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Abstract

This article offers an introduction to the special issue of *American Behavioral Scientist* on mental health courts (MHCs). We first provide an overview of the historical conditions that led up to the emergence of MHCs in the United States and how they are ideologically and operationally distinct from traditional courtroom justice. We turn to a critical examination of the state of the field; while there is a proliferation of MHC scholarship, we identify key theoretical and empirical gaps in our understanding of how MHCs work and how well they are achieving their stated objectives of reducing recidivism and improving clinical outcomes. We then summarize and highlight the major contributions of the five articles in this special issue to the MHC literature. The article concludes with a discussion of the promises and challenges of mental health courts as an alternative form of jurisprudence.

Keywords

mental, health, courts

The Emergence of Mental Health Courts

The history of American jurisprudence is propelled by novel innovations that shift practices and underlying assumptions about the proper role and scope of the criminal justice system. In recent decades, the rise of problem-solving courts has offered one compelling example of such innovation. Problem-solving courts, which differ markedly from traditional criminal courts, use a designated judicial, legal, and treatment team to divert individuals from the criminal justice system into community-based treatment in lieu of traditional case processing and sentencing. Typically, either participants will have their criminal charges reduced or dismissed or they will receive a

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reduced sentence following successful program completion (Castellano, 2011b; Miller & Johnson, 2009). Problem-solving courts look beyond sheer criminal culpability; they view offending behavior as interconnected to a broader array of potential personal troubles in the lives of offenders. Although problem-solving courts can take many forms, a large number of them invoke a model of therapeutic rehabilitation that perceives criminal activity as significantly motivated by some pathology in the individual offender. The most prominent of these courts have been the drug and alcohol courts that emerged in the 1990s and have since then expanded around the country.

More recently, we have witnessed the emergence and increasing popularity of mental health courts (often referred to by the acronym MHCs), which are specialized criminal courts that divert offenders with serious mental illnesses from the criminal justice system into community-based treatment. MHCs are staffed by legal and social service professionals who are committed to addressing the problems in offenders' lives that contribute to the cycle of arrests. These court personnel use judicial monitoring, case management, and other supportive services, including housing and employment assistance, to help individuals integrate back into their communities (Bazelon, 2003; Denckla & Berman, 2001; Steadman, Davidson, & Brown, 2001). An early example of separate judicial hearings for offenders with psychiatric disabilities can be traced back to Marion County, Indiana (Coons & Bowman, 2010). In 1980, judge Evan Goodman pioneered a court program to divert mentally ill offenders from jail to Wishard Hospital for evaluation. Court proceedings were held at the hospital, two floors above the psychiatric unit in the hospital's recreation area, which was converted to a makeshift courtroom. A psychiatrist conducted precourt assessments and a forensic team monitored participants' compliance with court-ordered outpatient treatment.¹ Although Goodman's court was disbanded in the early 1990s, a series of events in Florida then set the course for the rapid proliferation of mental health courts in the United States. In 1997, the Florida legislature allocated \$1.5 million to establish a mental health court in Broward County at the recommendation of a special task force investigating the increasing numbers of persons with serious mental illnesses incarcerated for low-level offenses, the lack of in-custody psychiatric assessments, and poor coordination of continued treatment in the community after release.

Most MHCs follow a basic model of operation, although the treatment modalities and judicial processes vary according to defendant characteristics, funding sources, and the political and cultural climate of the local criminal justice system. Eligibility for MHC participation is typically determined by the criminal charge and a psychiatric diagnosis of an Axis I mental illness (i.e., schizophrenia, major depression, and bipolar disorder). Defendants voluntarily participate in community-based treatment in place of traditional adjudication and sentencing for a designated period of time and also attend regularly scheduled hearings to review their progress. Following a postadjudication model, most MHCs require participants to plead guilty to the criminal charge as a condition of program acceptance. Participants graduate from the program when the court staff determines that they have achieved emotional wellness, desisted from criminal activity, and demonstrated an ability to live independently.

MHCs have emerged in response to court officials' increasing frustration with the tide of chronic offenders cycling through the judicial system. The prevalence of

inmates confined to American jails and prisons with serious mental health disorders is estimated to be 16% (or 350,000 people). Many scholars argue that the failures of deinstitutionalization along with massive fiscal cutbacks in public mental health services shifted responsibility to law enforcement agencies to treat and control the mentally ill. Persons with untreated mental illnesses have a higher percentage of police contacts because they participate in deviant behavior that exposes them to public scrutiny and increases the likelihood of arrest, such as public drunkenness, disturbing the peace, and illegal lodging. This offender population is more likely to be overdetailed, denied probation or parole, and placed in isolation for protection against victimization or for disciplinary purposes. In turn, the stress and alienating effects of incarceration often exacerbate symptoms of mental illness, and correctional institutions are often ill equipped to provide appropriate psychiatric care (Earley, 2007; Human Rights Watch, 2003). When released, the person may lack access to medication, counseling, and other basic human services, which further threatens public safety and results in additional expenses related to criminal case processing.

Spurred by state and federal funding, MHCs have expanded dramatically in recent years, with the Council of State Governments (2011) estimating that there are currently more than 250 MHCs operating in the United States. The first wave of mental health courts targeted nonviolent misdemeanor offenders. However, a new cohort of felony MHCs has opened up its doors to more serious, prison-bound offenders (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). Mental health courts have also evolved in scope and practice and now take on a variety of forms, including substance abuse and mental health (SAMI) courts, juvenile MHCs, and gender-specific MHCs.²

The innovations of MHCs directly address the challenging intersection of criminal jurisprudence and mental health care, but as yet, we have little empirical social science understanding of the practices, outcomes, and broader consequences of MHCs. The rapid expansion of MHCs in the United States has occurred in a context of minimal directive oversight or guidance beyond the local level. The establishment of these courts has often been fueled by an individual judge's passion and commitment to reducing the number of mentally ill individuals cycling through his or her court but with little knowledge of the organization and practices of other MHCs. Unlike drug and alcohol courts, which have developed comparatively uniform structure and policies, MHCs are at best on the cusp of creating more standardized organization and practices. Although hundreds of MHCs now exist across the country, little is known about their therapeutic value, their criminal justice and fiscal impact, and their potential unintended consequences. From both scholarly and social policy perspectives, the time seems ripe for research that will evaluate and inform MHC practices. The goal of this issue of *American Behavioral Scientist* is to help address this need.

Key Areas of Concern

The proliferation of MHCs across the United States has raised several concerns among criminal justice professionals, mental health scholars and practitioners, and social scientists. It is widely acknowledged that MHCs are a response to dysfunctional and

inhumane treatment of the seriously mentally ill in the criminal justice system. But just how effective are MHCs in alleviating the harsh treatment of mentally ill offenders? MHCs have three core objectives: (a) improving clinical outcomes to reduce recidivism, (b) decriminalizing persons with mental illness, and (c) restructuring legal processes to bring about therapeutic outcomes. As the subject of empirical inquiry, there is some evidence that MHCs are achieving these goals, but it is less clear which factors contribute to their success. The primary concern among the majority of scholars who conduct research on MHCs is the degree to which they reduce and prevent new arrests. MHCs typically target a population of offenders who are “truly sick” as evidenced by long criminal justice histories attributed to untreated serious mental health disorders. These courts operate on the assumption that judicially mandated treatment provides the necessary structure and incentive to curb habitual offending, however, it is difficult to isolate mental illness as the root cause of criminal deviance. The rehabilitative agenda of MHCs is complicated by the high percentage of participants with comorbid substance abuse disorders and other criminogenic factors that increase the likelihood of reoffending (Skeem, Manchak, & Peterson, 2010). Relatedly, although studies have shown that judicial leverage increases access to treatment, we have yet to establish specific correlates between types of treatment modalities and reduced recidivism or to determine whether specific subgroups might benefit from different therapeutic approaches. MHC effectiveness should also be examined in the broader context of possible selection biases that result in screening out offenders who might benefit from court-supervised treatment and terminating offenders for noncompliance who might eventually succeed with more or different types of services.

A second concern is the potential unintended consequences of MHCs. One issue in this regard is the possible net widening effects of MHCs. MHCs were established to decriminalize mental illness by reducing the legal penalties for persons determined to be less culpable for criminal behavior, yet some scholars suggest that they expand state power under the auspices of treatment in lieu of punishment. Part of this critique stems from the observation that MHC professionals take part in newly assigned roles that may compromise fundamental principles of their professional training in ways that undermine individual rights to due process and treatment confidentiality (Boldt, 2009; Casey, 2004). Relatedly, some scholars contend that segregating a group of offenders to a separate docket contributes to cultural stereotypes and stigmatization of mentally ill persons as having greater propensity for criminal behavior. Overall, the enrollment and participation requirements of MHCs may, they argue, unwittingly violate core judicial values and basic ethics of mental health care (Lane, 2003). Yet other scholars worry that the robust development of MHCs could divert funds from other mental health care needs. Nancy Wolff (2003) explains,

Overall, if funds are limited and must be targeted, targeting treatment resources to individuals who have the greatest criminal risk may take money away from those for whom treatment is most effective. That is, there may be a conflict between clinical and criminological priorities, and these different priorities may change the overall amount of symptomatic mental illness in the community. (p. 165)

Third, an important concern among academicians is formulating a more coherent theoretical basis to explain how MHCs work and why they are an appropriate form of jurisprudence for mentally ill offenders (Johnston, 2012). MHCs are premised on the notion that law can be used to help offenders resume productive lives, a principle commonly referred to as therapeutic jurisprudence (Corvette, 2000; Odegaard, 2007; Winick & Wexler, 2003). In lieu of criminal prosecution, MHC professionals practice what Diacoff (2005) calls “law as a healing profession.” They see particular offender problems from a broader perspective and depart from the edicts of common law to effect positive individual change. The practice of therapeutic jurisprudence involves more than shifting courtroom values from rational to substantive approaches to legal problems. It calls for the use of social science research to empirically document how law is restructured to meet therapeutic goals without subverting the standards of procedural justice (Winick & Wexler, 2003). The principles of therapeutic jurisprudence are implied or taken for granted, and we have yet to identify how MHC actors translate their objectives into clinical and legal encounters. When, for example, do therapeutic processes impede procedural justice, and when does upholding fair due process have therapeutic merit? Research needs to identify what strategies court staff uses to finesse the traditional boundaries of treatment of law and what types of skills sets and resources members rely on to do so.

Last, we need to understand how clients experience court-mandated treatment in conditions that can best be termed “constrained choice” (S. Burns & Peyrot, 2003). When given the option to remain incarcerated or participate in voluntary treatment, most arrestees opt for the latter and concede to the conditions of MHCs (and other problem-solving courts) with little power to protest. In the case of MHC participants, these conditions almost invariably include the requirement of adhering to a regimen of treatment with psychiatric medications that have known, and sometimes serious, side effects. Scholars and practitioners need to develop participant models that directly and sensitively address the legal, medical, and ethical issues related to consent to therapeutic control (Bonnie & Monahan, 2005; Poythress, Petrila, McGaha, & Boothroyd, 2002; Redlich, Hoover, Summers, & Steadman, 2010).

In summary, by virtue of their positioning at the intersection of mental health care and criminal justice arenas, MHCs present a variety of complex concerns beyond those traditionally addressed in the criminal justice system. Issues of health care, jurisprudence, social policy, ethics, and public finances are all involved. Although it is clear that MHCs are perceived today as responding to an urgent need in communities across the United States, the ways in which they do so—and their effectiveness in doing so—require rigorous empirical scrutiny.

Contributions of the Articles

The need for evidence-based understanding of MHCs to assess and improve MHC therapeutic efficacy, cost-effectiveness, and social justice served as the underlying motivation for this issue of *ABS*. In the summer of 2011, the Social Work faculty at Utah State University collaborated with mental health care and criminal justice professionals in the Intermountain West to sponsor the first national conference on MHCs

in the United States. Because of the success of that conference, a second conference was held in the summer of 2012, offering scholars, practitioners, and governmental agencies an opportunity to share common practices, concerns, and research findings related to MHCs. Throughout both conferences, participants were drawn to sessions that offered empirical data on the development, organization, and specific procedures and policies associated with MHCs. Building on their participation in these conferences, the coeditors of this issue felt compelled to expand the discussion of MHCs to broader venues. The publication of the articles in this issue serves as one of the first focused scholarly efforts to highlight and assess the MHC movement.

In the first article, Anchorage District Court judge Stephanie Rhoades and social worker Kathi Trawver (in press) provide a historical account from a judge's perspective of the inception and evolution of one of the country's original MHCs. The perspective "from the bench" on the development of MHCs is particularly important given that judges have played vital roles as key advocates or "moral entrepreneurs" (Becker, 1963) in the creation of these courts. Judge Rhoades and Kathi Trawver chronicle how the court was first created and then modified over time to better meet its goal of decriminalizing mental illness. They describe the decision to expand the target population beyond the Axis I criterion and the adoption of a "harm reduction model" to respond therapeutically to noncompliance. Of particular interest, Rhoades began to use correctional instruments to calculate clients' probability of reoffending. The use of the LSI (Level of Service Inventory), a standardized risk assessment device commonly used by probation officers, enriches our understanding of how MHCs transform legal tools for therapeutic purposes, which is a principle of therapeutic jurisprudence. Overall, the piece illustrates that long-term success in MHCs is a product of organizational learning as actors draw from a broad repertoire of legal protocols and therapeutic practices to best manage the welfare of both participants and the community.

In the next article, sociologists Padraic Burns, Virginia Aldigé Hiday, and Bradley Ray (in press) address the key MHC question for many criminal justice policy makers: Do MHCs reduce future criminal activity? Whereas the few previous studies of criminal behavior among MHC participants have focused on offending behavior during MHC participation or shortly thereafter, Burns and coauthors examine criminal recidivism of participants for 2 years after they no longer receive the court's services, supervision, and support—whether by virtue of MHC "graduation" or being terminated or quitting MHC participation. Drawing on data from their preenrollment-postexit study of participants in one MHC, combined with a matched set of countywide criminal data, the authors assess the relationship between MHC participation and two measures of recidivism: arrests and postexit jail days. Although data from one MHC cannot be broadly generalized to other courts, the authors promisingly find that participation in the MHC was associated with reduced criminal recidivism—with particularly dramatically lower rates of rearrest and postcourt jail time for MHC graduates. In short, their article provides compelling evidence that MHCs do have appreciably positive outcomes for a significant number of their participants.

Social work scholars Kelli Canada and Amy Watson (in press) turn our attention to the important yet understudied topic of clients' subjective experiences in court-mandated treatment. Specifically, the authors examine clients' perceptions of procedural justice, including feeling heard and being treated with dignity and respect by decision makers. Canada and Watson emphasize that law can produce therapeutic outcomes by relaying information to participants with clarity and thoroughness as well as explaining why and how decisions were made. Their findings illustrate the value of a rigorous mixed-method approach to data collection in MHC research. Their survey data, which provided documentation of clients' general satisfaction with the courts' adjudicative processes, are supplemented by qualitative interviews with MHC clients that offered in-depth insights into important subtleties in and subtexts of clients' routine communications with the court staff. For example, during the qualitative interviews, participants articulated an important distinction between "having a voice" and "feeling heard" or validated. Furthermore, whereas most studies on procedural justice focus on client and judge interactions during the courtroom status hearings, Canada and Watson suggest that clients' perceptions of fairness in the problem-solving courtroom should include interactions with all members of the treatment team. This is an important observation since participants interface with probation officers and case managers more frequently, and in a wider variety of contexts, than with judges. Overall, the article helps us to understand that the cultivation of positive relationships between clients and MHC personnel harnesses the potential to promote treatment compliance and positive individual change.

In the following article, public policy researchers Karli Keator, Lisa Callahan, Hank Steadman, and Roumen Vesselinov (in press) tackle the complex issue of mental health care services and outcomes for MHC participants. On the basis of a comparison of participants in three MHCs with a similar number of psychiatrically diagnosed "treatment-as-usual" jail detainees, these researchers find that MHC participants accessed community treatment more quickly than the comparison sample when released from jail. However, the authors report that mental health treatment in the 6 months after release from jail showed little, if any, correlation to criminal behavior in the following year, as measured by arrests and jail days. This is a disturbing finding since one of the key assumptions of MHCs is that their effectiveness depends on clients' treatment compliance. The authors argue that a significant part of the disjuncture between mental health treatment and reduced recidivism may lie in the nature of the services these MHC participants received. Effective treatment for optimum offender outcomes, they argue, must be directly aimed at reducing or mitigating criminogenic risk factors.

Social workers Shannon Hughes and Terry Peak's (in press) article takes us in a different, but equally important, direction by critically exploring the ethical conundrums of mandating psychotropic medications as a condition of compliance in MHCs. The authors emphasize the potential harmful effects of prescribed drugs and, in turn, question the appropriateness of courts acting as coercive agents in medication-related decisions. In particular, the authors document that the medication mandate is largely at

odds with precedent in case law that grants individuals some degree of self-determination in mental health treatment. The authors recommend alternatives for ameliorating the antitherapeutic effects of court-ordered treatment, such as informing clients of all possible side effects and adopting psychiatric advance directives into the treatment plan. These recommendations highlight a broader set of issues related to individual entitlements in MHCs. For example, since medication compliance is legally mandated, a condition of probation, informing the client about the possible side effects, may fall under the scope of due process rights. As the authors observe, the viability of these alternatives is uncertain given the institutional pressures on MHCs to treat and control participants' psychiatric symptoms quickly and effectively. Overall, the piece raises a larger question about clients' ability to negotiate the terms of their involvement in the MHC and, in turn, whether granting participants more autonomy in treatment decisions may actually increase program compliance.

Overall, the contributions in this issue of *ABS* provide valuable guideposts for addressing a number of the key concerns discussed above. They provide evidence and insights to help us understand both the promise and the challenges of MHCs, the issues with which we conclude this introductory overview.

Promise and Challenges of Mental Health Courts

The use of MHCs is growing rapidly across the country in large part because of their perceived effectiveness in reducing criminal recidivism and severity of future criminal activity, increased access to clinical and social services—as well as feelings of procedural justice—for mentally ill offenders, and provision of generally more humane and effective alternatives to the traditional criminal court system. The articles in this issue provide evidence in support of these perceptions while also acknowledging challenges that lie ahead as MHCs seek to mature and improve their delivery of both criminal justice and mental health outcomes. One key challenge in this regard is to better measure and understand the impact of various MHC policies on crime reduction among mentally ill offenders. Second, we need more empirical research on court organization and functioning, including detailed analysis of the roles played by various members of the MHC treatment teams. Additionally, few studies on problem-solving courts in general analyze the role and responsibilities of outside providers on the treatment team (Castellano, 2011a), yet social service workers are at the forefront of developing community-based alternatives for persons with chronic problems that will make them less prone to relapse and rearrest. The problem-solving model of justice that underlies MHCs is dependent on community-based organizations and other features of the welfare state. As Keator et al. (in press) argue in the following pages, “linking justice-involved persons with mental illness to suitable and sustainable community mental health services requires first that they be in place” (p. XX).

A third set of challenges focuses on the creation and adoption of effective “best practices” in MHCs across the country. The variability of MHCs is captured well in the currently common adage in the field that “when you’ve seen one mental health

court, you've seen one mental health court." MHCs are very new on the scene and developing fast and, until recently, without a well-recognized set of guiding principles. As this issue of *ABS* goes to press, the Council of State Governments Justice Center is preparing for online release of its new project, "Developing a Mental Health Court: An Interdisciplinary Curriculum," designed to disseminate best practices and establish a more coherent dialogue among MHC practitioners across the country. The promise of MHCs will be advanced significantly through the interaction and sharing of knowledge and insights across the range of MHC practitioners, researchers—and consumers.

Whereas U.S. mental health care has often in the past been built on innovations (from moral therapy to Freudian psychiatry) first introduced in Europe, MHCs have by and large emerged as an American innovation, one that in recent years has begun to be adopted internationally. Today, MHCs based on the American model are expanding in the United Kingdom, Germany, Canada, and Australia, among other countries (Nolan, 2009). The effectiveness of these innovative courts can be enhanced by scholarly analysis based in empirical research. We offer this issue of *American Behavioral Scientist* in the hope that it will exemplify and promote such work.

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Notes

1. In 1997, the court at Wishard Hospital inspired the Psychiatric Assertive Identification and Referral (PAIRs) program, which was a pretrial, postbooking diversion program for mentally ill offenders in Marion County, Indiana.
2. Cook County, Illinois, established separate felony mental health courts for women and men.

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Bios

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