill not only come to the attention

of law enforcement, but they are subsequently often incarcerated (Romero, Elkington and Teplin, 2009).

### *Substance Abuse*

Zero tolerance policing and harsher drug offense penalties create a predicament for the mentally ill. Substance abuse rates are high among the mentally ill. Deinstitutionalization and the lack of adequate care left many without the necessary medication to manage their illnesses, and so the mentally ill turned to drugs and alcohol to self-medicate. Approximately 71 percent of Bipolar Disorder patients reported a lifetime substance abuse disorder according to Torrey (2002). A 2011 SAMHSA report found that that 50 percent of homeless mentally ill have co-occurring substance abuse problems. Further, the mentally ill commit two broad categories of offenses that bring them into frequent contact with the police; these offenses include illegal acts committed as a byproduct of mental illness (e.g. disorderly conduct) and economic crimes (e.g. petty theft) which benefit them economically and are committed to meet necessary basic needs (The Sentencing Project, 2002).

### *Limited Police Responses*

Police are often called upon to deal with people with mental illness, and whose involvement falls into the categories of formal interaction and informal interaction. Formal actions include arrest and involuntary or voluntary hospitalization, while informal actions include releasing the mentally ill into a family member's custody or handling the situation outside official channels (Wells and Schaefer, 2006).

The formal options of hospitalization or arrest are difficult decisions for an officer to make. If the officer chooses to hospitalize an individual, it may be difficult to have them admitted, as many hospitals refuse admissions brought in by the police on the assumption that they are dangerous. If an arrest occurs, officers obtain a signed complaint form, which allows for legal arrest if a hospital refuses admission (Teplin, 2000).

An arrest, however, does not necessarily mean that a crime has taken place. Police sometimes utilize what are referred to as “mercy bookings” or “mercy arrests”. Mercy arrests or bookings occur when an officer chooses to arrest a mentally ill individual so that they will receive some mental health services in jail (Lamb, Weinberger and DeCuirJur, 2002). Police use this form of arrest when hospital admission is not an option, or when the individual’s behavior is disruptive enough to require action (Teplin, 2000).

Informal responses are perhaps preferable; officers’ familiarity with “neighborhood characters” and knowledge of their behavioral oddities makes dealing with the mentally ill easier as exemplified in a case involving a mentally ill woman who called police frequently, complaining that her neighbors were shooting laser beams into her home. An officer would respond and ask the neighbors to stop, which calmed the woman down (Teplin, 2000). However, despite the ability of officers to respond informally in some situations, arrest is necessary in others, and opens the door for criminal justice involvement.

### *Problems in Prison*

Incarceration poses unique problems to prisoners with mental illness. Prisons are unforgiving environments ruled by routine, security and strict regulations and expect

mentally ill inmates to abide by the same routines and comply with the same rules as all other inmates, regardless of their ability to do so. This “Custody-Conflict” is an “inherent tension between the security mission of prisons and mental health considerations...coordinating the needs of the mentally ill with rules and goals is nearly impossible” (Adams, 2008: 916).

Those with mental illnesses do not have the same capacity to follow prison regulations as other inmates. They may refuse to comply with orders from correctional officers, may exhibit disturbing behavior (e.g. talking to and hearing voices) and cause disruptions through violence or refusal to follow prison rules, all of which are potentially punishable behaviors (Adams, 2008). These behavioral by-products of mental illnesses result in people with mental illness having higher than average disciplinary rates. In Washington State, mentally ill inmates account for 18.1 percent of the prison population but represent 41 percent of all infractions.

The mentally ill are also more likely to be involved in altercations than are non-mentally ill inmates. James and Glaze (2006) found that 58 percent of state inmates with a reported mental health problem had been charged with violating prison rules and 20 percent had been injured in a fight since admission to prison.

A lack of correctional officer training adds to the behavioral problems of people with mental illness, as officers may not understand that what they perceive as misconduct is actually the product of mental illness. Officers issue misconduct citations to inmates who bang their heads against the wall, for instance, and believe the behavior to be willful manipulation when in actuality the schizophrenic inmate is trying to silence voices in his head (Fellner, 2006).

Mentally ill inmates are subjected to the same sanctions as non-mentally ill inmates, including solitary confinement. In this setting, inmates are held in small cells for up to 24 hours a day, with three to five hours of “out of cell” recreational and shower time per week and with little to no stimuli. This only serves to “provoke sufficient deterioration and exacerbation of the symptoms of mentally ill prisoners” (Fellner, 2006:404). Haney (2003) cites observations of anxiety, panic, rage, hallucinations, and self-mutilation by those confined in solitary confinement by mental health and correctional staff. Metzner and Fellner (2010:105) conclude that mentally ill inmates in solitary confinement “will not get better as long as they are isolated”.

Yet another prevalent issue that affects mentally ill prisoners is their disproportionate victimization within prisons. A study by Blitz, Wolff and Jing Shi (2008) found that in a sample of 7528 male and female subjects, physical victimization (e.g. beating, hitting, biting, etc) among mentally ill male inmates was 1.6 times higher than for non-mentally ill inmates, and that female inmates were 1.7 times more likely to be victimized by another inmate than non-mentally ill inmates.

Sexual victimization in prisons is also a prevalent issue. A Bureau of Justice Statistics report on prison sexual victimization found that during 2011 and 2012 an estimated 3.8 percent of prison inmates reported being sexually victimized by another inmate, while 3.4 percent of inmates reported sexual victimization by prison staff during the same year (Beck, 2013). They further found that the rates of inmate-on-inmate sexual victimization were two to three times higher for inmates taking prescription medications at the time of the offense, and three to four times higher for inmates who had received counseling.

From deinstitutionalization, to criminalization and subsequent incarceration, the mentally ill face unique difficulties both in and out of the criminal justice system. The movement that was intended to make life better for the mentally ill made it much more difficult, and over time, filled prisons and jails with people who require treatment, not punishment. As such, the criminal justice system was forced to respond, and one response came in the form of specialized courts to divert the mentally ill to treatment rather than incarceration.

## **CHAPTER THREE: MENTAL HEALTH COURTS**

### *What Is a Mental Health Court?*

Mental Health Courts (MHC) are specialized criminal courts that divert offenders with serious mental illnesses from the correctional system into community based treatment, often in lieu of incarceration (Castellano and Anderson, 2012; Almquist and Dodd, 2009). As with drug courts, which were developed in the late 1980's in response to the massive influx of drug offenders due to punitive drug laws, MHCs were developed in response to the large increase in the mentally ill individuals being processed through the criminal justice system. These problem-solving courts work to address the underlying problems (mental illness) that bring individuals to court in the first place and have special dockets for mentally ill defendants and seek to link defendants with community-based mental health treatment (Council of State Governments, 2008; Denckla and Berman, 2001).

The first MHC was established in Broward County, Florida, in 1997, followed by courts in Alaska, Washington, and California in 1998 and 1999; although there is argument that Judge Goodman in Marion County, Indiana, established the first MHC in the 1980's when he created a program to divert mentally ill offenders from jail to Wishard Hospital for evaluation before the program was terminated in the 1990's (Castellano and Anderson, 2012; Hasselbrack, 2001). Mental Health Courts seek to reduce criminal behavior and recidivism by treating the illness that is causing illegal

behavior and to depopulate jails and prisons by helping individuals who were cycling in and out of the criminal justice system and not improving with the traditional judicial model (Canada and Watson, 2013; Wolff, 2002). They also share the goal of reducing recidivism and criminalization by linking defendants with needed mental health services (Watson, Hanrahan, Luchins, and Luigio, 2001). It is important to note here that MHCs are not uniform, and that they differ in their eligibility criteria, sanctions, and resources available for mental health treatment by jurisdiction (Frailing, 2010; Council of State Governments, 2005). Treatment also differs depending on the individual defendant's needs as well as funding availability (Castellano and Anderson, 2012).

MHCs are funded federally through the 2003 Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). Congress authorized \$50 million in grant money to the Mental Health Collaboration Program through MIOTCRA to “help states, local government and tribal organizations improve responses to people with mental disorders who are involved in the criminal justice system” (Council of State Governments, 2014). In 2008, the Act was reauthorized and expanded to improve law enforcement responses to mentally ill individuals. The grant money awarded to states can be used for an array of programs, including Mental Health Courts. For example, in Outagamie County, Wisconsin, 2012 grant money was used to develop plans for a post-adjudication, recovery oriented MHC, focusing on individuals with a high likelihood of recidivism and violation of supervision. Funding amounts have decreased annually; in 2006 the MIOTCRA received \$5 million in federal funding, \$12 million in 2010, and in 2014, \$8.2 million.

MHCs differ from traditional courts in seven primary ways ( Rossman, Willison, Mallik-Kane, Kim, Debus-Sherrill and Downey, 2012). First, MHCs exclusively serve

defendants with mental illness; whereas traditional courts serve any and all defendants. Second, MHCs involve stakeholders from multiple fields; these include the criminal justice system, mental health system, and other related fields; traditional courts usually only involve the criminal justice system players. Third, MHCs require knowing and informed consent from the defendant for participation; this means that MHC participants are made aware of the requirements and expectations prior to choosing to participate.

Fourth, Participants are linked to community-based services; typically this involves treatment programs and counseling or substance abuse services. Traditional courts do not provide services of any kind, although some may be available in prisons and jails. Fifth, MHCs monitor treatment compliance of participants. Status hearings are held with the MHC team weekly or bi-weekly to ensure that each participant is progressing and is compliant with medication and other treatment. Sixth, MHCs use rewards and sanctions to encourage compliance and treatment among participants; traditional courts merely mete out sanctions (e.g. prison or jail sentences). Lastly, MHCs embrace the concept of Therapeutic Jurisprudence, that is to say, they attempt to use the law to provide benefits for participants, such as treatment and less recidivism upon completion of the MHC program (Rossman, et. al 2012).

Many MHCs require participants to sign a written contract upon enrollment, and MHC enrollment represents “a commitment to take medications, to attend and engage in mental health/substance abuse treatment appointments, to return to the court for status hearings, to meet with a case manager...” (Redlich, Hoover, Summers and Steadman, 2010; 3) and a myriad of other requirements. It is, in essence, agreeing to make significant and often difficult changes in ones life ... (Redlich, et.a l, 2010,3).

Another key element that distinguishes a MHC from traditional courts is the non-adversarial process (Erickson and Erickson, 2008). Instead of aggressive defense counsel (e.g. suppressing motions) and other practices associated with the traditional “win or lose” adversarial approach, the emphasis is on a collaborative approach among the courtroom workgroup and the defendant to produce therapeutic outcomes.

### *Therapeutic Jurisprudence and Mental Health Courts*

MHCs embody Therapeutic Jurisprudence (TJ). Therapeutic Jurisprudence, according to Wexler (1999) views the law as a social force capable of producing therapeutic or anti-therapeutic consequences. In other words, the written law, legal actors, legal rules, and legal procedures have an effect on, and have consequences for, those who fall under the law (e.g., offenders), and those consequences can either be therapeutic and beneficial, or anti-therapeutic and detrimental. In essence, Therapeutic Jurisprudence seeks to rehabilitate mentally ill offenders by providing treatment of the cause of their behavior (in this case, mental illness) without negating the important values of justice and due process that the criminal justice system must uphold.

Wexler (1999;5) provides an example of Therapeutic Jurisprudence, and how it can be made part of the legal process itself: A judge who is considering an individual for probation tells the defendant, “I want you to figure out why I should grant you probation and why I should feel comfortable that you’re going to succeed...” The defendant returns and tells the judge that they “mess up on Friday nights; therefore, I propose that I will stay home on Friday nights.” By requiring the defendants to consider their potential actions and the consequences of them, and how they will handle or avoid negative outcomes, the law acts therapeutically.

In her observations of a California MHC, Frailing (2010) noted that the MHC judges she observed began their status hearings by asking how the defendant's week had gone and whether it was a good one. The judges often praised and encouraged deserving MHC participants for their progress and success during status hearings with such phrases as "Good for you," "You're making us proud," and "Keep up the good work." Frailing (2010) also observed that praise and encouragement were used far more often by judges than were sanctions. Obviously, praise and encouragement from the judge is designed to spur the participant on to continue in their treatment, and is thus therapeutic.

Therapeutic Jurisprudence is accomplished through Procedural Justice, or the fairness of the MHC process. There are four fundamental components of Procedural Justice: (1) Neutrality, or the freedom from bias or preconceptions of defendants and their illnesses on the part of the MHC workgroup, (2) Participation; or the capacity of the participant to be heard and to have their views taken into account in decision-making and to contribute to the decision-making processes, (3) Dignity; which involves the participant being treated respectfully and being affirmed in their worth as a human being and as a citizen, (4) Trustworthiness; or whether the judge is sincerely concerned about the participant's welfare and whether the judge is committed to treating the participant fairly (Edgley, 2014).

Procedural Justice, then, promotes the law and legal actors behaving in a therapeutic manner in order to benefit the participant. Employing procedural justice provides a "powerful motivating force" for participants; the judge is seen as a caring, legitimate, and fair authority figure, something many participants have likely never encountered in traditional courts (Edgely, 2014; 5). Procedural justice motivates a

reciprocal respect between judge and participant and creates a “desire to please the judge or avoid disappointing him or her”, as well as motivates compliance and active, willing participation in programming (Edgely, 2014;5).

### *The Mental Health Court Workgroup*

MHCs are staffed by legal and social service professionals committed to addressing the problems in offenders’ lives that contribute to the cycle of arrests (Castellano and Anderson, 2012). The typical courtroom workgroup includes a judge, a prosecutor, the defense counsel, parole or probation officers, and a case manager or representative from the mental health treatment system (Almquist and Dodd, 2009). The workgroup takes on the non-traditional role of a collaborative team; often coming together to discuss MHC cases and goals for treatment for each defendant (Denckla and Berman, 2001). In a Louisiana MHC, the workgroup is specially trained in psychology, and the judge who presides over the MHC is permanently instated, so that they are able to “master the subtleties of law and mental illness” (Cummings, 2010).

A study of MHCs in Bronx, and Brooklyn, New York (Rossman, et al. 2012) elaborate on the roles of the MHC workgroup in the Bronx MHC, comprised of a judge, prosecutor, defense attorney, a clinical team, and treatment providers (Rossman, et al. 2012). The judge has presided over the MHC since it began, and is “...knowledgeable about the special issues related to offenders with mental illness, and helps maintain consistency in court mandates and sentencing” (Rossman, et. al. 2012; 33). Prosecuting attorneys reported spending 15 percent of their time on MHC cases, and play a large role in entry decisions. The defense attorneys refer participants to the MHC program, explain the MHC policies and other alternatives participants, and of course, advocate for the

participant during the MHC program. They also attend graduations, hearings about problem behavior and pleas, as well as sentencing.

The clinical team provides case management services and is composed of a clinical psychologist, consulting psychiatrists, a supervising manager and twelve case managers. The Clinical Director and psychiatrists perform comprehensive evaluations of the MHC participants. Finally, treatment providers work directly with the participants to provide mental health services such as therapeutic communities, outpatient drug and alcohol treatment, inpatient rehabilitation and temporary housing (Rossman, et. al. 2012; 34).

#### *How Mental Health Courts Function*

Entrance into an MHC typically follows the following chain of events:

Arrest/Custody → Screening → Referral to MHC → Acceptance into MHC → Treatment/Programming → Complete Programming → Graduation

As illustrated in the above path diagram, participation in an MHC begins with identification of arrestees with mental illness. This is usually done via mental health screenings within 24 hours of being in custody. Next, a referral is usually needed in order to have the individual considered for the MHC. Referrals come from a variety of sources, again, depending upon the court. Almquist and Dodd (2009) found that, according to a 2006 study of a Brooklyn, New York MHC, 44 percent of participants were referred via defense attorneys, 30 percent from competency hearings, and 10 percent from district attorneys.

After the referral is delivered, there are a wide range of waiting periods between referral to the MHC and acceptance into it. One study of seven MHCs in Florida,

California, North Carolina, Pennsylvania, Nevada, New York, and Idaho, found that the waiting period ranged from 0 to 45 days( Steadman, Redlich, Griffin, Petrila and Monahana, 2005). In the Broward County, Florida MHC, the time from referral to admission to the MHC was only a few hours (Petrila, Poythress, McGaha, and Boothroyd, 2001), while a Brooklyn, New York MHC had a waiting period of three months (O’Keefe, 2006).

Upon successful admission into the MHC, participants engage in community-based treatment for a designated period of time and attend regular status hearings. These status hearings occur at the discretion of the judge, and can be weekly, bi-weekly, or monthly. Status hearings involve a report on the progress of (e.g. level of participation in mandated treatment) of each participant by representatives. The hearings essentially serve to determine whether the participant is compliant with their treatment and medication, and to bestow sanctions or rewards as appropriate (Erickson and Erickson, 2008;Frailing, 2010).

When the participant has completed their mandated treatment and has, in the court’s eyes, achieved emotional wellness and has desisted from criminal behavior, he or she graduates from the MHC program and often either have their charges reduced or dropped completely (Castellano and Anderson, 2012). In Washoe County Mental Health Court in Nevada, completion is considered to have been achieved if the participant has participated in therapy groups, taken prescribed medication, had clean drug tests, attended all scheduled status hearings, and obtained shelter, transportation and other basic necessities, as well as have participated in educational training programs or reported to their workplace regularly (Palermo, 2010). Some courts hold a formal graduation

ceremony, attended by the MHC workgroup in which the judge awards a certificate of completion to each graduate and formally acknowledges their efforts (Frailing, 2010).

### *Mental Health Court Eligibility Criteria and Caseload*

While eligibility criteria differ among MHCs, central to all is whether the MHC employs a pre-adjudication model or post-adjudication model. In the Pre-adjudication model, a guilty plea or conviction is not required prior to admission to the MHC, while in a post-adjudication model, a guilty plea or conviction is required. To be eligible for the Washoe County Mental Health Court in Nevada, participants who have Bipolar Disorder, Schizophrenia, or Major Depression and with felony or misdemeanor charges are targeted. Defendants are deemed eligible if they plea guilty or no contest or a finding of guilty, and must agree to a minimum of one year of MHC program enrollment; with possible longer enrollment if the charges are more serious (Frailing, 2010).

The Bronx MHC accepts felony and misdemeanor charges, and participants must have a mental illness that cannot be adequately handled in a traditional court. The defendant's crime does not have to be directly related to their mental illness, as the court feels it is difficult to determine whether their actions were a direct consequence of the illness (Rossman, et. al. 2012).

The Broward County, Florida MHC admits non-violent misdemeanor defendants, except those charged with domestic violence or driving under the influence of alcohol or drugs, and those charged with simple battery may enter at the victim's consent. Participants have the option of opting out of the MHC and moving to traditional courts at any time they choose. The future enrollment of defendants with non-violent felony charges is a consideration (Watson, et. al. 2001).

Finally, the Akron, Ohio Mental Health Court requires a diagnosis of Schizophrenia, Schizoaffective Disorder or Bipolar Disorder, a misdemeanor offense (violent offenders may be admitted with the victim's consent), the defendant must be willing to take medication, understand all requirements of the MHC and the consequence of non-compliance, and must be able and willing to comply with the orders of the court. The court further requires that the defendant plead no-contest and be placed on probation for two years (Shoaf, 2002).

#### *MHC Locations and Prevalence*

Mental Health Courts are found in almost every state within the United States. According to an online survey conducted by the Council of State Governments (2005), approximately 125 MHCs were operational in 36 states, with western and southern states each housing 37 percent of the MHCs in the US. The Midwestern states had 15 percent of the total MHCS, and the Northeastern states had 11 percent. Further, over 40 percent of all adult MHCs are located in California, Ohio, Florida and Washington. The National Center for State Courts estimated that in 2010 there were over 250 MHCs operational in the US. That estimate increased in 2013 to 349 operational MHCS in nationwide. The table below provides a snapshot of some of the larger (in terms of annual enrollment) MHCs in the United States, including their location (State and City or County), Target Population (e.g. Misdemeanors or Felonies), and Annual Enrollment (number of participants per year).

**Table 4: Mental Health Court Locations and Enrollment**

STATE	CITY/COUNTY	TARGET POPULATION	ANNUAL ENROLLMENT
<b>Michigan</b>	Iona	Felonies	0-50
<b>California</b>	Los Angeles	Violations/Felonies	500+
<b>Florida</b>	Broward County	Felonies	500+
<b>Washington</b>	King County	Misdemeanors	201-500
<b>Pennsylvania</b>	Allegheny County	Misdemeanors/non- violent felonies	51-100
<b>Nevada</b>	Clark County (Las Vegas)	Violations/Felonies	51-100
<b>Nevada</b>	Washoe County	Non-violent felonies	101-200

(Source: SAMSHA GAINS Center Adult Mental Health Court Treatment Database. [gainscenter.samhsa.gov/grant\\_programs/adultmhc.asp](https://gainscenter.samhsa.gov/grant_programs/adultmhc.asp))

Typically, there are multiple MHCs within one state, usually located with county or city jurisdiction. For instance, Georgia has a total of 18 MHCs in locations from Appalachia to Athens-Clarke County and Fulton County. Michigan’s MHCs are located primarily in counties; specifically Jackson, Kalamazoo, Livingston, Oakland, Wayne, St Claire, Genesee and Berrien Counties. Similarly, Florida’s 25 MHCs are located exclusively in counties ranging from the well-known Broward, to Miami-Dade to Orange Counties.

Regardless of their locations, MHCs are prevalent in the United States and accept a wide variety of cases.

### *MHC Demographics*

The demographics of MHC participants are another interesting aspect of MHCs. While demographics vary from court to court, a few studies provide information on participant race, gender, referral sources, and the sentences of MHC participants upon their entrance into the MHC program. For instance, Frailing (2010) found that in Washoe County, Nevada's MHC, of 146 MHC participants, 121 were white, 13 were black, two were Asian and four were Hispanic.

Similarly, Palermo (2010) found that in his sample of 347 participants, 11 percent were black, 5 percent were Hispanic and a total of 4 percent were "other". Fifty-two percent of the participants he studied were male, and 48 percent were female. Whites dominated Ray (2014)'s sample of MHC participants at 60.4 percent, blacks at 37.0 percent, Hispanics at 1.6, and Asian participants totaled 1.1 percent. As did Palermo (2010), Ray had a higher percentage of males (68.4 percent) than females (31.6 percent).

Perhaps the most detailed demographics provided were from a Bronx MHC sample of 648 participants, which were vastly different from the aforementioned in terms of race. The Bronx MHC participants were primarily composed of Hispanics (58 percent) followed by blacks (33.8 percent) and then whites, at 7.3 percent. The Bronx MHC included referral sources, and found that the District Attorney referred 45.7 percent of participants, followed by self-referrals and or referrals from drug courts, at 39.7 percent.

A judge or court referred 13.5 percent, while the defense counsel referred 1.1 percent (Rossman, et. al 2012).

The Bronx MHC noted the sentences of participants upon their entry to the MHC program, and found that drug selling ranked highest at 72.36 percent. Participants who had committed assault totaled 3.26 percent, robbery 3.88 percent, and drug possession at 8.23 percent (Rossman, et. al 2012).

As evidenced, MHCs are complex problem-solving courts that provide mental health and substance abuse treatment services to eligible defendants with the intention of curbing recidivism among the participants who complete programming. The question of how MHC effectiveness is defined, as well as how it is measured, will be discussed in the following chapter.

## **CHAPTER FOUR: EFFECTIVENESS OF MENTAL HEALTH COURTS**

### *What Defines Mental Health Court Success?*

There are no universal measures that define the effectiveness of MHCs, as their diversity makes a meta-analysis difficult (Edgley, 2012). Recidivism is a prominently used measure in the literature, specifically in terms of re-arrest, re-offending, and jail days. Frailing (2010) found that participants who graduated from a Brooklyn, New York MHC engaged in “significantly less substance abuse, had significantly fewer psychiatric hospitalizations and experienced significantly improved psycho-social functioning” than prior to participating in MHC programming. Edgely (2012;1) argues that MHCs have “succeeded when they have achieved the right confluence of essential elements, including providing evidence-based treatment and psychosocial supports...”

Recidivism appears to be a definition of “effectiveness” inferred by the literature; while there is no specific definition of “effectiveness”, MHCs are “effective” if there is some reduction or delay in participant recidivism (e.g. Palermo, 2010, and Ray, 2014) compared to similar offenders processed through traditional courts, or to participants who did not complete programming versus those who did complete programming. This applies to other facets of recidivism, including the number of days spent in jail prior, during, and after MHC participation.

Regardless of the myriad of ways MHC effectiveness could be determined, this chapter examines MHC effectiveness in terms of participant recidivism; specifically, whether or not the participant was re-arrested or re-offended, and the number of jail days they had post-completion versus pre-completion of MHC programming. Program completion, while not a stand-alone factor, appears to have an impact on whether or not, and how soon, a participant recidivates. Edgley's (2012) argument that MHC success is determined by its confluence of essential elements will also be briefly discussed as it is an intriguing perspective, and offers insight into another dimension of success not covered elsewhere in this chapter.

#### *Recidivism as a Measure of MHC Effectiveness*

According to research, MHC participants are significantly less likely to recidivate upon completing their mandated MHC programming. Recidivism is defined as re-arrests, re-offending, and the number of jail days spent before and after MHC programming. A study of a North Carolina MHC by Hiday and Ray (2010) found that after two years of exiting the MHC, 72 percent of MHC program completers and 81 percent of non-completers, and 63 percent those who opted out of programming were re-arrested.

Further, MHCs appear to have a long-lasting impact upon participants, as they were less likely to recidivate for a full two years after graduating. These are noteworthy findings; they suggest that MHCs have both long-lasting and short-term therapeutic effects on participants, at least in the area of recidivism. Another study by Moore and Hiday (2006) found that, during a 12 month follow up of MHC participants and those processed through the traditional courts, that those who were processed through the MHC were 47 percent less likely to be re-arrested.

In his research on Washoe County MHC in Nevada, Palermo (2010) also found major differences in jail days of MHC participants. In 2007, participants averaged 5,011 days in jail one- year pre-MHC, and 1,086 during their participation, a difference of 3,925 days, or a 78 percent decrease. The decrease in jail days from during MHC participation to one- year post MHC is 856 days, (from 5,011 days to 230 days) or a 79 percent decrease. The decrease in jail days spent by those who participated in MHCs speaks to their effectiveness in reducing recidivism.

In terms of new charges and jail days, McNiel and Binder (2007) found that charges for a new crime for MHC participants was 27 percent lower than for non-MHC participants. Herinckx, Swart, Ama, Dolzeal and King (2005) found that MHC graduates were 3.7 times less likely to re-offend than non-graduates.

Christy, et. al (2005) found that after one year, MHC graduates were significantly less likely to spend days in jail than participants who were terminated; and that prior to MHC programming, participants averaged 23 days in jail, versus three days spent in jail post-MHC.

Using court administrative data, Ray (2014) examined post-MHC exit arrests for a minimum of five years for 449 defendants who participated in an MHC from 2000 to 2006; he also examined the differences between those who completed the MHC and those who did not. Data collection occurred during November 2011, providing a follow-up period of over a decade for participants who exited the MHC in 2001 and over five years for those exiting in 2006 (Ray, 2014). Findings indicate that completers and non-completers recidivated the most within the first year (completers at 20 percent and non-completers at 52 percent) and the least in years four through five 0.6 percent for

completers, and 2.4 percent for non-completers.) Completers' recidivism reached zero percent at years six through seven, and non-completers reached zero percent at years seven through eight (Ray, 2014).

The aforementioned studies suggest MHCs reduce recidivism significantly, this outcome is especially prominent among participants who complete MHC programming, as opposed to those who do not complete programming, although the latter shows reductions and delays in recidivism as well.

Sarteschi, Vaughn, and Kim (2011) conducted a meta-analysis of 18 studies of MHCs, and found not only that MHCs reduce participant recidivism, but that they may also contribute to the decriminalization of those with severe mental illness (Sarteschi, et. al. 2011; 13). Proponents of the criminalization hypothesis posit that criminal offending is caused by untreated mental illness. MHCs may reverse the criminalization trend by providing treatment, which serves to positively impact the participants' life, and by reducing recidivism by replacing sanctions with treatment (Sarteschi, et. al. 2011; 13).

#### *Edgely's Confluence of Elements as MHC Success*

A theoretical approach to MHC's success argues that MHCs are effective because they have "achieved the right confluence of essential elements, including providing evidence-based treatment and psychosocial supports, and using adroit judge-craft". (Edgely, 2014;1). Essentially, MHCs are successful not only *because* of what they do, rather they are successful due to *how* they achieve the results that they do. Edgely's argument lays out the three essential elements needed for MHC success; (1) Treatment alone is not effective, (2) Evidence-based program design is essential, and (3) Adroit

judge-craft; or the use of the judge's role and influence to promote rehabilitation and to psychologically motivate MHC participants is important.

First, Edgely argues that treatment alone is not sufficient to the MHC goal of reducing recidivism; she cites Blackburn's (2004) argument that "Although psychiatric symptoms are correlated with offending, they are not causative..." and that psychosocial supports (e.g. housing, case management, and vocational assistance) must go hand-in-hand with treatment to effectively reduce recidivism. A more holistic approach is called for, one in which the criminal justice system views offenders with mental illness as human beings and employs a relational versus authoritative approach. (Edgely, 2014; 3)

The second essential element in the confluence is evidence-based program design and practice. It is suggested that the "program design often departs from the requirements of the theoretical model" when it comes to offender rehabilitation through MHCs, and this makes analysis of the effectiveness of approaches difficult. Variations in eligibility criteria and sanctions among MHCs are also a problem; aside from the lack of uniformity of MHCs, the criteria used to determine admission into the programs, and the sanctions meted out by judges for non-compliance are not evidentially supported; in other words, there is no research to back the use of any particular criteria or sanction, thus causing the effectiveness of the MHC to suffer (Edgley, 2014; 3)

The Risk, Needs, and Responsivity (RNR) Model of rehabilitation is a frequently utilized model for MHCs and has a proven history of reducing recidivism (Andrews and Bonta, 2010; Andrews, Bonta and Hoge, 1990). The Risk Principle requires that the level of program intensity be matched with the offender's risk of offending, The Needs Principle requires the program target the offender's unique criminogenic needs, and the

Responsivity Principle requires that the style and mode of intervention matches the offender's cognitive abilities, personality, and learning style (Edgely, 2014;3). MHC interventions are tailored to meet the specific needs of each participant; addressing offender-specific needs also reduces that offender's likelihood of recidivism. The focus needs to be on holistic treatment that addresses both psychological and other relevant needs.

Lastly, the MHC judge plays a vital role in MHC success. The judge has many responsibilities, including oversight of participants and their treatment, and meting out sanctions and rewards for non-compliance and progress. The judge's most important responsibility in the MHC is to ensure procedural justice, and to psychologically motivate participants; both of these goals ultimately culminate in rehabilitation.

Procedural justice, as noted in Chapter three, is essentially the fairness of the MHC procedure; whether the participant's voice is given weight and consideration, whether there is lack of bias and preconceptions. The judge must employ procedural justice and simultaneously motivate the participant by "communicating an attractive vision of the future", creating challenging, individualized goals for participants, and to foster their enthusiasm and aspiration to meet the goals set for them, while receiving individualized support from the judge. The judge must provide empowerment, respect, positive reinforcement, and individualized treatment within a therapeutic relationship with each participant, and employ procedural justice; this is essential to "support their desistence from crime and improved health and functionality" (Edgely, 2014;6). Senjo and Leip (2001) also note that supportive reinforcement, rather than adversarial

comments from judges have a positive effect on reducing recidivism while promoting the psychological wellbeing of MHC participants.

### *Perspectives Of An MHC Participant and an MHC Judge*

This section presents two separate perspectives on MHCs. The first is a testimonial recorded by the Allegheny County Department of Human Services (DHS News, 2008) on behalf of a former MHC participant, who will be called “Joe”. Joe’s experiences in the Allegheny County MHC provide a personal and subjective perspective of MHCs. The second is the experience of Judge Elizabeth Mattingly of the Hamilton County Mental Health Court (Mattingly, 2004). Judge Mattingly provides several points of insight she gained in being an MHC judge; three of these points will be discussed and connected to previously discussed research, including Edgely (2014).

While these case studies do not reflect or encompass the experiences of all MHCs, they do provide a meaningful look at two individual experiences, and are intended to provide the reader with a unique viewpoint of MHCs. This section will also highlight some noteworthy observations both testimonials make about the human investments of MHC participants and judges in both treatment programming and the overall MHC process. The purpose of this section is to provide two unique perspectives of MHCs not represented in the wider available literature.

Joe, a former MHC participant who suffers from Bipolar Disorder and Substance Abuse problems, came to the Allegheny County MHC after being arrested, charged with a variety of crimes, and spending two months in jail. Although he showed progress (claiming to have completed three rehabilitative programs), Joe relapsed and acquired new misdemeanor charges at some point during his time in the MHC, and consequently

spent three weeks in jail while his MHC team “put together another game plan”. He recalls the MHC judge’s words as he entered the MHC courtroom after relapsing: “He (the judge) looked at me and said “J, I’m very disappointed in you”...those words cut me because Judge Zottola knew me and cared about me enough to be disappointed” (DHS News, 2008;2).

Despite his relapse, Joe successfully completed MHC programming and moved into his own apartment and secured a job; “In short, I have made an incredibly long journey to a healthy, happy, productive life”(DHS News, 2008). There are a myriad of noteworthy observations in the testimonial regarding the human investment by both MHC staff and participants needed to ensure the success of participants.

He notes that the MHC only works when “committed, passionate, professionals work together with the resources, discretion, and flexibility to look at each person not as a case number, but as an individual...” and when the “system recognized the difficult nature of its undertaking and the seemingly dismal odds against which they operated” (DHS, 2008;2). Perhaps most importantly, Joe notes that there is no “guarantee that any given intervention will work”, but that MHCs can “produce amazing, life-improving results for seemingly hopeless cases like mine” (DHS News, 2008; 3).

Judge Elizabeth Mattingly, one of two Hamilton County Mental Health Court judges, agreed to preside over the MHC after working as a Municipal Court judge for over eight years. In her article, Mattingly (2004) includes three major insights she gained as an MHC judge; the first addresses the personal investment participants make in their treatment when committing to MHC programming, the second echoes Edgely’s adroit judgecraft, specifically in terms of psychologically motivating participants to invest in

MHC programming, and the third speaks to what Mattingly feels defines the success of MHCs using specific examples from participants' lives.

As previously discussed, MHC participants must be made aware of the requirements of MHC programming prior to agreeing to participate (Rossman, et al. 2012; Redlich, et al. 2010). However, the research does not necessarily reflect the gravity of the agreement to participate in treatment on the part of participants. Mattingly acknowledges the significant investment that MHC participants make in themselves when they commit to MHC participation: "The ...small numbers on our docket reflect the very real determination and courage it takes for mentally ill offenders to commit to the Mental Health Court...dealing with severe mental illness requires the defendant to do the often grueling and difficult work of facing personal demons" (Mattingly, 2010;2). The investment of participants is an important factor to note, as it is not merely a "get out of jail free" pass, but rather a commitment to wellness and recovery.

Second, Edgely (2014) discusses adroit judgecraft as part of her confluence of elements that are needed in order for MHCs to be successful. Employing adroit judgecraft involves psychologically motivating MHC participants to actively participate in treatment, however Mattingly's desire to motivate participants extends beyond their present efforts: "I am far more interested...in working to provide counseling and support that the defendant views as useful so that he or she will continue to participate in these services after direct involvement with the Mental Health Court ends" (Mattingly, 2010;3). Admonishing and motivating participants to continue treatment beyond what is mandated by the MHC is vital to their success; it is easier to participate with the

encouragement and help of a judge than it is with little or no encouragement and assistance.

Lastly, the success of MHCs is predominately measured by whether or not the participant recidivates (Hiday and Ray, 2010; Palermo, 2010). Edgely (2014)'s confluence of elements posits that MHC success is determined by evidence-based treatment and adroit judgecraft. These measures, while meaningful and important, are not how Mattingly determines whether or not MHCs are successful. Rather, the definition of success depends upon the individual participant and their progress: "The fact is that, in Mental Health Court, success is most often found in baby steps, and not in dramatic...changes. Success may be helping one defendant to schedule her own medical appointments and get there on the bus...I have learned that each step toward a stable life is important..." (Mattingly, 2004;5) The success of MHCs, in Mattingly's view, is not the major step of not recidivating, but rather accomplishments that are significant to the individual MHC participant, things that allow them to lead a more stable and productive life, rather than whether or not they commit a new crime.

Defining and measuring MHC success is not uniform; while recidivism (or lack thereof) is a good indicator of the effectiveness of MHCs and their programming, it is not, as evidenced by Mattingly's (2004) perspective, the only meaningful measure. The lack of clearly defined measures of success will be discussed, as will recommendations for future research in the next, and final chapter.

## CHAPTER 5: CONCLUSION

The purpose of this thesis was to (1) document and explain the rise in mentally ill prisoners and (2) examine mental health courts as the criminal justice system response to the increase. Data presented indicate not only an increase in the mentally ill correctional population, but that the proportion of inmates with mental illness is growing at a much faster rate than the general correctional population. From 1997 to 2005, the total correctional population increased from 1,816,931 inmates to 2,195,471, a 20.8 percent increase. The mentally ill prison population grew from 283,800 in 1997 to 361,400 in 2005, an increase of 27.3 percent. Further, the aforementioned evidence suggests that the growth in mentally ill prisoners is not slowing down. The most recent estimates of the incidence of mental illness among inmates will be published in an upcoming issue of *Corrections Compendium*.

There are many reasons for the increase in mental illness among inmates. The first and perhaps most prominent is deinstitutionalization, a movement since the 1970's that has transferred thousands of people with mental illness from state mental hospitals to

their respective communities (Schneider, 1999). Mental hospitals created institutionalized behavior, and made transitioning from the hospital to the community difficult, and patients often relapsed (Aderlbigbe, 1997). Community care was viewed as more humane, therapeutic and cost-effective than mental hospitals (Lamb and Bachrach, 2001). Further, the introduction of psychiatric drugs, particularly chlorpromazine and two anti-depressants (Iproniazid and Imipramine) allowed for more effective symptom management outside hospitals (Accordino, Porter, and Mores, 2001).

Legislation was a major factor in deinstitutionalization. In 1946 The National Mental Health Act was passed. Its main concern was assisting veterans of war returning with “battle fatigue” and how to best treat them. It also established the National Institute of Mental Health (NIMH), an organization created to assist states in setting up mental health services, conducting research, and funding (Cutler, Bevlacqua and McFarland, 2003). The 1963 Community Mental Health Centers Act (CMCH) provided inpatient and outpatient treatment, crisis and emergency services, partial hospitalization and mental health resources in communities (Accordino et. al, 2001; Cutler et. al, 2003). Finally, President Jimmy Carter proposed the Mental Health Systems Act, whose purpose was to ensure the mentally ill were not institutionalized and given adequate community care (The American Presidency Project).

The Patients Rights Movement also influenced deinstitutionalization by changing existing involuntary commitment criterion through legislation. Previously, involuntary commitment required the person be considered mentally ill and fit for commitment by the treating psychiatrist (Erickson, Vitacco, and Van Rybroek, 2005). A 1964 law passed in Washington, DC declared that persons being involuntarily committed must meet two

criterion: (1) They must have a mental illness and (2) They must pose an imminent threat to themselves and others, or (3) be gravely disabled, and unable to meet their basic needs (Testa and West, 2010).

The Patient Rights Movement contributed to the decrease in hospital populations by making involuntary hospitalization more difficult, and requiring specific criteria to be met before the person could be hospitalized, and patients could not be merely fed back into the hospital system.

However, deinstitutionalization created unique problems. Due to budget cuts, community mental health resources were depleted. Patients who had to be hospitalized were treated acutely and returned to their communities, often relapsing. This revolving door of commission, treatment, release, and relapse created a large homeless mentally ill population. A 2005 federal survey cited by Torrey, Entsminger, Geller, Stanley and Jaffe (2008) found that one third of the 500,000 homeless single men and women are seriously mentally ill.

Homelessness, a lack of employment and housing, and untreated mental illness led to the criminalization of the mentally ill; a punitive reaction to people with mental illness that involves their inappropriate processing through the criminal justice system, rather than the mental health system (The Sentencing Project, 2002). Without needed mental health care, many mentally ill individuals turned to drugs and alcohol to manage their illnesses. A 2011 SAMHSA report found that 50 percent of homeless individuals have a co-occurring substance abuse problem, and 71 percent of Bipolar Disorder patients reported a substance abuse problem (Torrey, 2002).

In order to meet basic needs, the mentally ill tend to commit crimes that are either a byproduct of their illnesses (e.g. disorderly conduct) or economic crimes (e.g. petty theft). These crimes draw the attention of the police, who are often called upon to deal with the mentally ill in both formal and informal interactions. Formal interactions include arrest or voluntary hospitalization, while informal interactions might involve releasing the person into a family member or friend's custody (Wells and Schaefer, 2006). Individuals who are known to police are often not arrested, but dealt with personally, as the officer has knowledge of their mental health issues (known as neighborhood characters) and is able to remedy the situation without arrest or hospitalization. An officer may arrest an individual although they have not committed a crime. This allows the officer to either try and have the person admitted to a hospital, or to take them to jail where they will receive some mental health services (known as "mercy bookings" or "mercy arrests"), and often occurs when there are no informal options available and the individual's behavior requires action (Teplin, 2000). Formal action opens the door for criminal justice involvement, and possible incarceration.

Incarceration poses unique problems to prisoners with mental illness. Prisons are unforgiving environments ruled by routine, security, and strict regulations that expect mentally ill inmates to abide by the same routines and comply with the same rules as all other inmates, regardless of their ability to do so. This "Custody-Conflict" is an "inherent tension between the security mission of prisons and mental health considerations...coordinating the needs of the mentally ill with rules and goals is nearly impossible" (Adams, 2008: 916). Therefore, mentally ill inmates are more likely to receive sanctions (e.g. solitary confinement), which exacerbate their illnesses and lead to

more behavioral problems (Haney, 2003; Fellner, 2006). And, victimization in prison is more prevalent among mentally ill inmates. A study by Beck (2001) found that the rates of inmate-on-inmate sexual victimization were two to three times higher for inmates taking prescription medications at the time of the offense, and three to four times higher for inmates who had received counseling.

A major criminal justice system response to the increase in mentally ill prisoners comes in the form of specialized courts known as Mental Health Courts (MHCs). As with drug courts in the 1980's, MHCs were created to handle the large number of mentally ill offenders being processed through the criminal justice system, and to address the underlying problems (mental illness) that led to their involvement with the criminal justice system, to link them to community-based mental health treatment (Council of State Governments, 2008; Denckla and Berman, 2001).

The first MHC was established in 1997, in Broward County, Florida, followed by courts in Alaska and California in 1998 and 1999. However, Judge Goodman of Marion County, Indiana is also credited with establishing the first MHC in the 1980's when he created a program to divert mentally ill offenders for evaluation at Wishard Hospital before its termination in the late 1990's. Although MHCs are not uniform, they share the objective of reducing criminal behavior and recidivism by treating the illness that is causing illegal behavior (Canada and Watson, 2013; Wolff, 2002). MHCs are federally funded via the 2003 Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA), the purpose of which is to "help states, local government and tribal organizations improve responses to people with mental disorders who are involved in the criminal justice system" (Council of State Governments, 2014;1).

Mental Health Courts differ from traditional courts in seven primary ways. (1) MHCs exclusively serve mentally ill offenders. (2) Involve stakeholders from multiple fields, including mental health professionals and law enforcement. (3) Require knowing and informed consent from the defendant before admission. (4) Participants are linked to community-based mental health services. (5) Monitor participants' compliance to treatment via status hearings. (6) Use rewards and sanctions to encourage compliance with treatment. (7) Therapeutic Jurisprudence guides the process.

Therapeutic Jurisprudence views the law as a social force capable of producing therapeutic or anti-therapeutic consequences for those who fall under it (Wexler, 1999). Therapeutic Jurisprudence is accomplished primarily through Procedural Justice, or the fairness of the MHC process. Procedural Justice is achieved when participants feel they have been treated with respect and dignity, and have contributed meaningfully to their treatment.

MHCs are staffed by a courtroom workgroup, consisting of a judge, a prosecutor, the defense counsel, parole or probation officers, mental health representatives, and a case manager (Almquist and Dodd, 2009). The workgroup works collaboratively to create, implement, and oversee treatment plans for each participant, and can vary in composition by court.

Entrance into MHCs typically involves following chain of events: Arrest/Custody → Screening → Referral to MHC → Acceptance into MHC → Treatment/Programming → Complete Programming → Graduation. The process begins with identifying and screening mentally ill arrestees. A referral is then made to recommend the individual for

MHC admission. Referrals can come from family, friends, law enforcement or attorneys, depending on the court (Almquist and Dodd, 2009).

Once admission is granted, MHC participants are connected with community-based mental health treatment, and their progress is monitored via status hearings involving the judge, participant and treatment team. Participants graduate from the MHC upon successful completion of their programming (Frailing, 2010; Palermo, 2010).

Eligibility criteria vary greatly among MHCs, although all courts require a psychiatric diagnosis and for a crime to have been committed. Eligibility criteria may include a diagnosis of Bipolar Disorder or Schizophrenia, as well as a misdemeanor or felony offense. The demographics of participants vary as well, but appear to be predominately white males (Frailing, 2010; Shoaf, 2002; Ray, 2014). The extent to which MHCs are effective is uncertain, partly because there is no common indicator of MHC success. However, a study of a North Carolina MHC by Hiday and Ray (2010) found that after two years of exiting the MHC, 72 percent of MHC program completers and 81 percent of non-completers, and 63 percent those who opted out of programming were re-arrested. Another study by Moore and Hiday (2006) found that, during a 12 month follow up of MHC participants and those processed through the traditional courts, that those who were processed through the MHC were 47 percent less likely to be re-arrested. And it appears that participants who complete MHC programming are less likely to recidivate than those who do not complete programming. Christy, et. al (2005) found that after one year, MHC graduates were significantly less likely to spend days in jail than participants who were terminated; and that prior to MHC programming, participants averaged 23 days in jail, versus three days spent in jail post-MHC.

A theoretical approach to MHC's success argues that MHCs are successful because they have "achieved the right confluence of essential elements, including providing evidence-based treatment and psychosocial supports, and using adroit judge-craft"(Edgely, 2014;1). Essentially, MHCs are successful not only *because* of what they do, rather they are successful due to *how* they do it. Edgely's argument lays out three essential elements for MHC success; (1) Treatment alone is not effective, (2) Evidence-based program design is essential, and (3) Adroit judge-craft; or the use of the judge's role and influence to promote rehabilitation and to psychologically motivate MHC participants is important.

The experiences of a MHC participant from Allegheny County MHC, and of Judge Mattingly, who presides over the Hamilton County MHC were presented to provide participant perspective of MHCs. The participant, "Joe", makes several noteworthy observations regarding why he feels MHCs are successful, noting that MHC only works when "committed, passionate, professionals work together with the resources, discretion, and flexibility to look at each person not as a case number, but as an individual..." and when the "system recognized the difficult nature of its undertaking and the seemingly dismal odds against which they operated" (DHS, 2008;2). Judge Mattingly also offered insight from her own experiences. A noteworthy observation is her desire to psychologically motivate participants by providing them with support that they feel is useful in order encourage compliance after the participant has exited the MHC (Mattingly, 2004; 2).

While the literature presented in this thesis provides a wealth of vital information regarding MHCs, there are many questions remain unanswered, and are addressed next.

### *Limitations*

Several limitations are evident in the literature on MHCs. The first is that there is no current data on the number or location of existing MHCs, making it difficult to assess their prevalence and the extent to which they are used. Although the SAMSHA GAINS Center for Behavioral Health and Justice Transformation's Adult Mental Health Court Treatment Database is currently the most appropriate and comprehensive source for identifying where MHCs are located in the United States, it does not provide comprehensive information as to the types of offenders targeted for MHCs or annual enrollment. Key questions to answer are (1) How many MHCs are in existence in the United States currently? (2) Where are the MHCs located? (3) What is their annual enrollment, and what type(s) of offenders are targeted?

Second, there is no current data on the number of offenders who are eligible for MHC admission and who are accepted into MHCs, or for the number of offenders who are accepted into programming and complete it. This information would be useful in both determining the extent to which MHCs are utilized, as well as their effectiveness.

Third, research in terms of the role of Therapeutic Jurisprudence and MHC effectiveness is unclear. Are MHCs that incorporate Therapeutic Jurisprudence more effective than those that do not? In what ways (aside from Procedural Justice) is Therapeutic Jurisprudence evident in MHCs (e.g. eligibility criteria, sanctions, etc)? Does Therapeutic Jurisprudence have any effect on recidivism? One suggestion would be to conduct surveys of MHC participants to determine the level of procedural justice they experienced, and then to conduct a follow-up study three to five years later, to determine

participant recidivism rates. Such research may reveal whether procedural justice has any effect on recidivism.

Fourth, Recidivism is the primary measure of effectiveness used in current research (e.g. Palermo, 2010; Ray, 2014). However, it is not used in a consistent manner, and it would benefit the literature to identify other ways to determine effectiveness. One possible question is to what extent are MHCs effective due to how they operate (e.g. Edgely's Confluence of Elements)? For instance, does frequent praise from the judge and high perceptions of procedural justice influence outcomes? Do participants who report experiencing high levels of procedural justice complete programming more often than those who do not experience the same levels of procedural justice?

Another area of MHC effectiveness to consider is participant mental health outcomes. Do MHCs ensure that needed mental health services are available to participants even after they exit the MHC? Are participants connected with all appropriate and necessary treatment services? Research that provides data on the effect of MHCs on participant mental health outcomes is an essential step to determining their effectiveness.

Fifth, there is very limited research regarding the demographics of MHC participants. While a few studies document the demographics of participants in the MHCs under study (e.g. Ray, 2014; Palermo, 2010). Research that provides data on the demographics (e.g. gender, race, socioeconomic status, etc) of MHC participants is needed.

Although existing research does provide an idea as to how effective MHCs are, further work should be done to determine the extent, and reasons behind MHC success.

### *Theoretical and Policy Implications*

Therapeutic Jurisprudence and Edgely's Confluence of Elements are two theoretical perspectives that both have significant relevance for MHCs, and are deserving of further research. Therapeutic Jurisprudence is arguably the underpinning of MHCs; as evidenced, MHCs differ significantly from traditional courts, primarily due to their inclusion of Therapeutic Jurisprudence. MHCs seek to rehabilitate mentally ill offenders and therefore treat the criminality caused by their illnesses, thus using the law to benefit offenders who need it most.

Policymakers should consider enacting laws that would automatically divert mentally ill offenders from traditional courts and into MHCs. By diverting all eligible mentally ill offenders to MHCs, more would receive needed mental health treatment and lessen their likelihood of recidivating, therefore slowing the cycle of mentally ill individuals in and out of the criminal justice system. Policymakers should also consider standardizing eligibility criteria, sanctions, and funding for MHCs. In doing so, inequality in these areas would be eliminated and all participants would have access to the same quality of mental health treatment, and be equally eligible for admission, regardless of whether they have committed a violent felony and have Schizophrenia, or have a charge of petty theft and have a Depression diagnosis.

Lastly, improving the training and education of courtroom actors (e.g. attorneys) should be considered. Clarke and Neuhard (2005) argue that defense attorneys need to go beyond legal representation and provide treatment and services to their clients, or "whole client representation (Clarke and Neuhard, 2005;782). Several existing defense attorney practices have done so. The Georgia Justice Project requires clients sign a contract

obliging them to participate in needed counseling, drug rehabilitation, or to pursue their GED. Once released, clients are able to begin work at the GJP's landscaping company (Clarke and Neuhard, 2005; 786). Training attorneys and law students in Therapeutic Jurisprudence principles would allow defense attorneys to utilize the law in a therapeutic manner by providing both legal representation and connecting clients with needed treatment services, thus enhancing the stated rehabilitative goals of MHCs. Arming all courtroom actors with a thorough knowledge of Therapeutic Jurisprudence is essential to both enhanced collaboration of the MHC workgroup, and to reducing recidivism of the defendants they serve.

#### *Recommendations for Future Research*

Future research should concern itself with several tasks: (1) Expanding the existing literature on Therapeutic Jurisprudence, particularly what area(s) of MHCs it influences most, and whether it could be applied to traditional courts. (2) Determining the demographics of MHC participants, with special attention to gender, race, socioeconomic status, and criminal background. This information would be useful in determining whether differences in race, gender, socioeconomic status and criminal background exist in utilization of MHCs (e.g. is gender or race a factor in granting or denying MHC admission?) as well as whether such variables have an effect on the effectiveness of MHCs (e.g. is race a factor in the amount of praise a participant receives from a judge?). (3) Generating current estimates of the number and location of existing MHCs in the United States, the populations they target (e.g. type of offense, diagnosis, etc) and their annual enrollment. (4) Examining the mental health outcomes of MHCs (e.g. are MHCs effectively connecting participants to treatment?).

The National Center for State Courts (2010) outlines fourteen MHC performance measures that would be useful in research to assess several different areas of MHC performance. Performance measures include ensuring that participants are connected with the type and level of needed services (“Need-Based Treatment and Supervision”) and ensuring that the needed treatment and services needed by each participant are available upon their exit from the MHC (“Participant Preparation for Transition”). Future research should thus consider utilizing these performance measures to determine how MHCs affect mental health outcomes of participants.

Generating research that deals with the aforementioned limitations would not only benefit existing literature by expanding the current knowledge base, but also provide a basis from which to determine the effectiveness of MHCs and perhaps reveal further need of improvement.

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