



PUTTING THERAPEUTIC JURISPRUDENCE INTO PRACTICE: THE GROWTH, OPERATIONS, AND EFFECTIVENESS OF MENTAL HEALTH COURT*

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This article focuses on a court innovation for criminally involved people who are afflicted with serious mental illnesses, such as schizophrenia, bipolar disorder, or major depression. It describes a recently developed strategy for dealing with the challenges of working with mentally ill individuals during the pre- and post-adjudication stages of the criminal justice process: mental health court (MHC). The article also discusses the historical and legal underpinnings of these courts, their growth, and the defining elements and operations of the earliest MHCs, which are best viewed as evolving models of practice. Finally, the article reviews studies of MHC operations and effectiveness and suggests future directions for MHCs.



Fundamental changes in mental health laws and policies have brought criminal justice professionals into contact with the seriously mentally ill at every stage of the criminal justice process. Police arrest people with serious mental illnesses (PSMI) because few other options are readily available to handle their disruptive public behavior or to obtain for them much-needed treatment or housing (Teplin, 2000). Jail and prison administrators often struggle to treat and protect the mentally ill, judges grapple with limited sentencing alternatives for PSMI who fall outside of specific forensic categories (e.g., guilty but mentally ill), and probation and parole officers scramble to obtain scarce community services and treatments for PSMI and attempt to fit them into standard correctional programs or to monitor them with traditional case management strategies (Lurigio and Swartz, 2000). When the mentally ill are sentenced to community supervision, their disorders complicate and impede their ability to comply with the conditions of release and compound the difficulties of prisoner reentry (Council of State and Local Governments, 2002).

Other PSMI enter the criminal justice system because they have engaged in serious criminal behavior that is often—but certainly not always—related to their untreated psychiatric and substance-use disorders. Indeed, the growth of specialized police and diversionary programs that address low-level criminal behavior (e.g., disorderly conduct) by deflecting the mentally ill away from the criminal justice system and into the mental health system has likely reduced the actual criminalization of the mentally ill (Lurigio, Smith, and Harris, in press). Nevertheless, the lack of accessible and



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affordable mental health care in this country has contributed to the transinstitutionalization of the mentally ill, who are more likely to receive psychiatric treatment in a jail or prison than in a hospital (Council of State Governments, 2002; Lamberti, 2007).

PSMI often reside in highly criminogenic and impoverished environments that exert pressures on them to engage in criminal behaviors. The factors that characterize these environments (e.g., joblessness, gang influences, failed educational systems, and residential instability) also affect poor persons with no serious mental illness (Sliver, Mulvey, and Swanson, 2002). Draine et al. (2002) suggest that PSMI have many types of problems because of the social settings or contexts in which they typically live (poor and disadvantaged communities). Homelessness, crime, undereducation, and unemployment are endemic to such neighborhoods. A large percentage of poor persons experience these difficulties—irrespective of whether they have mental illness or not—which render them more susceptible to criminal activities and victimization (Lamberti, 2007).

This article describes a recently developed—but fast-growing—strategy for dealing with the challenges of PSMI during the pre- and post-adjudication stages of the criminal justice process: mental health court (MHC). This court innovation is for criminally involved individuals who are afflicted with serious Axis I diagnoses, such as schizophrenia, bipolar disorder, or major depression—chronic brain diseases that cause extreme distress and interfere with social and emotional adjustment. Some MHC programs also accept individuals with Axis II diagnoses, which are characterological problems that adversely affect interpersonal relationships and lead to school and work failure as well as other troublesome behaviors, including criminal acts and addiction (American Psychiatric Association, 2004; Gamble and Brennan, 2005). The historical and legal underpinnings of these courts, their growth, and the defining elements and operations of the earliest MHCs—which are best viewed as evolving models of practice—are explored. Finally, studies of MHC operations and effectiveness are reviewed, and the future direction of such courts is discussed.

Research on mental health courts is scanty, and much of it is more descriptive than evaluative in nature. Furthermore, the quality of research on the effectiveness of MHCs is quite variable. The bulk of studies have employed weak research designs. For example, few investigations are prospective or include comparison groups and random assignment to either specialized courts or services/supervision-as-usual. In addition, outcome measures are inadequate, and the duration of follow-up periods is short; when included, longitudinal data are not always censored for clients' time-at-risk. Hence, research on MHCs is currently inconclusive about the effectiveness of such programs in reducing rearrests and psychiatric relapses. The purpose of this article is to simply report the findings of major studies of MHC rather than to perform a meta-analysis or critical assessment of the literature. Our goal is to provide a snapshot of current MHC research and operations to inform future studies and practices.

HISTORICAL UNDERPINNINGS

MHCs were developed in response to a growing awareness that substantial numbers of PSMI were appearing before the judiciary (Bernstein and Seltzer, 2004). Evidence suggests that between 15 and 20 percent of those in correctional populations suffer from a serious mental illness—a percentage that is substantially higher than the representation of PSMI in the general population (Ditton, 1999). Very few of these individuals have met the standards for incompetency or insanity, or have had their illnesses addressed in sentencing or court supervision plans. As the Council of State and Local Governments (2002:9) observed, “People with mental illness are falling through the cracks of this country’s social safety net and are landing in the criminal justice system at an alarming rate.” Therefore, PSMI often cycle repeatedly through the criminal justice system, in part because of the court’s failure to recognize psychiatric illness as a factor that contributes to their continued criminal activity (Lurigio and Swartz, 2000).

Except for a handful of investigations (e.g., Teplin, 1990), the prevalence of psychiatric disorders has not been established with sound methodologies or epidemiological preciseness. Despite the shortcomings of most studies—including Ditton’s (1999) research, which is the only national investigation of mental illness within correctional populations—estimates of the mentally ill in the criminal justice system are fairly consistent. Previous studies indicate that 16 to 20 percent of prison inmates and 7 to 12 percent of jail detainees are afflicted with mental illness, excluding substance-use disorders (Lurigio and Harris, 2007). Nonetheless, more prevalence research must be conducted to specify the need for treatment and to provide baseline indicators of the nature and severity of mental illness for studies of program effectiveness.

In response to the apparent growth in the number of PSMI entering the criminal justice system, advocates, researchers, and legal scholars called for the creation of specialized programs that could respond justly, fairly, and humanely to PSMI at every stage of the legal process—from arrest to reentry from prison (Lurigio and Swartz, 2000). Two converging legal trends spurred the development of MHC as an appropriate mechanism for handling the problems of criminally involved PSMI: therapeutic jurisprudence and the drug court movement. The former laid the academic groundwork for specialized courts, and the latter developed and tested the basic elements of successful specialized court operations (Wexler and Winick, 1996).

Therapeutic Jurisprudence. The term therapeutic jurisprudence (TJ) first appeared in the law literature in the late 1980s, in the context of mental health law. TJ is defined as “the study of the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences for individuals involved in the legal process” (Hora, Schma, and Rosenthal, 1999:440). Since its introduction, TJ has emerged as an approach for examining an extensive array of legal subjects, including the response of the criminal court system to the problems and needs of PSMI and how legal decisions can affect therapeutic outcomes.

Legal scholars view TJ as the application of social scientific theories and method-

ologies from a wide variety of disciplines for the purpose of understanding and promoting the psychological well-being of participants in the legal process. As we noted above, TJ recognizes that the law and legal actors, as well as legal rules and procedures, can all have therapeutic (favorable and healthy) or anti-therapeutic (unfavorable and unhealthy) consequences for those who are affected by the court's activities and decisions (Wexler and Winick, 1996). The concept of TJ favors the court's adoption of a problem-solving, proactive, and results-oriented posture that is responsive to the current emotional and social problems of legal consumers.

TJ conceptualizes the law as a social force and judges as therapeutic agents who exercise the court's authority to promote clients' psychological health and social interests, while protecting their due-process rights and ensuring that justice is served in every case (Wexler and Winick, 1996). The National Association for Court Management and the National Center for State Courts widely touted TJ as an effective approach to the delivery of court services (Schma, 2005). Furthermore, the National Trial Court Performance Standards incorporated the TJ concept in Standard 4.5, which states that:

The trial court anticipates new conditions and emergent events and adjusts its operations as necessary. Effective trial courts are responsive to emergent public issues such as drug abuse, child and spousal abuse, AIDS, drunken driving, child support enforcement, crime and public safety, consumer rights, gender bias, and more efficient use of fewer resources. A trial court that moves deliberately in response to emergent issues is a stabilizing force in society and acts consistently with its role in maintaining the rule of law.

As our discussion suggests, mental illness falls within the purview of the TJ framework. Before the court turned its therapeutic attention to PSMI, however, it first employed TJ in its handling of drug cases.

Drug Treatment Courts. The most recent war on drugs, launched with the passage of the Anti-Drug Abuse Act of 1988, led to a massive influx of offenders at every stage of the criminal justice process, contributing to overtaxed court dockets and massive prison overcrowding (Lurigio, 2003). Specialized drug treatment courts (DTCs) were implemented in response to the unprecedented wave of drug offenders and their tendency to recycle through the criminal justice and treatment systems (Lurigio, 2000). Such drug courts are based on several major premises and include key components that have been adapted by MHCs, including specialized court dockets and a team approach to handling cases (cf. Cooper, 1998; Drug Courts Program Office, 1997).

DTCs regard addiction as a chronic brain disease that promotes or intensifies criminal behavior. During recovery, relapses are expected, but they also afford opportunities for personal growth and eventual sobriety. In DTCs, treatment is integrated with other rehabilitative services and with criminal justice case processing. When successfully treated, persons with addiction are less likely to recidivate in terms of

rearrest, reincarceration, and outpatient admission (Lurigio, 2000). DTCs use leverage or coercion to encourage offenders to begin and remain engaged in treatment programs. Judges exercise their moral and legal authority in overseeing the recovery process and take a strong professional interest in each offender's recovery.

Dade County's Felony Drug Court (Miami) was the first DTC in the nation. Situated in Florida's Eleventh Judicial Circuit, the court first heard cases in 1989, and it received wide praise for its innovative procedures and emphasis on teamwork, cooperation, and collaboration among members of the courtroom work group (Davis, Smith, and Lurigio, 1994). Drawing on the principle of TJ, its philosophy and operational design became the prototype for future DTCs. The court is based on the premise that addiction is a disease that promotes criminal behavior; it is, therefore, highly treatment oriented and supportive of clients' recovery efforts. Defendants are neither prosecuted nor punished for their substance-use disorders. Instead, the court provides or brokers drug treatment, as well as other services, to help offenders achieve sobriety and stability in their lives (Florida's Eleventh Judicial Circuit, 2007).

Like the Miami-Dade Court, most DTCs present defendants with the option of either pleading guilty and participating in mandatory treatment, or going to trial and risking incarceration or other criminal justice sanctions. Failure to comply with program requirements could culminate in a variety of judicial sanctions, ranging from a verbal reprimand to a probation sentence to confinement in jail or prison (Canadian Centre on Substance Abuse, 2007; Mugford and Weekes, 2006). In general, the defining components of DTCs are consistent with the Miami-Dade prototype. For example, the Drug Courts Program Office, United States Department of Justice (1997) and the National Association of Drug Court Professionals enumerated the following key elements of DTC, which have also become the guiding principles for MHCs (Drug Strategies, 1999):

- Prompt identification of clients and their immediate placement in treatment;
- Nonadversarial court proceedings enacted by a team of judges, attorneys, and treatment providers and designed to protect community safety as well as the due-process rights of defendants and offenders;
- Regular contact between clients and judges in judicial status hearings or other types of court sessions;
- Intensive supervision practices that include close monitoring and frequent, random drug testing of clients;
- Treatment interventions that are on a continuum of care, evidence-based, comprehensive, and integrated for individuals with co-occurring psychiatric disorders;
- Contingencies of rewards and punishments that encourage compliance with treatment and other conditions of program participation;

- Ongoing evaluations to monitor program implementation and measure the accomplishment of program objectives and goals;
- Close working relationships with a wide range of community service providers and public agencies; and
- Interdisciplinary educational opportunities to help the program staff stay current with the latest advances in offender drug treatment and case management strategies.

In 1997 more than 370 DTCs were operational or being planned in the United States; at that time, the largest numbers of DTCs were in California, Florida, Ohio, Oklahoma, and New York (Cooper, 1998). By April 2007, more than 1,000 DTCs were operational in all fifty states, as well as in the District of Columbia, Guam, and Puerto Rico. Forty-one states, the District of Columbia, Guam, and Puerto Rico have passed legislation that supports the planning and operations of DTCs (American University, 2007). The White House hailed DTCs as “one of the most promising trends in the criminal justice system” (White House, 2004).

The creation of MHCs not only benefited from the political support and successful implementation of DTCs, but also gained impetus from the reported success of drug courts. Although the quality of the research undertaken to evaluate DTCs has been questionable, most reviews of such evaluations have applauded the success of DTCs in decreasing recidivism, saving taxpayer dollars, and increasing retention in treatment (National Drug Court Institute, 2004).

In a review of research on drug courts, Marlowe, DeMatteo, and Festinger (2003) stated that “we know that drug courts outperform virtually all other strategies that have been attempted for drug-involved offenders.” However, studies of DTCs have several shortcomings. For example, many lack comparison groups, and few perform intent-to-treat analyses (Christie and Anderson, 2003). The serious limitations of these studies is noteworthy given the fact that MHCs are premised on the DTC model and both courts have experienced tremendous growth during their relatively short tenures in the criminal justice system. When the empirical evidence regarding DTCs is considered, the enthusiasm with which they are used as a model for sentencing alternatives—such as MHCs—is troubling (Huddleston, Freeman-Wilson, and Boone, 2004).

As the number of DTCs increased, so did the number of defendants in those courts who had mental health problems. In response to the growing presence of PSMI on court dockets, several jurisdictions—Honolulu and Ithaca, New York, for example—developed mental health tracks within their DTCs. Similarly, the DTC in Lane County, Oregon, developed two mental health tracks—one for PSMI and another for persons with personality disorders (Axis II). These consist of characterological problems and destructive behavioral patterns that affect people’s relationships and overall functioning (American Psychiatric Association, 2004). San Bernardino County, California has separate drug and mental health courts, with the same judge presiding over both (Rabasca, 2000). In the late 1990s, other jurisdictions began implementing independent MHCs.

In summary, the DTC model has transformed specialized criminal courts from adversarial and legalistic to therapeutic and rehabilitative and laid the foundation for MHCs (Fulton-Hora, 2002). DTCs adopt a common mission and team approach to working with drug-involved offenders. Judges, prosecutors, defense attorneys, probation officers, and treatment providers execute a coordinated case management plan that holds offenders accountable through graduated sanctions for rule infractions and rewards them through reductions in sentences and dismissals of charges for successful program completion (Belenko, 1998).

EARLY MENTAL HEALTH COURTS

Specialized MHCs are believed to hold great promise for diverting PSMI from the criminal justice system and ensuring that they receive psychiatric treatment and other services (Bazelon, 2004). As Goldkamp and Irons-Guynn (2000) indicated, pioneering MHC initiatives were implemented in response to three critical problems: the perceived public-health risk posed by offenders with serious mental illness, the challenges and costs of housing PSMI in crowded local jails, and the criminal justice system's pervasive inability to respond effectively and humanely to PSMI. Among the first three jurisdictions to establish MHCs were Broward County, Florida; King County, Washington; and Anchorage, Alaska.

Broward County. The first mental health court in the nation was implemented in Broward County, Florida, in May 1997. The Broward County program, which began as a part-time court, is dedicated to handling PSMI accused of nonviolent, low-level misdemeanor offenses, excluding the crimes of driving under the influence and domestic violence. The court was "created specifically to balance issues of treatment and punishment for defendants with mental illness and retardation" (Baker, 1998:20). "The mission of the mental health court is to address the unique needs of the mentally ill in [the] criminal justice system" (Mental Health Court Progress Report, 1998:4). Funding for the program was garnered from the budgets of state and county governments: \$1.5 million from state funds, \$250,000 from the Broward County Department of Human Services, and \$400,000 from a lawsuit settled against Broward County that stemmed from jail overcrowding.

Defendants charged with assault can be admitted to the program if they express a genuine desire to participate and seem able to achieve their therapeutic goals. The court is staffed by a judge, a state's attorney, a public defender, and a court monitor, all of whom have received considerable training in mental health topics and are assigned to the court permanently. The court liaison is a mental health professional, who refers defendants for psychiatric and social services (Goldkamp and Irons-Guynn, 2000).

Defendants in Broward County's program are initially evaluated for competency and, if necessary, are referred to inpatient or outpatient treatment for stabilization. Competent defendants appear in court for a review hearing. The MHC team decides whether a defendant is appropriate for the program and can be released safely into the community. The team then formulates a treatment plan for defendants accepted into

the program. A case manager and a court monitor oversee defendants' participation in treatment and prepare periodic reports to the court addressing the progress of each defendant. After a defendant has successfully participated in treatment and arrangements are made for longer-term psychiatric care, the MHC judge dismisses the defendant's charges.

During the first three years of the Broward County MHC's operations, the court screened more than 1,500 defendants for eligibility and accepted more than 650 of them for services. More than one-third of the clients had previous psychiatric hospitalizations and more than one-fourth were homeless when evaluated for MHC eligibility. More than two-thirds of the clients were men, and nearly 20 percent of all the clients had co-occurring psychiatric and substance-use disorders (Broward County, 2003).

King County. The MHC in King County, Washington was modeled after the Broward County program and was another early effort to bridge the chasm between the mental health and criminal justice systems for the mentally ill misdemeanor population. The court was initiated after a Seattle Fire Department captain was brutally murdered by a mentally ill man who had been found incompetent and was released by the Seattle Municipal Court immediately before the commission of the crime (Goldkamp and Irons-Guynn, 2000). Therefore, the court's primary goal is to protect public safety.

Other goals of the King County MHC are to process clients' cases expeditiously, to facilitate their access to public mental health care, to reduce their rates of recidivism and rehospitalization, and to improve their mental health conditions and well-being. King County's MHC establishes a single point of contact for PSMI. It is staffed by a judge, a prosecutor, a public defender, a treatment liaison, and probation officers (Mental Health Court Fact Sheet, 1999). The court is supported by funds from the Bureau of Justice Assistance and the local criminal justice and mental health systems, as well as by contributions of resources and staff from collaborating agencies. The initial, annual cost of the program was \$900,000, most of which was spent on treatment (Barker, 1999).

King County's MHC receives referrals from a variety of sources, including jail staff, police officers, attorneys, family members, and probation officers. The majority of defendants in the MHC are accused of nonviolent nuisance crimes, such as urinating in public, sleeping in airports, and harassing people in front of stores or restaurants. Participation in the program is voluntary, and defendants are asked to waive their rights to trial. Defendants receive court-ordered treatment in lieu of standard sentencing, and successful participation in the program can lead to a dismissal of charges.

The court liaison develops a treatment plan and links the defendant to mental health services. Defendants sentenced to probation are assigned to a probation officer who works in the MHC and carries a reduced caseload of fewer than forty cases, thus allowing the officer to deliver the intensive services that are necessary to respond to the needs of PSMI (Barker, 1999). The court holds regular status hearings to chart the treatment progress of clients.

Anchorage. The Court Coordinated Resources Project in Anchorage, Alaska consists of a team of court professionals, probation officers, judges, prosecutors, and defense attorneys. The primary goal of the project is to identify nonviolent, low-risk, mentally disabled misdemeanants for diversion from expensive jail beds and into community-based treatment facilities while they are out on bail or as a condition their of probation sentences. The court works in tandem with the Jail Alternative Services Project, a post-booking jail-diversion program operated by the corrections department. These projects were developed to address issues related to the large proportion of PSMI in jail and in response to a court order to reduce jail overcrowding (Goldkamp and Irons-Guynn, 2000; Rhoades, 1999).

The Court Coordinated Resources Project's MHC is an adjudication court, not a trial court. With the assistance of counsel, offenders who wish to have their cases heard in adjudication courts waive their right to a trial and plead guilty. A pretrial diversion model was considered infeasible, and local court administrators were disinclined to implement such a program. PSMI charged with nonviolent misdemeanors are eligible and participation is voluntary. Most participants have co-occurring substance-abuse or substance-dependence disorders. The state of Alaska has no misdemeanor probation. Hence, the MHC is the only monitoring strategy for these defendants. In their first year, the court and the jail-diversion programs provided much-needed probation services for misdemeanants and relieved some of the caseload pressure on the local probation department (Goldkamp and Irons-Guynn, 2000; Rhoades, 1999).

GROWTH OF MENTAL HEALTH COURTS

Since the inception of these and other bellwether courts, interest in MHC has grown tremendously. Numerous jurisdictions have implemented their own mental health models, tailored to local needs, resources, and political exigencies. In November 2000, President Clinton signed the Law Enforcement and Mental Health Project Act, sponsored in the Senate by Mike De Wine (R-Ohio) and in the House of Representatives by Ted Strickland (D-Ohio). The law authorized the allocation of funds to support the implementation of MHCs at the county level.

In fiscal years 2002 and 2003, Congress appropriated 5 and 4 million dollars, respectively, for seed grants to help inchoate MHC programs become operational. However, the House of Representatives allocated no funds in fiscal year 2004 for the support of MHCs. Furthermore, the Senate's Commerce, Justice, State, and Judiciary Appropriations subcommittees also allocated no dollars to launch MHCs. Despite the absence of these allocations, the number of MHCs in the United States mushroomed from 1 in 1997 to more than 100 in 2005; MHCs are now located in nearly forty states, such as California, Ohio, Florida, and Washington (Council of State Governments, 2006; Steadman et al., 2005). Since 2005, the number of mental health courts has risen more than 180 (consensusproject.org/mhresources/pubs).

PARTICIPATION AND PROCEDURES IN MENTAL HEALTH COURTS

Redlich et al. (2006) identified the basic characteristics that operationally define an MHC. They include a separate docket for PSMI and the goal of diverting the mentally ill away from the criminal justice system and into the mental health treatment system. They also include mandated community-based treatment as a condition of program participation; direct court supervision of clients, including attendance at regular status hearings in the court; and rewards and sanctions to encourage compliance with court mandates. These common elements are discussed below.

Program Eligibility. Similar to other specialty or problem-solving courts, MHCs are on a separate docket and include key actors in the courtroom—judges, attorneys, and court personnel—who have specialized knowledge of mental health issues (Bazelon, 2003a; Griffin, Steadman, and Petrila, 2002). When PSMI meet the MHC's eligibility criteria, public defenders or judges typically refer the individual to the specialty court (Steadman et al., 2005). Although MHCs were created to achieve similar goals (i.e., to reduce recidivism and provide access to psychological services), the eligibility criteria differ among such courts.

To be eligible for participation in an MHC, defendants must, of course, have an identifiable mental illness; however, more specific eligibility requirements are enumerated by each individual court. For example, in the National Survey of Mental Health Courts (NAMI et al., 2005), one-third of the courts limited eligibility to individuals with an Axis I diagnosis. Fewer than 10 percent of MHCs allowed individuals with developmental disabilities to participate, and only 3 percent allowed defendants with an Axis II diagnosis to participate.

Some courts in the national survey restricted eligibility on the basis of the severity of the mental illness as opposed to whether it lies on Axis I or Axis II. For example, approximately 25 percent of MHCs required the offender to have a "severe and persistent mental illness." Another 4 percent of the courts further defined mental illness as including a severe and persistent mental illness in one of the following diagnostic categories: schizophrenia, schizoaffective disorder, bipolar disorder, and major depression (NAMI et al., 2005). Most of the defendants accepted for participation in an MHC suffer from the above mental disorders (Steadman et al., 2005). As the NAMI survey found, the majority of MHCs also reported that a significant number of clients had co-occurring substance-use disorders; one-quarter of the MHCs specified as eligible individuals with mental illness and drug addiction (NAMI et al., 2005).

Besides diagnosis, a few MHCs considered other factors relating to an individual's mental illness. For instance, 8 percent of the courts limited participation to defendants whose mental illness contributed directly to the offense for which they were charged. A small percentage (4 percent) of courts based eligibility on the availability of treatment for the defendant, and a few MHCs also considered the "treatability" of the defendant and the defendant's willingness to take medication as part of the treatment plan (NAMI et al., 2005).

The type of offense committed can also be considered in eligibility decisions (Griffin, Steadman, and Petrila, 2002). In a study of four mental health courts, three of them restricted eligibility to defendants charged with misdemeanors (Griffin, Steadman, and Petrila, 2002). Similarly, in the National Survey of Mental Health Courts, 27 percent of the courts restricted eligibility to misdemeanor charges, 46 percent to nonviolent misdemeanor or felony charges, and 3 percent to felony charges. Only 5 percent of MHCs considered all types of charges in their client-eligibility review process (NAMI et al., 2005).

Other exclusion criteria employed by MHCs included offender types such as child abusers, first-time offenders, chronic offenders, sex offenders, and offenders who used a firearm in the commission of a crime. Several MHCs also excluded persons with driving-under-the-influence and domestic-violence charges because their districts already had specialty courts for defendants convicted of those offenses. In summary, common eligibility criteria for MHCs included defendants with Axis I diagnoses or co-occurring substance-use disorders. Most courts also restricted eligibility by offense type—excluding persons charged with felonies or violent crimes. PSMI who fail to meet MHC eligibility criteria are removed from the court's docket. Defendants may also decline to participate in the court because acceptance into the program requires a guilty plea, which they can refuse to enter.

Defendants who participate in MHC are frequently placed under court supervision for longer periods than would have been required if they were sentenced in a standard criminal court. Defendants who transfer to an MHC and then wish to return to criminal court could be penalized for doing so. Specifically, 56 percent of the MHCs in a national survey prohibited defendants from transferring back to the traditional court without sanction (Bazelon, 2003a).

In addition to meeting the criteria established by individual MHCs for eligibility to participate in the court's proceedings, defendants also must be competent to stand trial. MHC researchers have expressed concern about the issue of competency (Stafford and Wygant, 2005). Although a defendant must be competent to be accepted into MHC, few safeguards are in place to ensure that defendants remain competent while in the program. Moreover, few studies have examined the number, characteristics, and outcomes of prospective clients who were deemed incompetent to enter an MHC program (Stafford and Wygant, 2005).

In fact, it is highly likely that when MHC clients become psychotic—and probably incompetent—the court continues to exercise its authority over clients to compel them to adhere to treatment. After all, MHCs principally involve criminal proceedings—even if they operate under the banner of a “mental health” court. Stafford and Wygant (2005) concluded that “a number of defendants with major mental illness and misdemeanor charges lack the capacity to waive their constitutional rights and make the informed decisions necessary to participate in mental health court. Therefore, the goals underlying both the legal and service-providing aspects of MHCs may sometimes be conflicting” (p. 257).

Along similar lines, offering MHC to a mentally compromised defendant can appear to be antithetical to the principle of therapeutic jurisprudence because participation often demands a sentence with stringent conditions of supervision. However, most MHC clients must also initially consent to participate in mandated services, which can provide a unique opportunity for treatment for individuals who would have otherwise been sentenced to incarceration or standard probation without services. Mandated treatment supplies the leverage to serve risky clients in the community. MHC participants have typically experienced several failed treatment attempts and incarcerations. Court mandates, and the combined efforts of the MHC team, help engage clients in services and give them an opportunity to complete the program successfully (Lurigio et al., 2008).

Program Operations. As we indicated above, participation in MHC generally includes court supervision. For example, Griffin et al. (2002) found that MHC supervision ranges from being supervised “as-needed” to meeting with the court weekly. Griffin, Steadman, and Petrila (2002) identified three models of MHC supervision. In the first model, the MHC staff refers clients to community treatment and requires them to report to the court regularly. In the second model, the MHC staff directly supervises clients, while in the third model a team of MHC staff supervises clients. The length of supervision for MHC clients also varies greatly. Some mental health courts limit the length of supervision to the state’s maximum sentence for the crime (Griffin, Steadman, and Petrila, 2002). Other mental health courts mandate supervision from three months to open-ended periods of supervision (NAMI et al., 2005).

Most MHCs impose on clients a variety of sanctions for their failure to participate in mandated services. Bazelon (2003a) found that 36 percent of MHCs required more services and 27 percent increased the frequency of supervision for clients who failed to adhere to the conditions of supervision. Nearly two-thirds (64 percent) placed clients in jail and 18 percent removed clients from the program for failing to follow court orders. Similarly, the National Survey of Mental Health Courts (NAMI et al., 2005) found that 60 percent of MHCs used jail as a sanction, and 39 percent modified treatment plans when clients violated court mandates. Other sanctions included more stringent supervision, electronic monitoring, curfews, verbal warnings, and written essays. Jail is used as a sanction more often in courts with felon participants than in those with misdemeanor participants (Redlich et al., 2006). Thus, MHCs use a wide range of sanctions, including detention, to increase compliance with court-ordered mandates.

Effectiveness of Mental Health Courts. Attempts to examine the effectiveness of mental health courts have been fraught with several challenges. Unlike DTCs, in which the ultimate goal is to help clients refrain from illicit drug use, the goal of MHC is not quite so clear-cut. Obviously, the court cannot require clients to stop being mentally ill. In addition, PSMI who participate in MHCs have a variety of different illnesses and symptoms (Bureau of Justice Assistance, 2000). Therefore, defining success for MHC participants is difficult and often must be done case by case.

The problem of defining success for MHC participants has complicated studies about the effectiveness of the courts. Petrila (2002) explored the effectiveness of one of the nation's first mental health courts, the Broward County MHC. In his study, a standard misdemeanor court sample was compared to a sample of MHC clients. He found that in the MHC, judges spent more time speaking with clients and court procedures were less formal. Participants in the MHC reported that they had a greater chance of being heard as well as greater access to mental health treatment than those in the comparison court. In addition, participants who were in treatment before entering the MHC were more likely to remain in treatment, compared to those adjudicated in the standard misdemeanor court (Petrila, 2002). MHC clients were also more likely to have access to and to participate in treatment. Petrila (2002) also observed that the judge in the Broward County MHC rarely used jail as a sanction for clients; in fact, detention was viewed as anti-therapeutic and a failure of the justice system (see Bureau of Justice Assistance, 2000). Hence, the judge's understanding about the importance of treatment might account, in part, for the success of the Broward County MHC.

Few MHC outcome studies have specifically examined the impact that MHC participation has on criminal recidivism. A study of two mental health courts in Seattle found that offenders who participated in MHC had fewer arrests during a nine-month period than those who did not (Trupin and Richards, 2003). Similarly, in a randomized controlled trial in Santa Barbara, MHC clients who received assertive community treatment had a lower one-year recidivism rate than those who were sentenced in criminal court and received traditional case management services. In Broward County's MHC, however, participants had similar rates of rearrests compared to a group of nonparticipants (Christy et al., 2005).

Moore and Hiday (2006) examined the overall effectiveness of MHC in reducing recidivism rates. They found that for clients who completed MHC, the rate of recidivism was significantly lower than the rate for similar offenders who did not participate in the court. Yet those who failed to complete the MHC did not differ in their rate of recidivism from those sentenced in traditional criminal court.

Evaluation of the Broward County MHC also showed that clients who participated in the court experienced no clinically significant changes in their symptoms compared to clients who did not participate in the court. Although this finding could be interpreted as a failure of MHC, Boothroyd and colleagues (2005) argued that it reflects the severity of MHC clients' mental health needs, as well as the ineffectiveness of the mental health treatment that those clients received.

Cosden et al. (2004) conducted an experimental evaluation of the Santa Barbara County MHC. During a three-year period, eligible defendants who consented to participation were assigned to one of two groups: the MHC or the treatment-as-usual group. All participants were PSMI who had been charged with felonies or misdemeanors. The researchers hypothesized that MHC participants would be less likely to engage in criminal activity.

Cosden et al. (2004) found that 10 percent of the participants in MHC were sent to prison during their participation, while 10 percent spent more days in jail after than before entering the MHC. Clients who failed had more severe substance-use problems than other participants. Apart from the clients with drug addiction, MHC clients spent significantly fewer days in jail than those PSMI who received treatment-as-usual. Nonetheless, both groups spent fewer days in jail after their participation in court than before their participation. Similarly, both groups of clients exhibited an increase in functioning and a decrease in drug and alcohol use. MHC clients also had slightly better results on these outcomes than did the treatment-as-usual clients (Cosden et al., 2004). Hence, treatment was effective for the majority of clients but was especially so for MHC participants (Cosden et al., 2004). Although most of the PSMI considered in the study showed an increase in functioning and a decrease in jail days, 20 percent of the clients overall were sent to prison. As we mentioned above, “failed” clients had the most severe substance-use disorders, suggesting that PSMI who also have co-occurring substance-use disorders require more intensive, better integrated treatment than the services provided to both the treatment-as-usual and MHC groups.

Teller et al. (2004) examined the effectiveness of the Akron, Ohio MHC in reducing incarcerations and hospitalizations among participants. They compared offenders who successfully completed MHC treatment requirements to those who did not. The researchers found that successful clients were more likely to be Caucasian, male, single, and better educated. Offenders who successfully completed treatment also had fewer incarcerations and days in a psychiatric hospital. Offenders who failed to complete the program had more psychiatric hospitalizations than those who did not.

The National Survey of Mental Health Courts (NAMI et al., 2005) provided general evidence regarding MHC effectiveness. In the survey, the Greene County MHC in Missouri reported that 24 percent of the participants failed to complete the program. Only 3 percent of these clients committed felonies during their participation in the MHC, while 21 percent were noncompliant with the judge’s orders. The DeKalb County Jail Diversion Treatment Court Program in Georgia reported that 41 percent of the defendants in MHC were removed from the program and only 37 percent fulfilled the court’s requirements. Approximately 4 percent of the clients withdrew voluntarily from MHC participation. More PSMI were removed or withdrew from the MHC than completed the program (NAMI et al., 2005).

The Woodbury County, Iowa MHC evaluators reported that 26 percent of the clients completed the program, 18 percent failed to comply with conditions, 19 percent were rearrested, and 8 percent were hospitalized. The Orange County Community Resource Center in Hillsborough, North Carolina reported that 25 percent of its clients were removed from the program, while 75 percent fulfilled the mandates of the MHC. Among the participants of the MHC in the city of Lee’s Summit, Missouri, 31 percent fulfilled the court’s requirements and 25 percent failed the program (NAMI et al., 2005).

In the Bernalillo County, New Mexico, Metro MHC, 90 percent of the individuals who were accepted by the court received treatment, 10 percent completed treatment, and 10 percent dropped out of treatment. The Alachua County MHC in Maryland reported that 27 percent of its clients completed the program, 27 percent failed it, and 14 percent were arrested while under court supervision. Two-thirds of the PSMI accepted by the MHC administered by the Superior Court of California, San Francisco were in treatment one year after the court's inception (NAMI et al., 2005).

Of the 900 individuals accepted into the King County MHC since 1999, 17 percent completed treatment while 33 percent failed treatment. After one year in the program, the Seattle Municipal Court reported that 66 percent of the MHC clients were still engaged in treatment (NAMI et al., 2005). Researchers found that King County MHC clients received more treatment and other services than a comparison group of PSMI who refused to participate in the program. Participants were also less likely than nonparticipants to be rearrested and to spend time in jail (Trupin et al., 2001). Finally, the Superior Court of California, Orange County, Dual Diagnosis Court reported that 13 percent of its clients were hospitalized and 13 percent were terminated from the program (NAMI et al., 2005).

In summary, the rates of success reported in the National Survey of Mental Health Courts varied between 10 percent and 75 percent, whereas reported failure rates varied between 10 percent and 41 percent. In addition, several of the MHCs reported similar rates of client failure and success. Despite the scope of this important survey, it had several limitations. For example, rates of program completion and recidivism are critical in determining the effectiveness of MHCs. However, because of the fairly recent implementation of MHCs, outcome statistics were preliminary and completion rates were unavailable for many of the courts considered in the national study. Moreover, comparing these rates to those reported by courts that do not specialize in the supervision of PSMI is critical in gaining an understanding of the overall impact of MHCs. As we noted above, the NAMI study produced a wide range of estimates of the success and failure rates of the courts. More research is solely needed to identify the variables that account for these varying results. Similarly, longitudinal research is necessary to help understand the long-term effects of participation in MHC (see below). Finally, few MHC outcome studies have specifically examined the relationship between MHC participation and criminal recidivism. Although these studies have suggested that MHC clients are less, or no more, likely than their counterparts in standard criminal courts to recidivate, they provide little information regarding the MHC's contribution to broader public safety.

BASIC LESSONS LEARNED

The experiences of trailblazing MHCs suggest that a number of elements, such as staffing, are essential to the court's success (Bernstein and Seltzer, 2003). So far, the operational history of MHCs demonstrates that they function best when using a team approach for brokering treatment and other services for PSMI. Representatives from

the mental health system must become core members of the team; they are experts in diagnoses and treatment, and they are knowledgeable about the availability and accessibility of mental health services. Program staff members are most effective and productive when they have been cross-trained in one another's respective areas; i.e., court staff should be trained on mental health policies and procedures, while mental health staff should be trained on criminal justice policies and procedures (Bureau of Justice Assistance, 2000).

Multiple layers of services should be available to MHC participants. Although PSMI suffer from common afflictions, the service needs of clients can be quite varied, depending on the severity of their mental illness, their treatment history, and their social support network. Hence, the court's treatment plans should be comprehensive, flexible, and tailored to each participant. Access to a variety of services is more likely when the court has established and clarified its relationships with the professionals involved in assessment, case-planning, treatment, and relapse-prevention activities. These relationships should be solidified early in the MHC implementation process with the full cooperation and approval of mental health authorities at the state and county levels.

PSMI should be allowed to volunteer for the program and must be able to provide their informed and competent consent to all aspects of program participation. In general, MHC procedures should be no more coercive or oppressive than those in standard criminal court, and they should carry no greater likelihood of damaging a client's prospects for housing, employment, or health care (Bazelon, 2003a).

The constitutional rights of MHC participants must be protected. Specifically, defendants should decide whether to transfer their cases to MHC. Some transfers can require a guilty plea (Stafford and Wygant, 2005), which often leads to longer periods of supervision than sentences imposed in standard criminal courts. Indeed, involuntary transfer violates the Sixth and Fourteenth Amendments, as well as the American with Disabilities Act, which provides for equal protection under the law, the right to a jury trial, and prohibition against state discrimination (Bazelon, 2003a).

To protect the rights of MHC clients, an attorney with a background in mental health should be assigned when a defendant initially enters the system, not only to help the client understand court procedures but also to act as the client's advocate (Bazelon, 2003a). For example, the attorney can help the client comprehend the ramifications of pleading guilty (Griffin, Steadman, and Petrila, 2002). Only one-third of MHCs dismiss charges or allow the criminal records of clients to be expunged after they have successfully fulfilled court mandates. In addition, expungement is not automatic and involves a complicated process. Moreover, having a criminal record makes it significantly more difficult for an individual to obtain housing and employment (Bazelon, 2003b). Hence, a guilty plea could result in the creation of future barriers for PSMI, and these should be negotiated only with the help of an advocate.

MHC participants should be fully aware of the sanctions for failing to fulfill court mandates. The imposition of sanctions as a result of failure to participate in MHC serv-

ices is consistent with the goals of the criminal justice system; however, sanctions are not always helpful for PSMI. The Bureau of Justice Administration (2000) suggests that sanctions are appropriate for some PSMI but not all of those who participate in MHC. In some cases, sanctions can be detrimental to PSMI who have difficulty functioning and grasping the expectations of the program. In addition, reviewing the treatment plan for MHC participants should be the first step in program placement with jail being used as the sanction of last resort in response to noncompliance with court orders.

To increase the impact of MHCs, several aspects of the mental health and court systems must be addressed. Community-based treatment and resources for MHC participants are imperative (Bazelon, 2003a; Watson et al., 2001). Greater access to services is also critical to the successful implementation of these courts. In short, MHCs were developed in response to the failure of the community to provide appropriate mental health treatment for PSMI (Bureau of Justice Assistance, 2000). Therefore, the availability of treatment programs in the community is an integral—indeed a crucial—component of MHC (Bazelon, 2003a). However, many jurisdictions have created few if any new services for PSMI; thus, a judge's order to participate in those services does not guarantee that the program is available in the community (Steadman, Davidson, and Brown, 2001). In addition, MHC personnel must collaborate with community treatment providers to ensure that the services they offer match the needs of the clients.

A wide range of services are essential to the successful implementation of MHC, including housing, drug treatment, and educational programming (Denekla and Berman, 2001). Yet, as a national study demonstrated, 63 percent of MHCs have no authority or influence over the community's mental health or social services network (Bazelon, 2003a). Consequently, the court might order services that are unavailable to clients; conversely, clients might receive services that differ from those ordered for them at sentencing or placement in the program. Furthermore, a judge might order services for individuals in MHC who should never have been arrested in the first place.

At present, little is being done to correct this system failure (Bazelon, 2003a), which raises the issue of whether mental health services are becoming increasingly available, overall, for PSMI or whether the mentally ill who come into contact with the criminal justice system are being served ahead of the mentally ill in the community who also need mental health services. If that is the case, then such activities leave just as many PSMI underserved as before the establishment of such specialized courts (Steadman, Davidson, and Brown, 2001). In addition, if MHCs are making fewer services available to other PSMI, they could be creating a future pool of offenders through the lack of treatment (Wolff, 2002). Therefore, a systemic change is needed to address the paucity of treatment options for all PSMI.

The mere presence of an MHC in a jurisdiction does not guarantee that defendants with mental illness will be processed through the specialized court. For example, MHCs are instituted on the assumption that a serious mental illness is related to an

individual's criminal behavior. Hence, treatment is a strategy for promoting individual health and public safety. On the other hand, research shows that many MHCs restrict client eligibility on the basis of criminal charges. As we noted earlier, some courts will accept only those defendants who have been charged with misdemeanors, and most accept only defendants with nonviolent charges. Limiting MHC participation to only those charged with less serious crimes ignores the fact that some PSMI commit serious offenses and also should receive treatment (Mikhail, Akinkunmi, and Poythress, 2001).

The goals and structure of MHCs should be clearly defined. MHCs evolved from DTCs but never have reflected the precise, universal models that characterize drug courts. Specifically, a review of MHC programs found no single program "model." Each MHC has its own rules and procedures (Bazelon, 2003a), and although no single model for MHCs would fit all jurisdictions (Watson et al., 2001), consistency among similar jurisdictions would be quite useful. Because of this inconsistency, MHCs have fewer resources than DTCs, and research into the effectiveness of the components of MHCs is negligible (Steadman, Davidson, and Brown, 2001). MHCs should have clearly stated eligibility criteria and standard operating procedures; in other words, such programs should be manualized.

FUTURE DIRECTIONS

As we previously stated, continued research into MHCs is essential to their future development. Redlich et al. (2006:359) enumerated important unanswered questions about MHCs, including: "Do [mental health courts] do justice well?" "Do mental health courts work?" "If so, for whom?" "And why?" Defining success for MHCs will help facilitate research on the courts' operations and outcomes. Comparing the effectiveness of MHCs to traditional courts will not only help determine the impact of the court, but can also assist in determining the most useful elements of MHCs.

Notwithstanding its importance, research on MHCs has lagged significantly behind the rapid growth of such programs. This lack of empirical attention might be attributable to the notion that DTC evaluations have produced a wealth of data and knowledge that can be generalized to MHCs. However, the conflation of such evaluations (and programs) is problematic because of fundamental differences in the clientele of drug and mental health courts. Among the former, the expression of a brain disease (i.e., addiction) is, in itself, a criminal behavior. Repeated drug use (i.e., relapse) is a sanctionable offense in DTC. Success there is defined by a straightforward, measurable, and clear-cut outcome (i.e., sobriety and abstinence).

In contrast, the expression of a brain disease (e.g., schizophrenia) among MHC clients might not be criminal. Serious and persistent mental illness can be more difficult to treat than addiction and is often accompanied by substance-use disorders. Furthermore, responses to MHC clients who commit crimes are more complicated: Should mentally ill probationers who commit a crime because of break-through symptoms or failed medication be prosecuted and sentenced to incarceration or placed in a

hospital for stabilization, treatment, and return to probation? This is one of many thorny questions that should be addressed in studies of MHC operations.

Related to the above issue is the formulation of a differential definition of MHC. Much more has been written about the similarities than the differences between drug and mental health courts. Process evaluations should be conducted to pointedly illuminate the distinctive features and critical elements of MHCs, which differentiate their models of sentencing and supervision from those of DTCs. The National Survey of MHCs should continue its work on refining the operational definition of such courts, which is a critical first step in conducting productive and meaningful process and outcome evaluations.

As the current review illustrates, the results of MHC evaluations, to date, are widely discrepant and difficult to interpret and aggregate in order to create a general sense of how MHCs operate and affect offender outcomes. Few studies have employed research designs that allow causal inferences about the effects of MHCs on clients' short- and longer-term habilitation and criminality. The best studies have employed a randomized experiment to test whether MHC participants do better than treatment-as-usual clients. However, such designs have been adopted in only a handful of investigations.

Longitudinal research is also needed for examining MHC operations and effectiveness. So far, we know little about the lives of PSMI who have completed MHC treatment. What proportion of them are rearrested, rehospitalized, and reincarcerated after successfully leaving MHC (Erickson, Campbell, and Lamberti, 2006)? Denekla and Berman (2001:14) enumerate several other basic, unanswered questions about MHCs.

Many individuals who end up in mental health courts have already been in the mental health system at some point in their lives. What evidence is there that courts can bring about different results? What do they bring to the table that's unique? Is it simply coercion? Or is it something else? Can courts promote enhanced system integration, bringing together criminal justice, mental health and drug treatment agencies?

To overcome the limitations of MHCs, Wolff (2002) presented alternative models of standard court operations for PSMI. She suggests that instead of processing PSMI on separate dockets, all courts should have access to information about the psychiatric history of a defendant, and those with mental illness should have a "mental health representative" to assist them throughout the court process. To ensure equal protection under the law, judges would apply the same rules for all defendants, regardless of mental illness, to gauge competency and guilt. After a finding of guilt, the judge could consider therapeutic interventions as part of a sentencing package. For example, the judge could order mental health treatment and formulate a discharge plan to be enacted when the offender is placed on probation or released from jail or prison. Judges' orders would consider whether mental illness was a root cause of the criminal behavior, rather than simply relying on the MHC's assumption that all mental illness correlates with or causes criminal activity. **jsj**

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