

The Evolution of Mental Health Courts and a Prospective Study of Aggregate
Recidivism Rates for Mentally Ill Criminal Offenders

by

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Thesis submitted in partial fulfillment of
the requirements for the degree of
Master of Science at the Duke Global Health Institute
of Duke University

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ABSTRACT

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Abstract

In response to the alarming rate of serious mental illness among incarcerated individuals, local communities have operationalized the principles of therapeutic jurisprudence and forged collaborations between criminal justice and mental health communities. Over 300 specialized mental health courts have emerged across the country since 1997. Yet, because mental health courts are relatively new, lack standardization, and developed in a disjointed manner, there is little sound empirical research evaluating outcomes. Methodological flaws in existing studies and inconsistent results prevent strength of conclusions. Thus, the processes and outcomes of mental health courts are not well understood.

This paper aims to facilitate greater understanding of the evolution of mental health courts, perceived advantages and disadvantages, and the current state of research. Additionally, a prospective study is designed and recommended using the synthetic control method to measure aggregate recidivism rates of mentally ill criminal offenders.

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1. Introduction

1.1 *Brief history*

In response to the alarming rate of serious mental illness among incarcerated individuals, local communities have forged collaborations between the criminal justice and mental health communities through the establishment of mental health courts. Mental health courts have specialized court dockets and employ a problem-solving, collaborative model of court processing for eligible mentally ill offenders. Designed to address the underlying mental health issues that contribute to the cycling of individuals through the criminal justice system, mental health courts place a priority on treatment goals over punitive sanctions [1]. By streamlining community resources, mental health courts provide an opportunity to leverage interdisciplinary competencies to improve societal responses to mentally ill citizens.

The first recognized mental health court was founded in 1997 in Broward County, Florida [2].¹ Fueled by federal funding² and the spread of anecdotal success stories, over 120 similar courts were operational by 2006, and today there are over 300 mental health courts functioning across the country [3, 4, 5]. Without federal or state

¹ The Broward County court is most widely considered to be the nation's first mental health court, however, the first identifiable mental health court was established in Indiana in 1980 before being suspended in 1992 and reopened as a diversion program [7].

² Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Public Law 108-414, (authorizing funding, training, and technical assistance for collaborative efforts between criminal justice and mental health agencies, including mental health courts); America's Law Enforcement and Mental Health Project Act of 2000, Public Law 106-515 (granting funding for the development or expansion of mental health courts). See Appendix C for legislation text.

guidelines governing their proliferation, mental health courts developed in an ad hoc manner reflecting the idiosyncrasies and resources of each community. While the county-based system is a positive model for fostering ingenuity and building community relationships, a lack of uniformity makes it difficult to provide consistent programs and outcomes. The lack of central planning has resulted in considerable diversity in mental health court policies and procedures: courts vary in the charges and mental illness diagnoses they accept, eligibility of individuals with a history of violence, plea requirements, treatments and services offered, level of court scrutiny and duration of supervision, possible sanctions, and the impact of program completion on participants' criminal cases [6, 7, 8, 9].

This divergence in court processes may enable existing mental health courts to serve as laboratories for best practice experimentation, yet, from a research perspective, it is important to utilize interventions that are evidence-based. Today, with over 300 existing mental health courts and many more being built, courts have begun to face criticism for the lack of a solid body of research evaluating court functioning [8, 71]. Some researchers suggest that "it may be advisable for communities to slow the tide of new mental health courts until the specified effectiveness of current ones can be demonstrated" [8].

1.2 Study rationale

Despite the considerable proliferation of mental health courts across the country in the last decade, the effectiveness of mental health courts in reducing recidivism rates for mentally ill participants has yet to be empirically established. Given the disjointed manner in which mental health courts have formed and the extensive variability between them, the evaluative literature is scattered with individual mental health court studies that are unaggregated and relatively unhelpful in gauging the empirical status of a diverse body of research studies [6, 10]. Existing process and outcome studies should not be wholly rejected because of their methodological shortcomings; rather, they should be supplemented by rigorous analysis of court functioning and outcomes [6, 10, 11, 12]. Whether mental health courts reduce recidivism rates, to what extent, and what accounts for that reduction has not been clearly established [4, 6, 13].

Without a consensus in empirical analysis, policy-makers face obstacles in making key funding decisions to support the continued expansion of mental health courts. Whether and to what extent mental health courts achieve their intended goals, as well as how courts' interdisciplinary teams function and the connection between operational design and results, should be more clearly determined to help guide future diversionary program efforts.

1.3 Study objective

This study seeks to trace the evolution of mental health courts and propose a sound methodological study for future analysis of outcome measures. Partial accounts of the mental health court movement and inconsistent approaches to analyzing their functioning and effects currently muddle the mental health court literature. This study aims to provide a comprehensive account of mental health courts, their history, the rationale prodding their development, operational details, and what current research concludes about their effectiveness as an intervention for mentally ill criminal offenders. By evaluating the historical and theoretical underpinnings and the factors that led to a rise in mental health courts, the methodological flaws of existing studies become clearer and the need for a new approach is evident. In response to this amalgamated analysis, this study puts forth a proposal for subsequent research that has the potential to avoid many of the validity challenges limiting mental health court research. The study design employs the synthetic control method, making it possible to measure the aggregate effects of mental health courts with regards to recidivism rates among mentally ill offenders.

2. Review of Foundational Literature

2.1 *Mental illness defined*

In order to compare estimates of mental illness produced across surveys and studies, it is useful to first provide a definition and understanding of the most commonly used measures of mental illness.¹

Serious mental illness (SMI)²: defined among persons aged 18 or older as having (currently or at any time during the past year) a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities [118].

All of these disorders have episodic, recurrent, or persistent features. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g.,

¹ Most mental health courts require participants to have an Axis I disorder, but many mental health courts also accept individuals who have a co-occurring Axis II disorder. Axis I disorders, as they are referred to in the DSM-IV, include clinical syndromes such as depression, schizophrenia, and bipolar disorder. Axis II disorders, as defined by DSM-IV, are developmental and personality disorders, including paranoid, antisocial, and borderline personality disorders [118, 121].

² On May 20, 1993, the Substance Abuse and Mental Health Services Administration (SAMHSA) published its definition of serious mental illness in the *Federal Register* pursuant to Section 1912(c) of the Public Health Services Act, as amended by Public Law 102-321. This definition guides statutorily recognized funding allocation, government estimates, and government responses to populations with serious mental illness. The U.S. Department of Health and Human Services, SAMHSA, and the National Institute of Health all follow this definition, as well as most state and local actors [122].

eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts [122].³

Individuals with SMI vary across a wide spectrum in terms of severity, symptoms, causes, responsiveness to treatment, duration, and degree to which impaired functioning is experienced [16]. Schizophrenia, bipolar disorder, and major depressive disorder are the most common disorders reported among mentally ill offenders [128].

Schizophrenia is a group of mental disorders characterized by major disturbances in thought, perception, emotion, and behavior [118]. It impairs a person's ability to think, make judgments, reason, respond emotionally, remember, communicate, interpret reality, and behave appropriately [128]. Schizophrenia can be accompanied by disorganization, hallucinations and delusions [118]. Of the general population in the United States, approximately 1.3 percent is estimated to have schizophrenia [129]. Of prison inmates, this rate has been measured at around five percent [27].

Bipolar disorder is a mood disorder that includes a number of variations and subtypes. Generally, individuals with bipolar disorder experience serious mood swings, episodes of mania that alternate with episodes of deep depression. Mania is characterized by elevated, expansive, or irritable mood, well beyond what would be

³ Also note that mental health and mental illness are considered points on a continuum [122].

considered typical [118]. Often, individuals appear to have an inflated sense of self-worth or grandiosity, and the person's thoughts or speech may be very rapid and difficult to follow. Manic episodes are usually accompanied by poor judgment, and substance abuse is not an uncommon accompaniment, making bipolar disorder difficult to diagnose [128]. Bipolar disorder is thought to affect six percent of the prison population [128], while only afflicting four percent of the United States general population [27].

Major depressive disorder is a mood disorder that generally occurs as an episode or series of episodes of very severe depression. Individuals with major depression may have difficulty concentrating, focusing, remembering things, or making simple decisions, and even experience psychotic symptoms such as delusions. Persons suffering from major depression are at increased risk for suicide and may be preoccupied with thoughts of death [118]. Major depressive disorder affects approximately 14.8 million American adults, or about 6.7 percent of the U.S. population aged 18 and older in a given year. The prevalence of major depressive disorder among women is greater than among men [144, 145].

Mental illness or any mental illness: defined among adults aged 18 or older as having a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic

criteria specified in the DSM-IV currently or in the past year, regardless of functional impairment level.

Some mental health courts accept individuals suffering from mental illness that does not rise to the definitional level of serious mental illness. These disorders may include anxiety disorders or personality disorders.

Anxiety disorders are a group of mental disorders characterized by intense states of apprehension or anxiety or by maladaptive behavior designed to relieve anxiety [27]. These include panic disorders, phobic and obsessive-compulsive disorders, and post-traumatic stress disorder.

Personality disorders are characterized by personality traits and patterns of behavior that begin in adolescence or early adulthood, are inflexible, maladaptive, and persistent, and cause significant functional impairment or distress to individuals. They include paranoid personality disorder, schizoid and schizotypal disorder, antisocial personality disorder, borderline personality disorder, histrionic personality disorder, narcissistic personality disorder, and obsessive-compulsive personality disorder [27, 128].

Mental health problems: often used in the literature to denote circumstances in which an individual's signs and symptoms are of insufficient intensity or duration to meet the criteria for any mental disorder [121].

Co-occurring disorders: substance-related and mental disorders that are diagnosed as being present in an individual simultaneously and can be established independently (not simply a cluster of symptoms resulting from a single disorder) [122].

Mental health: a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. While some of the key ingredients of mental health may be readily identifiable, mental health is nonetheless difficult to define, in part because the concept of “health,” itself, is tied to cultural and subcultural values. Thus, the meaning of being mentally healthy is subject to diverse interpretations that are rooted in value judgments that vary across time and space [122].

2.2 Incarceration of the mentally ill⁴

More than seven million people reside inside America’s overcrowded jails and prisons or under correctional supervision [17, 18, 19]. On any given day, over two million men and women sit behind bars [130].⁵ Representing more than one-fifth of the world’s entire prison population, the U.S. prison community is tantamount to a small

⁴ There is significant disagreement about the definition of the terms “mentally ill offender” and “offender with serious mental illness;” for the purpose of this paper the definition will be what many researchers refer to as individuals with “serious mental illness,” as defined above [14, 15, 16].

⁵ This figure captures the adult correctional system populations at year-end in 2010. Probation: 4,055,514; Parole: 840,676; Prison: 1,518,104; Jail: 748,728; Multiple statuses (e.g., jail and probation): 86,823; the total was 7,076,20. Note, however, that the number of persons under supervision of adult correctional authorities declined by 1.3 percent (91,700) offenders [130].

country [131].⁶ The incarcerated population has increased more than fivefold since 1972, marking a revolutionary shift in American incarceration relative to a previously stable baseline [19].⁷

A grossly disproportionate segment of this population suffers from mental illness [20, 21, 22, 23, 122]. Studies of incarcerated populations in the U.S. have consistently found higher rates of serious mental illness relative to the general population, varying between 16 and 54 percent [21, 23].⁸

Beginning in the 1970s, researchers began to note an increase in the number of individuals with SMI residing in jails and prisons [123, 124]. For example, in 1975, researchers evaluated five California county jails and reported that almost seven percent of inmates were individuals with SMI [124]. Shortly after, a 1982 study found that mentally ill offenders constituted six percent of the prison population [125].

⁶ Levels of imprisonment were evaluated across 218 independent countries with most figures relating to data collected between 2006 and 2008. While comparability may be compromised by different practices in different countries, as well as estimations of overall populations, this study found the United States had the highest prison population rate in the world, followed by Russia, Rwanda, St. Kitts & Nevis, and Cuba [131].

⁷ "The American rate of incarceration...is higher than even the most violent societies and most oppressive regimes on the planet" [19].

⁸ In the most commonly cited study, researchers estimated 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates suffer from mental illness [21]. Inconsistent practices in selection, sampling and diagnostic tools have contributed to the variations in study results. For example, although most of the prevalence studies used randomized sampling, others used biased samples such as prisoners referred for psychiatric evaluation. While the majority of investigators used standardized structured interviews to establish a diagnosis of mental illness, several used less reliable methods such as self-reports or "diagnostic impressions" [21].

The rise of increased incarceration among those with SMI was further illuminated by the 1992 National Alliance of the Mentally Ill (NAMI) and Public Citizen's Health Research Group in a report that discussed the high rates of those with SMI coming into contact with the criminal justice system [126]. This study sought to build on a 1984 study that demonstrated mentally ill individuals in Chicago were arrested at disproportionately higher rates compared to the general population [127]. The report revealed that many people with SMI were arrested for minor crimes related to their untreated mental illnesses and that the minor crimes committed by many of those suffering from SMI were predicated on the need for survival (e.g. shoplifting, stealing food) since many were homeless, had virtually nowhere to go, and often had nothing substantial to eat. As a result, many homeless individuals with a mental illness wound up cycling in and out jail and prisons, often charged with petty crimes [126].⁹

By 1999, the Bureau of Justice Statistics found that 16.3 percent of inmates reported either a mental condition or an overnight stay in a mental hospital during their lifetime [35].¹⁰ By 2006, this number quadrupled, with 64 percent of inmates reporting a recent "mental health problem" [21].¹¹

⁹ Some researchers also believe that mentally ill individuals may be arrested at disproportional rates compared to the general population. In 1984, researchers observed the Chicago police over a 14-month period. They found that individuals displaying psychiatric symptoms had a higher probability of being arrested than those not showing signs of mental illness [127].

¹⁰ This study used survey methodology and relied on self-reporting.

¹¹ The 2006 findings were based on personal interviews with inclusion criteria that included all inmates who reported one or more symptoms of mental illness. Mental illness was defined by symptoms of depression, mania, delusions, or hallucinations present during the 12 months before the interview and included in the

The most recent and methodologically sound survey of mental illness among inmates was published in 2009 [23].¹² Researchers assessed inmates in five jails (two in Maryland and three in New York) using a structured diagnostic interview to determine the existence of serious mental illness during the previous month. A total of 16.6 percent of the prisoners met the diagnostic criteria. Of the jail population, 31 percent of women had SMI compared to 14.5 percent of men. That number rose to 34.3 percent of women and 17.1 percent of men when post-traumatic stress disorder was included as a diagnostic category [23]. This finding is consistent with higher rates of mental illness among women reported in the 2006 Bureau of Justice Statistics study (state prisons: 73% of females and 55% of males; federal prisons: 61% of females and 44% of males; local jails: 75% of females and 63% of males) [21].

Compared to the 1982 study, which used a comparable methodological approach, this evidence presents a tripling of serious mental illness among those

clinical diagnosis or treatment history by a mental health professional. This statistic may be over-representative given that data on functional impairment and duration of illness were not collected, and inmates were not excluded if their symptoms were a result of general medical conditions, bereavement, or substance use [21].

¹² This study collected data during two data phases (2002–2003 and 2005–2006), looking at recently admitted inmates screened with the Brief Jail Mental Health Screen (BJMHS) and selected to receive the Structured Clinical Interview for DSM-IV (SCID) [117, 23]. [See appendix E for BJMHS form.] Selection was based on systematic sampling of data from the brief screen for symptoms that was used at admission for all inmates. The SCID was administered to a total of 822 inmates and serious mental illness was defined as: major depressive disorder; depressive disorder NOS; bipolar disorder I, II, and NOS; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder NOS [23].

incarcerated [21, 24, 125]. These results are bolstered by studies reporting that 40 percent of individuals with serious mental illnesses have been in jail or prison during their lifetime [24].

Finally, substance abuse and dependence is also pervasive among inmates. It is estimated that 25 percent of the jail and prison population exhibit active alcohol abuse and dependence and that 20 percent of the population has drug abuse or dependence issues [25, 26]. About one in six inmates has both a serious mental illness and a co-occurring substance abuse disorder [6]. For those diagnosed with schizophrenia, bipolar disorder, or major depressive disorder, the prevalence of co-occurring substance abuse is estimated to be 90 percent [27].

2.3 Criminalizing mental illness

2.3.1 Historical background

For the past 50 years, the number of mentally ill criminal offenders coming into contact with the criminal justice system has increased at an alarming and steady rate. To understand why incarceration of mentally ill individuals has trended upwards, there are five contributing historical factors to address.¹³

¹³ Of course, these factors are not exhaustive. For a substantive discussion of contributing influences, see Grob, G.N. 1994. *The mad among us: a history of the care of America's mentally ill*. New York, New York: The Free Press; Torrey, E.F., Stieber, J., Ezekiel, J., Wolfe, S. M., and Sharfstein, J. 1992. Criminalizing the seriously mentally ill: The abuse of jails as prisons. Public Citizen's Health Research Group and the National Alliance for the Mentally Ill; Sarteschi, C.M. 2009. Assessing the effectiveness of mental health courts: A meta-analysis of clinical and recidivism outcomes. University of Pittsburgh; Scherer, R.A. 2008. Toward a twenty-first century civil commitment statute: A legal, medical, and policy analysis of preventive outpatient

1. Evolution of psychotropic medicine: The introduction of anti-psychotic medications in the 1950s marked a distinct shift in society's approach to caring for the mentally ill. Hailed "miracle drugs," the widespread hope and expectation was that new medications would effectively treat even the most severe disorders through outpatient programs [28]. Families and care providers would be free from closely scrutinizing the behavior of their mentally ill family members and charges; society assumed the risks and dangers of mental illness would disappear [29]. While antipsychotic drugs did offer improvement for many, there was a delayed recognition that most patients continued to be unable to make rational and informed decisions about their needs or maintain medication compliance [20].

2. Deinstitutionalization: At the same time as the promise of new drugs was emerging, civil rights advocates and the federal government began to openly address the inadequacy and arguably inhumane treatment provided by state-run mental institutions. The response was a push for deinstitutionalization. Premised on a systematic shift in resources available for treating mentally ill populations from state-run psychiatric hospitals to community settings, deinstitutionalization was intended to

treatment. *Indiana Health Law Review* 4: 361-430; Rhoden, N.K. 1982. The limits of liberty: Deinstitutionalization, homelessness, and libertarian theory. *Emory Law Journal* 31: 375; Mechanic, D., and Grob, G. 2006. Rhetoric, realities, and the plight of the mentally ill in America. *History and health policy in the United States: Putting the past back in*. Piscataway, New Jersey: Rutgers University Press.

protect individuals by enabling local communities to provide compassionate care [30]. The success of deinstitutionalization relied on two assumptions: first, that needed services for mentally ill individuals would be available; and second, that those services would be accessible at the community level. Yet, the mass release of people from mental institutions during the 1960s and early 1970s coincided with political and economic changes that thwarted funding efforts and prevented these assumptions from holding true [3]. Communities were ill equipped to support the services and treatment necessary to accommodate the influx of mentally ill individuals [31]. Individuals who had stabilized on medication were released into their communities with no access to treatment. The absence of sufficient treatment and the failure to provide continuity of care led to an inundation of mentally ill individuals into the criminal justice system.

3. Tightening of civil commitment statutes: In another attempt to protect the civil rights of mentally ill Americans, advocates campaigned for a change in commitment statutes. Before deinstitutionalization, mentally ill individuals could be involuntarily committed based exclusively on the grounds that they were ill and needed treatment [136]. This policy corresponded with a decades-long period where mental hospitals effectively served as dumping grounds for mentally ill people whose families were unable (or unwilling) to care for them. Successful advocacy efforts to bound commitment qualifications resulted in stricter standards for forcibly placing mentally ill individuals in psychiatric hospitals [32]. Courts implemented the dangerousness

standard and intervened to strike down statutes authorizing involuntary hospitalization for non-violent individuals.¹⁴

Family members and care providers were left with little leverage for pre-emptive intervention. Without this preventative stopgap, decompensating individuals became more likely to commit an offense triggering institutional involvement.

4. The rise of homelessness: Deinstitutionalization and the advent of the dangerousness requirement for involuntary admission led to an increase in non-dangerous mentally ill individuals in the community, with the expectation that treatment delivery would occur within the community setting [136]. Unfortunately, in addition to funding shortages, stigma accompanied this community population shift. Social prejudices related to mental illness condemned former hospital patients, causing residents to block the establishment of community care centers and group homes in their neighborhoods. With fewer psychiatric hospital beds available and limited housing to supplant them, previously hospitalized mentally ill individuals found themselves without proper places to live. The effects mental illness can have on maintaining employment coupled with a lack of affordable housing led to a spike in homelessness

¹⁴ *O'Connor v. Donaldson*, 422 U.S. 563, 575-76 (1975) (holding that a state cannot confine an individual who does not pose a danger to his or her community and who is capable of surviving without assistance and that a showing of mental illness alone is insufficient to order a civil commitment); *Lessard v. Schmidt*, 413 F. Supp. 1318, 1318-20 (E.D. Wis. 1976) (holding that a Wisconsin statute proscribing authority for civil commitment constituted a violation of the plaintiff's due process rights because it could be shown that she was not a danger to society, and thus the state's interests were deemed to not be furthered by her commitment).

among the mentally ill. In 2001, researchers estimated that one-third of all long-term homeless individuals met the criteria for serious mental illness [137].

Homelessness has been labeled an “important pathway to incarceration among mentally ill” [137]. Surveys of jails conclude that mentally ill inmates are twice as likely as non-mentally ill counterparts to have been homeless at arrest or for a period of time in the year before arrest [21]. Abnormal social behaviors related to serious mental illness draw attention from law enforcement on the street. Law enforcement, facing the difficult task of making quick on the spot decisions regarding severity and cause of an individual’s behavior, often perceive mentally ill individuals as intoxicated and effectuate an arrest for public disorder types of offenses (e.g. trespassing, disorderly conduct, loitering). Sometimes, the mentally ill may be arrested for no apparent reason. A 1992 study survey of jails across the United States found that 29 percent of jails reported locking up homeless mentally ill individuals with no criminal charge against them [126].¹⁵

5. Change in criminal law and law enforcement goals. A harshening in societal attitudes towards street crime and a shift in criminal justice jurisprudence exacerbated the criminalization of the mentally ill. Until the 1970s, society largely adopted the criminal law principle of rehabilitation, but toward the end of the 20th century, the

¹⁵ The technical reason provided for such detentions were that mentally ill individuals were able to be detained while awaiting a psychiatric evaluation within the criminal justice system, or while waiting for a bed or transportation to an inpatient psychiatric hospital [126].

primary purpose of the criminal justice system became punitive in nature. Both federal and state governments adopted a series of laws reflecting this new policy ideal: minimum sentencing requirements, “three strikes” laws, and increased arrest mandates [20]. Additionally, the war on drugs emerged as a top priority with incarceration as the primary weapon employed [33].

The combined effect of mandatory minimums that curtailed courts’ discretionary powers, police focus on low-level quality-of-life crimes, and the significant number of mentally ill individuals with co-occurring substance and mental health disorders magnified the criminalization of the mentally ill. The majority of mentally ill offenders commit only minor crimes. The five most common offenses leading to the incarceration of mentally ill individuals is reported to be: assault (41 percent); theft (30 percent); disorderly conduct (29 percent); alcohol or drug-related (29 percent); and trespassing (20 percent) [138, 137].

The amalgamation of these historical factors triggered the mass incarceration of those with mental illness. By the end of 2000, there were nearly one million adults with psychiatric disabilities in jail, prison, on probation, or parole [34].¹⁶

¹⁶ This was a conscious government decision to create policy deeply criminalizing drug-related crimes. Since declaring the “war on drugs,” the federal government has prioritized spending and grants for drug task forces and widespread drug interdiction efforts often targeting low-level drug dealing. These highly organized and coordinated efforts have been very labor intensive for local law enforcement agencies. The focus on drugs is believed to have also redirected law enforcement resources in a manner resulting in more drunk driving and decreased investigation of violent crime laws. Researchers have linked the focus on low level drug arrests with an increase in the serious crime index. See Stevenson, B. 2011. Drug policy, criminal justice and mass imprisonment. Geneva, Switzerland: Global Commission on Drug Policies.

2.3.2 Diminished capacity of mental hospitals

The effects of these historic shifts in ideology, policy, and practice led to a major shortage in mental health care capacity. For example, in 1955 there were enough psychiatric beds for one out of every 300 Americans; by 2005 the number of psychiatric beds available was barely enough to provide one for every 3,000 Americans [29]. Studies indicate that the prevalence of serious mental illness among the incarcerated population in the United States is at least two to four times greater than the prevalence of serious mental illness in the general population [35]. In some states, such as Arizona and Nevada, there are almost ten times more mentally ill individuals in jails and prisons than in treatment facilities [29]. The criminal justice system and its over-burdened jails and prisons have supplanted mental institutions and become surrogate mental hospitals and care providers to hundreds of thousands of mentally ill offenders [7, 36].

2.3.3 Conflating law and medicine: Resource misallocation

An added tension aggravating the criminalization of mental illness is the emergence of involuntary civil commitment schemes for categories of sexual offenders. The result has been a muddling of clearly established evidenced-based approaches to treating mentally ill individuals and has caused substantial resources to be diverted to diagnostically inappropriate criminal offenders [141]. Twenty states, as well as the

District of Columbia, permit civil commitment of sexual offenders [141]. In 2006, Congress mirrored state legislation by enacting the Adam Walsh Child Protection and Safety Act (AWA), which authorizes a system for the civil commitment of federal sexual offenders [142]. Generally, these laws provide a legal mechanism for the confinement of some adult sexual offenders (those who are likely to engage in future acts of sexual violence) in a secure treatment facility after the corresponding criminal sentence of incarceration has been served.

The Supreme Court deemed the civil commitment provision a permissible exercise of federal authority under the Necessary and Proper clause, analogizing the commitment program to “federal prison-related mental-health statutes that have existed for many decades.”¹⁷ The difference between statutes authorizing civil commitment of dangerous mentally ill individuals and this new dominion of civil commitment is the specific focus on “*sexually*” dangerous persons.”¹⁸

Implicit in this ruling is the presumption that a diagnostically determinable indicator exists for “sexual danger.” Yet, the legal mechanism by which offenders are detained when civilly committed depends on clinical criteria primarily created or defined by legislative bodies rather than by the scientific or mental health communities [141]. Civil commitment for the purpose of AWA is based on diagnoses that are “so

¹⁷ *United States v. Comstock*, 130 U.S. 949, 958 (2010).

¹⁸ See *United States v. Comstock*, 130 U.S. 949, 961 (2010).

devoid of content, or so near-universal in [their] rejection by mental health professionals” that they must violate due process rights.¹⁹

To uphold the legitimacy of legally determined mental illness categorization, DSM diagnoses should be a basic requirement (although not necessarily sufficient) to satisfy AWA’s civil commitment authority. DSM diagnoses are based on empirical research, clinical study, and professional consensus, and are intended to provide a basis for treatment. The DSM itself does not claim to offer legally sufficient diagnoses. The text states that the inclusion of diagnostic categories in the DSM “does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability” [118]. The legal definition of mental illness should not be more expansive than what is included in the DSM. The AWA inquiry for civil commitment, whether the individual will have serious difficulty refraining from sexually violent conduct, should not use disorders that are absent from the DSM and that lack associated characteristics of sexual deviance. This creates a slippery slope and conflates understanding of mental illness and appropriate systemic responses.

Additionally, there is concern about the legitimacy of detaining someone as a mentally ill person when there is doubt about the accessibility of effective treatment [141]. This raises the issue of diverting scarce mental health resources away from

¹⁹ *McGee v. Bartow*, 593 F.3d 556 (7th Cir. 2010).

individuals diagnosed with severe, persistent, and debilitating mental health difficulties in order to serve a limited population of sexual predators who tend not to have such diagnoses and for whom the use of correctional resources may be more prudent [141].

Ultimately, the AWA and similar state statutes use perceptions of mental illness as a vehicle for retribution for sexual crimes. Leveraging imprecise, non-evidenced based and non-medically determined understandings of mental illness to reach a punitive goal is problematic for the legitimately mentally ill population. This policy exacerbates stigma and codifies criminalization of mental illness while simultaneously diverting substantial resources away from those who need mental health treatment [141].

2.4 Traditional incarceration is harmful to mentally ill offenders

2.4.1 Exacerbation of harms and risks

Prisoners have a constitutional right to adequate health care, including mental health treatment,²⁰ and the swelling of correctional populations has strained the limited capacity of jails and prisons to respond to the health needs of inmates [132]. The situation is particularly challenging in the case of inmates with serious mental illnesses requiring specialized treatment and services [29]. Jails and prisons were not intended to

²⁰ *Estelle v. Gamble*, 429 U.S. 97, 103, 104 (1976) (holding that denying medical treatment to prison inmates causes pain and suffering, and the “deliberate indifference” by prison staff providing for inmates’ medical needs constitutes a violation of the Eighth Amendment which involves “unnecessary and wanton infliction of pain”) (internal citations omitted); see *Ramos v. Lamm*, 639 F.2d 559, 578 (10th Cir. 1980) (holding single monthly prison visit from a psychiatrist violated an inmate’s rights because this provision of mental health care was “ridiculously pathetic” and inadequate).

replace mental hospitals, and they continue to be structurally inappropriate for the mentally ill. In fact, the Supreme Court directed states to transfer mentally ill offenders from an institutional setting to community-based treatment when an offender can be effectively accommodated in the community.²¹

Designed to mete out punishment and protect society, the primary mission and goals of jails and prisons are incompatible with the provision of treatment. The correctional facility's overriding need to maintain order and security, as well as its mandate to implement society's priorities of punishment and social control, greatly restrict the facility's ability to establish a therapeutic milieu and provide the necessary interventions to treat mental illness successfully. Conditions of confinement within these facilities and the punitive methods frequently used by correctional staff to respond to people in crisis further exacerbate psychiatric symptoms [37].

In addition to the inability to sufficiently provide psychiatric care to inmates, it has been well documented that most types of discipline used in correctional facilities are particularly unsuitable for the mentally ill. People with mental illness in correctional facilities enter a stressful environment with diminished capacity for coping and adaptation, making it difficult for them to ascertain the rules of behavior dictated by

²¹ *Olmstead v. L.C.*, 527 U.S. 581, 587 (1999) (citing support in the Americans with Disabilities Act which puts forth anti-discrimination policies for individuals with disabilities in public services) (internal citation omitted).

either corrections or the inmate code [38].²² Studies have found elevated rates of incident reports for inmates who rated positive on the schizophrenia scale during their first 90 days of incarceration [133].

Other inmates may view mental illness as a weakness, or may be unsettled by the bizarre or disorganized behaviors exhibited by mentally ill individuals who are at increased risk of decompensating due to limited mental health treatment within correctional facilities [126]. This can lead to the verbal, physical, or sexual abuse of those with SMI. In a survey of American jails, 40 percent of jail officials questioned admitted witnessing abuse of mentally ill inmates by other inmates [126]. Further, the Bureau of Justice Statistics found that mentally ill inmates were twice as likely as other prisoners to be involved in a fight [35]. This triggers a cycle of inappropriate behavior, and ultimately isolation from the prison population. Solitary confinement and isolation further disintegrate a mentally ill inmate's link to reality and makes it even more difficult to regulate behavior [38].

The inferior ability of mentally ill inmates to understand and follow jail and prison rules results in longer stays (and costs) for mentally ill inmates. For example, Florida's Orange County jail found that the average stay for inmates is 26 days, but for mentally ill inmates it is 51 days. In New York's Riker's Island Jail, mentally ill inmates

²² Serious mental illness may affect an inmate's ability to comply with certain orders or procedures. Those with major depressive disorder or bipolar disorder may exhibit aggression or irritability. Mental illness can evoke fears, hostile reactions, and negative responses from other inmates and staff [35, 133].

stay for an average of 215 days compared to the 42-day average for all inmates. Both studies show that mentally ill inmates are twice as likely to be charged with facility rule violations, and another study in Washington concluded that mentally ill inmates account for around 40 percent of prison infractions despite only constituting 19 percent of the prison population [38].

Further evidence of the heightened risks mentally ill inmates face in prison is manifested in suicide statistics: multiple studies show that over half of all inmate suicides are committed by seriously mentally ill individuals. A 2002 study reported the prevalence of mental illness among inmates who attempted suicide was 77 percent, compared with 15 percent in the general jail population [39, 40]. Schizophrenia and manic-depression were the most common mental illnesses associated with suicide attempts and completions [39].

2.4.2 High rates of recidivism and costs

Reintegration is a well-documented challenge for formerly incarcerated individuals. Ninety-five percent of the approximately 13.5 million people incarcerated in U.S. prisons or jails over the course of a year are released to local communities, and they carry with them the physical and psychological tolls from their time in prison. Returning to communities after time in prison or jail is often accompanied by dramatic culture shock and the intense stress of re-adaptation. The order, rules, and routines of prison no longer provide structure, and these individuals must meet their own basic needs of food,

shelter, clothing and medical services. For those with SMI, these challenges are exacerbated by conditions of their mental illness [40].

Additionally, since criminal justice systems and mental health treatment systems remain uncoordinated for the most part and mentally ill individuals typically lack adequate support or independent access to treatment, most leave jail or prison with little or no access to psychiatric care. The result is a much higher rate of recidivism than that of non-mentally ill former offenders [41, 20].

A related issue is the problem of homelessness discussed above. Although not all mentally ill inmates are homeless when arrested, many are by the time they are released. During periods of incarceration, even minimal ones, a mentally ill offender may lose eligibility for benefits pertaining to housing or services [139]. Many mentally ill individuals depend on Social Security and other public assistance benefits, yet, the longer incarceration period, the more likely these benefits will be terminated. Even a two or three-day jail stay may negatively affect access to community support and resources [139].

Evidence of these challenges is well established. Of individuals supervised in the community on probation or parole, mentally ill parolees and probationers are significantly more likely to have their community term suspended or revoked [42]. In one sample study of 44,987 offenders, researchers found that mentally ill parolees were over twice as likely as non-mentally ill parolees to return to prison within one year of

release [43, 44]. Among mentally ill jail inmates, the Bureau of Justice Statistics reported that 42 percent had served three or more prior sentences of probation or incarceration compared to 33 percent of jail inmates without mental illness [21].

The confluence of these dynamics hold mentally ill offenders hostage in a “revolving door” of the criminal justice system as they cycle in and out of correctional facilities, failing to achieve adequate treatment and simultaneously aggravating their SMI symptoms [34].²³ Costs to maintain high levels of incarceration are exorbitant and politically unpopular, particularly during periods of fiscal conservatism [40]. The situation exacts a significant toll on the lives of mentally ill individuals, their families, and their communities, as well as creates an enormous burden to the already overwhelmed criminal justice system [3].

2.5 The rise of problem-solving courts

The development of alternatives to traditional criminal prosecution stemmed from the overcrowding and expense of maintaining jail and prison populations and the growing recognition that customary criminal justice processing was ineffective in achieving positive outcomes for certain types of offenders [46].²⁴

²³ While incarcerated, a mentally ill offender typically struggles to maintain medication and treatment regimens, housing, and a job; psychiatric symptoms worsen and after a relatively short period of time (1-6 months) he or she is released back into the community in a worse condition than at the time of arrest. The “revolving door phenomenon” describes the series of events when the decompensated individual is then re-arrested and charged with another crime soon after release from jail [109].

²⁴ For example, on Aug. 12, 2011 Charlie Savage noted in the *New York Times* that support for reduced incarceration was increasing in traditionally conservative states. See also, Webb, J. 2007. Mass incarceration

In the late 1980s, the advent of drug courts marked a watershed development. Until then, drug-related offenses were viewed as necessarily punitive with incarceration as the understood punishment. It was well documented, however, that incarcerating people for drug-related offenses led to a costly cycle of arrest, incarceration, release, and re-arrest [47]. As a local response to this issue, Dade County, Florida established the first drug court to address the underlying cause of offenders' behavior by providing treatment, case management and social services while maintaining close judicial supervision [47, 48].

The success of drug courts in reducing drug use and criminal recidivism led to the development of several other problem-solving courts adapted from the drug court model [50]. Several characteristics differentiate problem-solving courts from traditional court functioning: (1) a separate docket for specified defendants; (2) ongoing status hearings with a dedicated judge presiding over both the initial and subsequent status hearing; (3) a collaborative approach to decision-making with input from the judge, counsel, and relevant professionals; (4) voluntary defendant participation; (5) intensive

in the United States: At what cost?. Hearing Before the J. Econ. Comm., 100th Cong. 1-2 (“[T]he United States now imprisons a higher percentage of its citizens than any other country in the world ... The growth in the prison population is only nominally related to crime rates ... [W]e are spending enormous amounts of money to maintain [the prison] system.”); Gingrich, N. and Nolan, P. 2011. Op-Ed., Prison reform: A smart way for states to save money and lives. *Washington Post* (Jan. 7, 2011) (exploring the substantial potential of decarceration to reduce costs and crime).

judicial supervision of participants; and (6) the possibility of reduced charges, sentences, or dismissal for successful program completion [49].

2.6 Theoretical underpinnings of problem-solving courts

Problem-solving courts reject the premise of criminal justice as the pursuit of proportional punishment, deterrence, and incapacitation, and instead embrace a rehabilitative regime focused on therapeutic jurisprudence. This concept operates on the assumption that an offender has committed a crime because of an underlying pathology or from a learned anti-social behavior and that improved outcomes may be achieved by addressing the underlying issue [46]. Formally, therapeutic jurisprudence 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” [46].

Advocates of therapeutic jurisprudence posit that society should utilize the theories, philosophies, and findings of various disciplines to help shape the development of the law [50]. Examining the effects of legal instruments on individuals may illuminate how laws and legal processes support or undermine the public policy justifications behind them.

Proponents, however, do not argue that this approach should trump traditional considerations such as the due process of law and recognized procedural and constitutional rights [50]. Rather, the focus should be to probe beneath the rhetoric or

rights and focus on the needs and interests of the individual to pursue creative convergence and compromise [107]. Whereas a trial is focused toward the ultimate outcome (typically binary: guilty or not guilty), and the institutionalized protections of procedure and precedent are geared toward ensuring fairness of that outcome, the philosophy of therapeutic jurisprudence emphasizes the process by which to identify factors at the basis of the offender's problems in order to lessen recidivist tendencies and benefit the individual, as well as the court's caseload. Thus, the therapeutic jurisprudence theory of criminal justice structures criminal law, rules, actors, and procedures to achieve beneficial outcomes beyond the immediate case disposition, while still preserving due process and other criminal justice values [50].

Problem-solving courts reject the rigid, inflexible sentencing schemes and mandatory incarceration penalties favored in the mid to late 20th century in favor of a tailored approach to dealing with specific offender issues [50, 51]. When applied effectively, this model benefits the individual defendant and serves the public interest of improving safety and reducing costs [46].

3. Review of Emerging Mental Health Court Literature

3.1 Mental health court basics

3.1.1 Theoretical foundation

Mental health courts operationalize the theory of therapeutic jurisprudence by calling attention to the harmful consequences of existing punitive schemes for mentally ill criminal offenders and by promoting the purview of the law as a therapeutic agent for this population [52, 106]. Specialized mental health courts developed in response to the disproportionately high rates of incarcerated mentally ill offenders, the unique challenges and costs associated with correctional system care for SMI inmates, and a concern that the criminal justice system lacked the ability to respond effectively and humanely to people with SMI [53].

Adopting the theoretical model of drug courts, the objective is for mental health court actors and cross-disciplinary professionals to collaborate in a flexible approach to handling mentally ill offenders in order to produce the greatest possible therapeutic outcome for the offending participant and the public [54]. Under this theory, two core elements promote therapeutic outcomes: mental health treatment and ongoing judicial monitoring to facilitate treatment compliance and reduce criminal behavior [50]. The motivating theory behind mental health courts is thus distinct from the modern penal system, which is generally considered to be structured to advance the predominant goals of retribution, deterrence, and incapacitation.

Ultimately, two converging legal trends spurred the development of mental health courts as the appropriate mechanism for handling the issues associated with mentally ill criminal offenders: therapeutic jurisprudence and the drug court movement.¹ The former laid the academic groundwork for mental health courts, and the latter developed and tested the basic elements of successful specialized court operations [47, 50]. Congressional legislation established the therapeutic approach embraced by mental health courts as a national priority by authorizing and approving funding for mental health court development under the Mentally Ill Offender Treatment and Crime Reduction Act [55]. This prominent piece of legislation recognized the benefits of “increase[d] public safety by facilitating collaboration among criminal justice, juvenile justice, mental health treatment, and substance abuse systems”[55].

3.1.2 Working definition

Despite the recent expansion of mental health courts, no nationally accepted criteria defining what constitutes a mental health court developed. The considerable degree of diversity among mental health court programs makes it difficult to reach a consensus on a core definition [53, 7]. Courts vary in the charges and mental illness diagnoses they accept, eligibility of individuals with a history of violence, plea requirements, treatments and services offered, level of court scrutiny and duration of

¹ Over 370 drug courts existed when the first mental health court was created in 1997. By 2007, there were over 1,000 drug courts that were operational across all fifty states. Vocal political support and the successful implementation of drug courts benefitted mental health court advocates in establishing their own specialty courts [111].

supervision, possible sanctions, and the impact of program completion on participants' criminal cases [9].

By distilling the common characteristics shared by most mental health courts, a working definition of "mental health court" has only recently been published.

"A mental health court is a specialized court docket for certain defendants with mental illnesses that substitutes a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, non-adherence may be sanctioned, and success or graduation is defined according to predetermined criteria"

[7,3].

3.1.3 Core goals

Communities invest in the development of mental health courts within the framework of a problem-solving model and an emphasis on linking offenders to effective treatment [6]. Hoping for better outcomes for mentally ill offenders than would otherwise be obtained under traditional criminal case processing, mental health court planners and actors cite specific goals that fall into four categories [3, 56]. The first is to reduce high recidivism rates for mentally ill offenders cycling through the criminal justice system, thereby also improving public safety. The second is to increase treatment engagement by facilitating connections with appropriate and comprehensive support networks and services. Third, is to improve the quality of life for participants by connecting them with community-based treatment, housing, support systems, and other

services that encourage recovery and teach life skills. The final goal is to effectively allocate resources by reducing the number of repeat offenders and by providing treatment in the community where it is more effective and less costly than in correctional institutions [3, 56].

3.1.4 Ten essential elements

Lacking federal or state guidelines to impose uniform development, mental health courts formed in response to idiosyncratic community needs, available resources, and the legal regulations of particular jurisdictions. Consequently, there is no single mental health court model, but rather considerable diversity in court policies and procedures [3, 6].

In response to community requests for technical assistance in developing functional mental health courts, the Justice Department's Bureau of Justice Assistance published *The Essential Elements of a Mental Health Court* in 2006 to provide explanations of core mental health court characteristics and how they can be achieved [57]. These elements are not researched-based, but rather stem from the anecdotal experience of existing courts at that time [57].²

² Studies conducted after this 2006 publication use the definition above and the Essential Elements when determining inclusion criteria for what constitutes a mental health court.

1. Planning and administration: Establish a broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and have community actors the planning and administration of the court.

2. Target population: Design eligibility criteria to address public safety with an awareness of a community's treatment capacity and the availability of alternatives to pretrial detention for SMI defendants.

3. Timely participant identification and linkage to services: Participants should be identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible.

4. Terms of participation: These should be clear, promote public safety, facilitate the defendant's engagement in treatment, be individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.

5. Informed choice: Defendants should fully understand the program requirements before agreeing to participate in a mental health court. They are to be provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures should exist in the mental health court to address, in a timely fashion, concerns about a defendant's competency whenever they arise.

6. Treatment and support services: Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community.

They strive to use and increase the availability of treatment and services that are evidence-based.³

7. Confidentiality: Health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and their constitutional rights as defendants. Information gathered as part of the participants' court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.

8. Court team: A team of criminal justice and mental health staff and service and treatment providers should receive special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.

9. Monitoring adherence to court requirements: Criminal justice and mental health staff should collaboratively monitor participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery.

10. Sustainability: Data should be collected and analyzed to demonstrate the impact of the mental health court, assess its performance periodically (and modify

³ Evidence-based practices are mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes. Knowledge about which treatments are most effective should help shape and target court-ordered treatment [135].

procedures accordingly), institutionalize court processes, and cultivate support for the court in the community [8, 57].

3.2 Development and proliferation of mental health courts

3.2.1 Early mental health courts

The first mental health court was established in 1997 in Broward County, Florida as the result of growing concern about mental illness and an increase in suicides in the county jail. A local judge convened a task force of mental health and criminal justice stakeholders to examine methods for better integrating the two systems. The Broward County Mental Health Court convened on a part-time basis and initially only processed low-level misdemeanor cases [53]. Funding for the program was generated from state and county government budgets: \$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 [53].

Soon after its creation, the Broward County mental health court model was adopted in Seattle, Washington, Anchorage, Alaska, and San Bernardino, California. These locations are considered the “founding” mental health courts [53].

Early studies and anecdotal responses were promising, suggesting success in reducing recidivism rates [59]. For example, Broward County’s mental health court reported a decline in re-arrest rates among program participants [60]. Between October 2001 and September 2002, only 27 percent of program participants were re-arrested [61].

Further, none of the first 675 participants had committed a violent offense when evaluated five years after their enrollment in the program [61, 62].

Similarly, in King County's mental health court, recidivism rates decreased appreciably with 75 percent of program graduates arrest-free in the year following their graduation, and 85 percent of participants having committed one offense or less in that time period. The court also claimed an 88 percent reduction in violent criminal activity among court participants [63].

In the face of escalating criminal justice costs, increasing mental illness awareness, and preliminary research supporting the success of the founding mental health courts, states across the country began committing to models of collaborative justice and decreased reliance on incarceration [64].

3.2.2 Federal driven expansion

Recognizing the extensive criminal justice problems associated with mental illness and the "positive results" of these early mental health courts, the federal government adopted legislation to expand implementation of the court model at the county level [65]. Congress enacted America's Law Enforcement and Mental Health Project, a bipartisan Act signed into law by President Bill Clinton on November 13, 2000 [65]. Initially providing federal funding to establish 100 mental health court programs around the country, the Act has since funded 123 mental health courts in 39 states [66].

Federal support continued to propel the mental health court movement when Congress unanimously passed the Mentally Ill Offender Treatment and Crime Reduction Act, signed into law by President Bush in October 2004. Designed to foster collaborations between the criminal justice and mental health communities, this bill authorized an additional \$50 million per year to be allocated to states and local communities. Grants under this bill could be used for a variety of purposes, including jail diversion, treatment for incarcerated individuals with mental illnesses, community reentry services, or cross training of criminal justice, law enforcement and mental health personnel [55].

Mental health courts are expected to continue to grow rapidly. Alongside state-initiated reforms, federal legislation, and community support, recent attention to prison conditions has emphasized the immediacy and necessity of alternatives to incarceration. In 2011, the U.S. Supreme Court held that the conditions of California's prison system amounted to cruel and unusual punishment in violation of inmates' constitutional rights [67]. The Court gave California a two-year time frame to observe its mandate that California reduce its prison population by over 25 percent, equivalent to the removal of 30,000-40,000 prisoners. The effect of this ruling is to shift prisoners, particularly those with mental illness, over to local control and to promote interagency cooperation. Since mental health courts already utilize a multi-actor model to divert mentally ill offenders

from the criminal justice system to treatment, they are viewed as crucial to freeing up correctional resources [67].

3.2.3 Current status and variability of mental health courts⁴

While federal initiatives advance mental health court development, they still must rely on state and local backing to succeed. The mix of local, state, and federal support has enabled the mental health court model to rapidly spread to every state in the country. In 2006, 100 mental health courts existed; by 2011 this number grew to around 300 [4, 8].

Each jurisdiction has distinct priorities and resources, and the mental health court model has been tailored accordingly to reflect community needs, resources, and local exigencies. Consequently, the characteristics of courts vary across jurisdictions on several key elements [see Appendix F for a comparison of court features found in five diverse mental health courts].⁵

Geographic distribution: Mental health courts are disproportionately prevalent in the west (37 percent) and south (37 percent), with few courts in the northeast (11

⁴ In general, the criminal justice system is complicated; it is comprised of several overlapping, competing, and sometimes conflicting systems. Every county, city, and state has its own criminal justice system (in addition to a federal one), and no two operate precisely alike. Differences result from variations in formal mechanisms, institutional components, allocation of resources, and local precedent and custom. Yet, the operation of the criminal justice process carries substantial similarities among the federal and various state criminal justice systems that are unlike similarities that can be found in mental health courts [108].

⁵ This list is not exhaustive; additional areas where mental health courts show a wide range of policies and procedures include: how potential participants are referred to mental health court, the length of the waiting period between referral and enrollment, the process by which participants are linked to services in the community and establish long-term relationships [6].

percent) or midwest (15 percent). Additionally, over 40 percent of mental health courts are located in California, Ohio, Florida and Washington. There is also an uneven presence of mental health courts in non-rural compared to rural jurisdictions; over seventy-five percent of mental health courts exist in non-rural locations [69].

Caseload size: The number of offenders accepted and processed in mental health courts range significantly from court to court. One survey of 90 mental health courts found an annual caseload range of 3 to 852 clients, with a median size of 36 active participants [8].

Plea conditions: Jurisdictions generally follow one of two models for mental health court entry: pre-adjudication or post-adjudication. The pre-adjudication model defers prosecution until the client has completed the program. The case disposition is suspended for the duration of mental health court involvement, and participant performance deeply impacts the case outcome. In contrast, the post-adjudication model conditions acceptance into the program on a guilty plea. Most courts offer the potential for the plea charge to be reduced or even expunged upon successful program completion. The specific circumstances and individual offender traits are taken into consideration when this determination is later made.

The post-adjudication model is more common, particularly among mental health courts that accept felony offenders [6]. A 2006 survey of existing courts showed that

almost 70 percent required guilty pleas as a condition of enrollment, with an additional 16 percent requiring guilty pleas for a subset of their clients [69].

Advocates of the post-adjudication model argue that deferring prosecution creates challenges with future trials if a client is unable to successfully complete the mental health court program. For example, if a client fails the program or opts out after two years of enrollment, the prosecutor may be unable to find witnesses or sufficiently refresh witness recollection of the incident.

On the other hand, by pleading guilty, the defendant assumes legal guilt before any meaningful adjudication takes place. If the defendant fails out of the program, he retains the admission of guilt despite the lack of an adversarial process in securing the verdict. Critics also argue that the plea requirement is unconstitutionally coercive, implicating both the Fourteenth and Sixth Amendment [69, 70].

Legal eligibility: Most mental health courts employ varying degrees of exclusion criteria based on specific criminal offenses (e.g., child abuse, first time offenses, sex offenses, arson) or categories of crime (e.g., felonies or violent crimes). Mentally ill offenders who fail to meet the court's eligibility criteria are removed from the court's docket and returned to regular court processing.

The clearest delineation between courts with regard to legal eligibility is the inclusion or exclusion of felony offenders. In 2005, half of surveyed mental health courts accepted both misdemeanor and felony offenders [71]. Of the federally funded mental

health courts, two-thirds of programs rendered clients with violent offenses automatically ineligible [72].

Early mental health courts typically focused only on misdemeanor criminal offenders, but recently courts have begun to remove this restriction. A study of “first and second generation” mental health courts determined that four of the six “first generation” mental health courts that originally accepted only people charged with misdemeanor crimes had begun to accept people charged with felony offenses on a case-by-case basis. Of the seven “second generation” mental health courts examined, all accepted individuals with felony charges, three either focused on or accepted only people charged with felonies, and only one focused primarily on misdemeanors [8].

There are several rationales for granting felony offenders access to mental health courts, including that mental health courts are no longer an untested model with uncertain outcomes; the initial public safety concerns about releasing into the community individuals who might otherwise be incarcerated have been assuaged. Moreover, by focusing on felony offenders, court professionals have the opportunity to engage participants in treatment for longer periods of time because they are more likely to opt into mental health court participation. Since the maximum jail sentence for a misdemeanor is one year, misdemeanor defendants often are not motivated to participate in mental health court, which can carry longer periods of supervision. Treatment providers and court professionals recognize that treatment needs can be

misaligned with legal status, and by focusing on felony offenders, providers have a better chance of ensuring meaningful treatment and continuity of care [6].

Clinical eligibility: There is no uniform standard as to which mental illnesses make a defendant eligible to participate; many courts use broad criteria (e.g., “has an Axis I diagnosis”) while others exclude defendants with personality disorders or substance use disorders [See Appendix A for definitions and categories of diagnoses]. Courts also vary regarding limitations imposed for severity of symptoms appropriate for qualification. The acceptance of traumatic brain injuries, developmental disorders, and Axis II or personality disorders also are controversial clinical eligibility issues. Some courts purposely exclude these diagnoses, whereas other courts are willing to accept participants with these conditions on a case-by-case basis.

For example, the National Survey of Mental Health Courts found that one-third of courts limited eligibility to individuals with an Axis I diagnosis, fewer than 10 percent of mental health courts admitted individuals with developmental disabilities to, and only three percent accepted defendants with an Axis II diagnosis [5].

Another survey of 90 mental health courts found that 16 percent of responding courts reported “some specifications” as to what types of mental illnesses they accepted, 37 percent of respondents accepted individuals with an Axis I disorder, 21 percent accepted individuals with a “serious and/or serious and persistent” mental illness, and 26 percent had no mental illness-specific admissions criteria [69].

Screening process: Once a prospective client is deemed clinically and legally eligible, mental health courts vary in their process for determining an offender's mental health needs. Some courts use informal assessment procedures to identify mental illness and associated treatment needs, while other jurisdictions conduct extensive, systematic psychiatric evaluations complete with record gathering from external sources and interviews with relatives and caretakers [72].

San Francisco's Behavioral Health Court (BHC) illustrates one end of the spectrum in its comprehensive screening process [140]. BHC only evaluates defendants in custody. Jail Psychiatric Services conducts a thorough mental status evaluation of referrals to determine diagnostic eligibility. Information about the defendant's biopsychosocial history is then researched through interviews with friends and family, community mental health and medical treatment providers, San Francisco General Hospital's Lifetime Clinical Record, San Francisco County's community mental health database, court records, police reports and rap sheets, and Jail Health and Jail Psychiatric Services records. The first time a defendant appears in BHC, the BHC legal team reviews the case and determines whether he or she is legally eligible to participate. Jail Psychiatric Services then makes a clinical presentation about the defendant, including a recommended treatment plan. The District Attorney makes a presentation about the facts of the case, including victim input and impact, the strength of the case, restitution obligations, and the defendant's criminal history. If the defendant is on

probation, Adult Probation Department makes a presentation about past compliance on probation. Assuming a defendant is eligible for BHC, a final decision on whether the defendant may enter is made by the entire BHC team, which includes the Judge, District Attorney, Public Defender, Adult Probation, Jail Psychiatric Services, and Citywide Case Management Forensics. The defendant's legal status may be an open misdemeanor or felony case, a probation sentence with BHC as a condition of probation, or a probation modification with BHC as a condition of probation [140].

After acceptance to BHC and the team's approval of a treatment plan, the Court signs a release order. Jail Psychiatric Services will then collaborate with the community provider to ensure continuity of care for the client. Defendants are released to the community with a treatment plan that includes housing and, often, the provision of medication. For individuals in need of residential treatment, Jail Psychiatric Services completes the referral for an intake assessment to be completed by the San Francisco Department of Public Health, Community Behavioral Health Services Placement Committee, and helps the defendant obtain any necessary medications, identification, and entitlements [140].

Court staff and services: The structure of the mental health court team and forms of treatment vary according to community resources and the individual jurisdiction's court. Typically, a mental health court "team" includes a judge, a prosecutor, a defense attorney, probation or parole department representatives, and a

case manager or representative from the mental health treatment system. The greatest variability between courts is between those with rotating attorneys and those with permanent attorneys, as well as courts with internal versus external treatment and case management providers [6].

Court supervision: Once accepted into a mental health court program, clients may experience vastly different forms of supervision and court monitoring. Supervision in the community may be the responsibility of treatment providers, probation officers, mental health court personnel, or other criminal justice agencies. Additionally, judicial status hearings may range from multiple times per week to quarterly appointments, although most courts have participants begin with weekly to monthly hearings [71].

Incentives and sanctions used: Courts differ with regard to the mechanisms used to motivate and sanction clients' compliance or noncompliance [8]. The most extreme and controversial sanction is incarceration for noncompliance with court mandates or treatment plans. There is a wide range in the extent to which courts use incarceration as a sanction: eight percent of courts report never using jail as a sanction, and the largest portion of courts (39 percent) report using jail sanctions in 5 to 20 percent of cases. Mental health courts with more felony offenders, and with more frequent status hearings, tend to use jail sanctions more often [71].

Successful completion. Like its drug court predecessor, mental health courts may terminate client participation for failure to comply with court requirements and

after exhaustion of sanction options. Moreover, since mental health courts are voluntary, clients may choose to leave the program at any time and return to traditional court processing. A 2010 study of 400 participants from four mental health courts found that one year after entry into the court, 48 percent of participants had graduated and 23 percent remained in the program. Differences in court termination rates ranged from 17 to 41 percent, but no rationale was provided as to why these offenders left the program [73]. Another study compared the characteristics of mental health court participants who successfully completed the program and those who were prematurely terminated and found no difference between the two groups in criminal history, mean age, race, or gender [49].

3.3 Criticisms and controversies

3.3.1 Overview

Although mental health courts have become a popular approach for responding to offenders with mental illness, some concerns have surfaced. The central criticisms of mental health courts are discussed below [10, 70].

3.3.2 Voluntariness, potential for coercion, and competency

Mental health courts have been heavily criticized for failing to adequately protect the voluntary participation of mentally ill criminal defendants, a precondition of mental health court entry [63]. The Bazelon Center for Mental Health Law contends that truly voluntary transfer to mental health courts is crucial, and to allow defendants to be

diverted otherwise would stand in violation of a defendant's constitutional rights [74]. Since a defendant waives his or her right to a trial by jury when opting into an alternative court system, and since a defendant is subject to court orders for treatment and activity compliance, critics and supporters alike argue it is imperative that participants' choices are informed when entering and choosing to remain in the program [73]. Whether attaining meaningful consent is possible remains a huge point of contention.

Additionally, critics worry that mental health courts function as coercive agents in ways similar to the intervention of outpatient commitment, compelling an individual to participate in treatment under threat of court sanctions. Almost every mental health court requires the individual to "follow the treatment plan." This broad mandate has the power to require a range of behavior and compliance on the part of the defendant. Further complicating the voluntary election of mental health court involvement is the fact that such decisions are made when the defendant is likely to be under considerable stress, having been arrested and taken into custody, and perhaps having spent time in a jail cell, often without treatment of any kind. Currently, there are no standardized procedures in place protecting the informed choice prerequisite [71].

In examining whether 200 newly enrolled mental health court clients made knowing, informed, and voluntary decisions to enter the court researchers found competing indications. On the one hand, more than half of the participants: 1) claimed it

was their decision to enter the mental health court; 2) knew that not just any person charged with a crime could participate; 3) could articulate advantages to mental health court participation; and 4) demonstrated no more than minimal impairment regarding understanding and reason on a measure of adjudicative competence [73]. On the other hand, more than half of the participants: 1) claimed not to have been told the decision to enroll in the mental health court was voluntary prior to enrolling; 2) professed not to be told of the court's requirements; 3) were unaware that beyond eligibility determinations, the decision to enter the court was theirs to make; 4) did not know they could terminate their participation; and 5) could not articulate even one disadvantage to mental health court participation [73].

In addition to meeting the criteria established by individual mental health courts for eligibility to participate in the court's proceedings, defendants also must be competent to stand trial. Researchers have expressed concern about the issue of competency. Although competency is a threshold issue for acceptance into mental health courts, few precautions are in place to ensure that defendants remain competent while in the program. Serious mental illness is chronic in nature and mental competency is not binary or static. Moreover, few studies have examined the number, characteristics, and outcomes of prospective clients who were deemed incompetent to enter a mental health court program [75].

3.3.3 Inadequate procedural safeguards

Critics argue the informal, non-adversarial nature of mental health courts further compounds the issue of voluntariness and coercion, leaving defendants without the procedural safeguard guarantees of traditional courts [10]. Among these is the judge's power to rule based on idiosyncratic views rather than law [76]. The concern is that traditional procedures designed to ensure fairness and establish legitimacy in the justice process may be lost as a result of a hands-on, interactive judge. A highly informal, flexible court carries the risk that impaired individuals will impermissibly participate and that the connection between treatment success and program completion will be conflated, potentially "walk[ing] a fine line between social beneficence and social control"[78].

Additionally, mental health courts place defense attorneys in conflicting positions that may intrude on attorney-client privilege and marginalize counsel's ability to act in the best interests of the client [79]. Defense attorneys are expected to zealously advocate for their client's best interests. Yet, they are also expected to collaborate with other mental health court team members to ensure the participant complies with treatment mandates [78]. The tension between short-term and long-term liberty interests and the need for collaboration has led critics to question whether mental health court participants receive appropriate representation.

3.3.4 Liberty considerations

It has also been suggested that mental health court supervision and monitoring has the potential to infringe upon participants' liberty interests by expanding the scope of court control beyond what it would be in regular court [78]. Similar to concerns regarding voluntariness, the minimization of the adversary process within mental health courts has the natural effect of decreasing certain protections that exist in the traditional court system [8]. This may increase the court's ability to control participants by providing the court more time to supervise participants than they would have had in the traditional criminal system [78]. Others, however, have argued that an increase in compliance and adherence is necessary to thwart the cycle of arrest and release that plague mentally ill offenders [80]. Similarly, the opportunity to avoid a criminal record and receive necessary services that are designed to prevent future violations of law has been said to be more humane than any other procedure currently in place [81].

3.3.5 Stigma and further entrenchment in system

Some mental health advocates believe that mental health courts further stigmatize and criminalize mentally ill individuals by involving criminal courts in the mental health system [82]. If charges are filed against mentally ill people as a means of diverting them into community treatment, this constitutes further entrenchment in a system they might otherwise be able to avoid [32].

3.3.6 Selection bias and “creaming”

There is no clear understanding of how mental health court participants are chosen. Critics speculate that courts engage in “creaming” practices, where mental health court actors only accept clients with few risk factors who are likely to succeed regardless of program participation. The issue of creaming is particularly important when considering evaluation methodology. Since admission into these programs includes the subjective assessments of multiple stakeholders (e.g., judge, prosecutor, clinical team), there is a risk of selection bias where more promising presenting less danger to the community and less risk of failure are chosen for participation [83].

Some studies indicate the presence of creaming, where mental health court judges chose participants and made decisions on program entry based on personal knowledge of an individual's history [2, 49]. Two implications stem from this issue: first, mental health courts may be capturing only a portion of the potential population they should be; and second, this practice could skew research results. It is clear that a more in-depth understanding of why some individuals are excluded from mental health court programs is needed.

3.3.7 Funding and resource allocation

A concern about mental health courts is the limited impact they can have without additional funding and investments in community mental health systems. Part of the intervention theory behind the promise of mental health courts is that participants

will continue to receive treatment once the court no longer has direct supervision and mandate authority over the offender. Without sufficient resources in the community, there may not be this continuity of care [84].

Furthermore, some argue mental health courts merely shift a scarcity of resources to a priority group of people with mental illness (to those coming into contact with the criminal justice system) [7]. By connecting mentally ill offenders with community resources, mental health courts may prevent mentally ill persons who are not part of the criminal justice system from receiving the same necessary services [53]. Responses to this argument center on the blame it places on mentally ill offenders for receiving services rather than blaming lawmakers for their failure to ensure all people have access to the same services [81]. There also is scant evidence supporting the argument [70].

3.3.8 Unknown use of evidence-based practices⁶

Related to the issue of scarce resources is the opaqueness of existing studies and reports regarding how mental health court resources are utilized. Specifically, how are treatment programs selected and how do they function? Mental health courts have emerged at a time when the field of medicine is moving entirely toward the implementation of evidence-based practices (EBPs) in care-delivery. To qualify as an

⁶ For more detailed information on evidence based practices in mental health courts, see Osher, F. and Levine, S. 2005. Navigating the mental health maze: A guide for court practitioners. New York, New York: Council of State Governments.

EBP, empirical research must demonstrate that a specific practice or intervention increases the likelihood of positive outcomes [147]. The underlying rationale is that limited fiscal resources are best expended on programs and practices with proven abilities to improve mental health functioning and reduce further criminal behavior. Yet, the appropriateness of existing treatment used by mental health courts and the extent to which EBPs are incorporated in mental health court models has not been empirically studied [134].⁷

Defendants should have access to a wide array of effective treatments that match their particular needs with appropriate care. While not all community-based services for people with mental illnesses qualify as EBPs, and EBPs have not been established for every condition or disorder, several EBPs have particular relevance for court consideration.⁸ The following is a non-exhaustive list of EBPs that have been deemed appropriate for mentally ill criminal offenders.⁹

Assertive Community Treatment (ACT): Treatment coordinated by a multi-disciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for case management and treatment to meet their clients' needs.

⁷ To achieve better results, the natural pre-requisite for using EBPs for treatment is having reliable diagnosis. The importance of accurate evaluation cannot be overemphasized, because the diagnosis should always guide the treatment decisions that follow [147].

⁸ Several guides are available that provide information communities and mental health courts can use to develop and implement core services based on EBPs. For example, see the National Leadership Forum on Behavioral Health/Criminal Justice Services. 2009. *Ending an American tragedy: Addressing the needs of justice-involved people with mental illnesses and co-occurring disorders*. New York.

⁹ Of course, there are several potential challenges associated with implementation and the resource requirement to meet demand in communities where mental health courts connect offenders to treatment.

Psychotropic medications: Medications designed to reduce anxiety, depression, or psychosis by acting on the chemistry of the brain.

Integrated services for co-occurring mental illness and substance disorders: Practices by which providers trained in both substance abuse and mental health services develop a single treatment plan addressing both sets of conditions; consistent interaction with the individual occurs in order to reassess and update appropriate treatment plan accordingly.

Supported employment: A practice that trains people with serious mental disabilities and matches them to jobs where their specific skills and abilities make them valuable assets to employers.

Family psychoeducation: The provision of information and education to families, significant others, and mentally ill individual regarding mental disorders and their treatment to enhance involvement of others who may be essential in assisting the individual in maintaining treatment.

Illness self-management (also known as illness management and recovery): Teaching consumers skills and techniques to minimize the interference of psychiatric symptoms in daily activities.

Cognitive Behavioral Therapy (CBT): A therapeutic approach that attempts to solve problems resulting from dysfunctional thoughts, moods, or behavior through brief, direct, and time-limited structured counseling.

Motivational Enhancement Therapy: A consumer-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

Given the significant impact the appropriateness of treatment and services can have on outcomes, insight into contextual contingencies and programmatic functioning is important. Without clarifying the influences and degree of implementation of evidence-based treatment practices for mental health court participants, it is difficult to draw causal conclusions about subsequent outcomes [95].

3.4 Evidence of positive outcomes¹⁰

3.4.1 Linkage to services and clinical outcomes

Despite a lack of systemic insight into the nature of linkage, evidence indicates that mental health courts do increase utilization rates of mental health services by participants. For example, two Florida mental health courts reported linking 82 percent and 73 percent of its participants to mental health services. At the eight-month follow-up, the latter figure dropped to 57 percent but mental health court participants remained at a higher level of treatment compared to individuals in traditional misdemeanor court [2].

¹⁰ Studies have generally fallen into two categories: process-based and outcome-based evaluations. Process studies examine the inner-workings of mental health court processes. This paper is primarily concerned with outcomes measures, thus this section focuses on studies seeking to evaluate the effects of mental health courts. Some examples of process evaluations, however, include: (1) general descriptions of court processes; (2) participant eligibility criteria; (3) examinations of how mental health court judges interact with participants; (4) participant perceptions of procedural justice; (5) the decision-making calculus and processes of the mental health court; and (6) factors predicting successful mental health court completion.

Other studies mimic these results. Clark County Mental Health Court participants received more hours of case and medication management and attended outpatient services more frequently than they had before mental health court involvement. A 2007 RAND study of the Allegheny County, Pennsylvania mental health court also found higher rates of linkage for court participants when compared to individuals in the traditional jail system [86].

Moreover, a few studies demonstrate a connection between mental health court participation and improved clinical outcomes [87], although one study found no significant changes in the psychiatric symptoms of mental health court participants [88]. A recent meta-analysis further clouds consensus on this issue; researchers concluded that mental health courts do not significantly improve clinical outcomes [83]. Thus, the extent of clinical outcome improvement and the mechanisms producing successful mental health court impact on clinical outcomes remains unclear.

3.4.2 Reduction in recidivism rates

The primary justification used to support mental health courts is the corresponding reduction in recidivism rates for court participants. A growing number of studies show that mental health courts may reduce recidivism for mentally ill offenders [41, 49, 89, 90, 91], moderate the severity of re-arrests [49], or at the very least, that recidivism rates do not increase for mental health court participants [87, 88]. A recent meta-analysis of 18 studies found that mental health courts are moderately effective in

reducing criminal recidivism, and to a lesser extent, improving clinical outcomes [83]. The researchers cautioned, though, that the studies were not methodologically strong, thus limiting any conclusions.

One such study was completed in 2010 in a North Carolina rural mental health court among individuals who successfully completed the program [92]. Graduates of the program were found to be 88 percent less likely to recidivate than their mentally ill counterparts who had failed to complete the program. Re-arrested graduates enjoyed longer periods before re-arrest compared to those removed from the program or those who opted out before completion. Even incomplete program participation correlated with fewer re-arrests after program abandonment than before court entry. However, another study found that non-completers re-arrest rates were not significantly different from that of traditional criminal court defendant [49]. Finally, although this study is limited by its methodology and cannot be generalized across mental health court populations, it is the first study to evaluate participant recidivism two-years after program completion. This suggests that mental health courts may have a sustained impact on participants' risk of recidivism.

Another study, again not statistically significant, evaluated data from the first mental health court in Broward County, Florida and found that recidivism rates were 47 percent for those in the mental health court group compared to 56 percent for the comparison group [88]. Recidivism was measured by re-arrest both in terms of

prevalence (percentage of individuals in each group re-arrested) and incidence (mean number of arrests per group) and evaluated one year after offenders' initial court hearing [63].

In addition to measuring incidence of re-arrests among mental health court participants, another study also examined the severity of the underlying offenses and compared mentally ill defendants to similar defendants in a traditional criminal court not self-selected for mental health court participation. During a 12-month follow up, the traditional court defendants were re-arrested 47 percent more than the mental health court participants and among those re-arrested, mental health court participants did not differ from traditional court participants with regard to severity of the offense [49].

Utilizing a better methodological design, a 2007 San Francisco mental health court study found participants went longer without being charged with a new crime than non-mental health court participants [90]. Researchers used propensity weighting to correct for baseline differences, and the survival analysis showed the likelihood of being involved in a new crime was 26 percent lower for mental health court participants compared to the non-participant group 18 months after mental health court involvement. Furthermore, researchers found the likelihood of mental health court participants being charged with new violent crimes to be 55 percent lower than the comparison group [90].

The study that likely puts forth the strongest methodological findings in support of mental health court outcome success was published in 2011 and examined criminal justice outcomes of mental health court participants in four jurisdictions compared with propensity score-matched controls (to mitigate against selection bias) [4]. The study found that mental health court participants across the four jurisdictions were less likely to be arrested, experienced a larger reduction in arrest rate, spent fewer days incarcerated in the 18 months after program entry compared with matched mentally ill offenders in traditional criminal processing. For mental health court participants, researchers found that substance abuse, schizophrenia, or depression diagnoses, the absence of pre-mental health court treatment, and greater criminal history were correlated with worse criminal justice outcomes [4].

Other examples of positive findings from individual studies include mental health court participants spent fewer days in jail post-release than they had before going through the mental health court [87]; and mental health court participants spent less time in jail than other offenders with mental illness [88].

3.4.3 Reduced criminalization of mentally ill individuals

Another potential advantage to mental health courts is a reduction in the criminalization of mentally ill individuals. By treating the underlying illness that leads to the behaviors for which mentally ill individuals are arrested and prosecuted, mental health courts may help to reverse the trend [93]. Furthermore, focusing on the

rehabilitation and treatment of mentally ill offenders can provide meaningful improvement to quality of life and stem repeated cycling through the criminal justice system. Finally, allowing mentally ill offenders to remain in their communities and receive treatment, as opposed to being incarcerated, helps to break historical stigma and negative perceptions of mentally ill individuals. One study looking at mental health court program completers in Ohio found former participants experienced a higher quality of life through stigma reduction [94].

3.4.4 Cost effectiveness

Mental health court stakeholders frequently cite cost effectiveness as a central reason to expand the reach of existing courts. While some data supports this notion, evidence is limited. Only a handful of cost-focused studies exist. The most referenced study examines the fiscal impacts of the Allegheny County mental health court [86]. Researchers estimate the program saved taxpayers approximately \$3.5 million over a two-year period. Within the first year, mental health service costs increased, but incarceration costs decreased, thus offsetting overall costs related to mental health court operation. A subset of participants was followed for a longer period of time and both average mental health service costs and incarceration costs decreased during that extended period. Reduction in mental health service costs was believed to be the result of Medicaid assistance, which was the primary funding source for mental health services. Moreover, savings appeared greater for participants with felony cases,

psychotic disorders, severe impairment, and low estimates of global functioning.

Finally, the authors specifically pointed to the decrease in cost of the most expensive treatments (like hospitalization), as evidence of the potential for mental health courts to decrease overall costs [86].

Another study reached a similar conclusion with regard to cost of treatment [2].

In this study of the Broward County mental health court, researchers found that traditional court defendants utilized emergency services more than their mental health court counterparts. While these findings are positive, they are not necessarily able to be generalized to other mental health courts.

3.5 Shortcomings of existing research

3.5.1 Generally

Although studies mostly show positive outcomes for mental health courts, methodological weaknesses of studies prevent stakeholders from generalizing across jurisdictions or reaching confident conclusions [3]. Relatively little is known about how the variations in mental health court procedures, treatment, sanctions, and criteria for participation are associated with criminal justice and clinical outcomes. Moreover, many studies rely only on self-reported outcomes, have short-term follow-up, and lack random assignment.

Additionally, most extant studies only examine single, individual mental health court programs. Validity issues are rampant given that mental health courts are non-

standardized by design, highly dependent on macro and local influences within the environment, personal preferences, and relationship dynamics [9]. While this may help to explain conflicting findings across studies, attempts to generalize from these accounts may be particularly misleading without heavily caveating the many important contextual factors.

Commonalities and differences among mental health courts, such as those outlined in descriptive reviews, may be more related to contextual contingencies rather than to the court models [53, 82]. Clarifying how contextual factors impact the implementation of empirically validated treatment models is increasingly understood as central to expanding the application of such models [95]. These principles should be applied to those studies where the effectiveness of individual courts has been demonstrated; understanding the impact of contextual factors informs divergent environment and study validity.

Given the discretion afforded to mental health court judges in terms of adjudication, monitoring, and motivation, inconsistencies in process and outcomes should be expected to the extent that personal preferences and notions of justice have been enshrined. Analogously, the treatment orientation and style of the mental health worker are also likely to be preserved in the treatment plans of clients and in the way compliance is defined and measured. Inter-court variation may arise because personalized decision rules and processes guide the actions of the court staff but also

may result in intra-court variation over time after personnel changes on the court team, especially the replacement of the judge [9].

Additionally, as discussed above, selection bias created by creaming further compromises study validity [83]. This presents a challenge to evaluation studies comparing outcomes to other offenders with mental illness who may already have a higher risk for reoffending than those participating in the mental health court from the outset. It is clear that a more in-depth understanding of why some individuals are excluded from mental health court programs is needed.

Furthermore, there is scant research focusing on questions of efficiency and cost. The Allegheny County cost study is frequently cited as proof that mental health courts reduce the cost burden of incarcerating mentally ill offenders. However, the analysis attempts to translate mental health court impacts, such as reduced future contact with the criminal justice system, into monetary values that are directly compared with the costs associated with traditional court cases. Additionally, this study has little external validity because it only evaluates one particular court.

3.5.2 Recidivism studies

The strongest test of criminal justice diversion programs is the extent to which they actually reduce crime. It is difficult for researchers to draw meaningful conclusions about such criminal justice outcomes for mental health courts. Mental health courts are a relatively recent development, operate idiosyncratically, have few enrollments, and are

strategically difficult to research given the high degree of confidentiality and inaccessibility of mental health treatment records [96]. The lack of rigorous study design among existing studies of recidivism and other outcome measures impedes efforts to draw clear conclusions. Both the external and internal validity of existing studies are questionable.

Systematic error is the greatest source of concern in existing studies. Systematic error results from biases that occur during the design and conduct of the study which lead to spurious associations or measures of association that depart systematically from the true value seeking to be measured.

Sample bias: To identify the causal impact of program participation, the robustness of estimated treatment effect depends on the assumptions that 1) the treated and untreated are balanced on observed covariates and 2) there are no unobserved systematic differences between mental health court participants and their comparison groups. It is likely that important unobservable or unmeasured characteristics distinguish the treatment and comparison groups, and impacted measured recidivism rates.

Self-selection bias: Since mental health courts are voluntary, an intrinsic self-selection bias may skew outcome measures. The San Francisco study is the only existing study that accounts for this by using an “intent to treat” design [90]; this controls for participant motivation and self-selection bias evident in studies used study groups

comprised only of participants who completed the program or met program eligibility requirements.

Motivation and other biases: None of the recidivism studies control for the critical consideration of participant motivation [97]. It is unclear how personal motivation may factor into program success (e.g., completion, commitment to treatment). For example, were mental health court participants more motivated for treatment than nonparticipants? Did the incentive of reduced charges provide a compelling legal motivation that overrode any treatment reluctance? Were program completers more motivated than non-completers [97]? To what extent does creaming impact outcomes? Some data suggests that nonparticipants had more severe mental health diagnoses than participants. While one study used an intent-to-treat model to account for this, most studies did not account for this in their findings.

Confounding variables: It is likely that various confounders are mediating the results researchers claim. Study participants vary on many factors not captured in study data and to the extent that these variables are not identified or accounted for in study design, study results are limited. For example, mental health courts work with many treatment providers that have different specialties, capacities, and treatment approaches. Measuring the linking of a participant to a treatment provider creates a binary result as to the exposure (treatment), but does not account for the variations that likely affect

treatment success. The nature and extent of treatment provided should be captured in future studies.

A further qualification to these positive findings is the assumption researchers made that participants would not have been linked to treatment without the assistance of the mental health courts.

Additionally, higher rates of mental health court participant recidivism could have been the result of police refraining from arresting mentally ill offenders they knew to be in the mental health program. Also, simply being re-arrested or not does not necessarily provide a true measure of recidivism. Moreover, criminal activity that went undetected by police is not included in the dependent variable.

Inadequate statistical power: In most of the studies, there may have been inadequate statistical power to detect certain effects, which is important to consider in light of the environment within which the study findings were constructed. Failure to detect an effect when one exists (Type II error) may have just as much impact on the policy implications of the data as the more typical concerns about reporting an effect where none exists (Type I error).

3.6 Conclusion

Ultimately, there is mixed evidence with regard to mental health court outcomes and their effectiveness in reducing criminal behavior. There are five main challenges to the assessment of mental health courts that make the case study approach and existing

research methodologically problematic: (1) the nature of the intervention; (2) the control condition; (3) the subject sample; (4) the exposure protocol; and (5) the observation period. To conduct an effective evaluation of these courts, the emphasis needs to be on how variation in the environmental conditions, program characteristics, and the selection process might interact with the mental health court intervention in ways that limit the validity of findings [9]. Currently, it is not necessarily the data that is driving the results, but rather the assumptions regarding the functional form of the relationship.

Weaknesses in experimental design notwithstanding, existing studies suggest that mental health courts are achieving at least some of their intended goals, including the primary goal of reducing criminal justice system involvement for mentally ill individuals [49, 91].

In summary, studies have claimed:

- High levels of satisfaction and perceptions of fairness with mental health court procedures and treatments by participants [2].
- Reduced recidivism after participation in a mental health court [49, 88, 90, 91, 94].
- Fewer days spent in jail by those in the mental health court system than those processed in the traditional court system [2].
- Improvements in outcomes such as reduced homelessness, psychiatric hospitalizations, frequency and levels of substance and alcohol abuse and improvements in psychosocial functioning [87].
- Community cost savings associated with mental health court functioning [86].

Given the state of the field, additional research is warranted to fill gaps in knowledge and help stimulate informed decision-making and investment by

practitioners who are either implementing new mental health courts or strengthening existing efforts.

4. Research Methods

4.1 Objective

The substantial numbers of people with mental illness in prisons and jails has been the focus of policy makers and social scientists for the past several decades. Mental health courts represent an area of social science research in which empiricism struggles to keep pace with policy and practice. Since 1997 when the Broward County mental health court accepted its first defendant, 300 mental health courts have developed and a cluster of research attempting to document the positive effects of mental health courts has recently emerged [49, 88, 92]. Yet, it is almost impossible to calculate the long-term or systemic impact of mental health courts on mentally ill criminal offenders. Because existing courts enroll a relatively insignificant proportion of this population, have limited duration, and vary wildly in procedures and resources, no study has been able to produce generalizable data with regard to outcome measures.

As communities, states, and the federal government look to allocate precious resources toward proven, evidence-based initiatives, the promise of mental health courts must be better established with aggregate level outcome data using viable counterfactual analysis. By utilizing a novel research methodology that looks at aggregate level data, this study aims to overcome many existing methodological flaws for determining whether participation in mental health courts reduces recidivism rates for mentally ill criminal offenders.

4.2 Proposed study design: Synthetic control method

4.2.1 Synthetic control method

The purpose of this study is to evaluate the aggregate effects of specialty mental health interventions on the rates of recidivism for mentally ill criminal offenders. To do so, this study proposes the use of the synthetic control method initially introduced by Abadie and Gardeazabel in 2003 [99] and later extended in Abadie et al. in 2010 [100].¹

The synthetic control method is a data-driven mechanism for examining the effects of policy interventions, in particular for case studies where a limited number of units undergoes a “treatment” (e.g. a policy or legislative change) in a given sample period. The basic idea is to construct a weighted combination of control units based on pre-intervention characteristics, which is expected to provide a better counterfactual than a single control unit for the treated unit(s) [99, 100]. The relative contribution of each available control unit is made explicit in the model, as well as the degree of similarity prior to treatment between a treated unit and its synthetic counterpart.

Furthermore, this method incorporates a test for statistical significance of the estimated intervention impact by using a placebo test [100]. Akin to permutation tests, a placebo test applies the synthetic control method to each control unit, treating each as if

¹ The synthetic control method has recently garnered increased attention among researchers and policymakers. A growing number of studies are employing this method [110, 112, 113, 114, 115, 116]. Most recently, the World Bank published a blog post drawing attention to the empirical benefits when evaluating effects of policies at the national, state, or regional level. McKenzie, D. 2013. Evaluating regulatory reforms using the synthetic control method. *Development impact: News, views, methods, and insights from the world of impact evaluation*. World Bank (March 4, 2013).

it were exposed to the intervention and comparing the actual estimated effect with that of each control unit. If the hypothesis is that the intervention impacted observed outcomes, the actual estimate will be large relative to the distribution of the placebo estimates.

4.2.2 Rationale for synthetic control method

Policymakers and stakeholders focus on causal questions about the effects of historical events and policy interventions on aggregate units, such as counties, cities, and states [100]. Since impacts can only be understood as relative measures – in comparison to either different groups of people or to different points in time – comparative case studies are typically used to assess effects. In a comparative case study, researchers estimate the evolution of aggregate outcomes (e.g. rates of crime, disease, income) for a unit affected by the occurrence of a particular event, intervention, or policy and compare it to the evolution of the same aggregate estimates for a control group that is unaffected by the event, intervention, or policy. While comparative case studies are a way to measure impact, these research studies are limited by empirical challenges: ambiguity or difficulty in choosing valid comparison groups (as described earlier) and biases where data may be selected on a sample of disaggregated units and inferential techniques that measure only uncertainty about the aggregate values of the data in the population.

These limitations plague existing mental health court studies. Mental health court research evaluating recidivism trends for mentally ill offenders have been constrained by resource and practicality issues, generally requiring courts to seek comparisons for each case within itself (i.e. focusing on how court participants perform before court participation compared with during and after mental health court participation) [101]. Where researchers have been able to conduct studies using a comparison control group, the plethora of selection biases, limited time-frames, and idiosyncratic contextual factors make it doubtful that control units used can credibly proxy for counterfactual outcomes of mental health court participants. The result is that findings cannot be generalized and it is unclear whether outcomes reported can be attributed to the mental health court intervention. As discussed above, case studies have proven ineffective in achieving meaningful conclusions.

Randomized controlled trials, often hailed the gold standard of clinical trials, are also inappropriate for the study of mental health court outcomes. The distinguishing feature of a randomized trial is that study subjects are assessed and deemed eligible for program participation and then randomly assigned to either a control or treatment group. The groups are followed in the same way, and theoretically, the only differences between the care they receive is the treatment or program being evaluated [150]. The primary benefit of this research method is its ability to minimize selection bias and confounding.

While random control studies may be desirable, they are impractical for the evaluation of mental health court outcomes. Additional criteria must hold in order to establish causality and avoid bias for interventions that must change human behavior to be effective [150]. These include: 1) the intervention “can be isolated from other activities...and the purpose of the study is to assess the isolated effect;” 2) the intervention has “a short timeframe” between its implementation and maturity of its effects; 3) the causal mechanisms “have a stable and predictable relationship to exogenous factors;” and 4) the causal mechanisms “would act in the same way if the control group and intervention group were reversed” [150].

Mental health courts cannot be isolated from other activities because they function in a multi-faceted context. Moreover, mental illness and recidivism rates are the product of a complicated web of factors. The effect of any one or cluster of programmatic elements is almost impossible to isolate. Additionally, mental illness and recidivism are not binary or static. Plus, to see the positive effects of mental health court participation it generally takes longer than “a short timeframe.” Finally, the deep variability in all aspects of mental health court functioning and the unique contours of each individual participant’s mental illness make this research method insufficient to

estimate mental health court outcomes (even if the ethics of random assignment were suspended).²

Thus, to evaluate whether lower recidivism rates can be attributed to mental health courts, a new methodology is needed. The synthetic control method can avoid these pitfalls. This model shares the benefit claimed by the randomized trial of reducing discretion in the construction of comparison control groups. It also forces affinities between affected and unaffected units to be demonstrated using observed quantifiable characteristics [100]. Further, the synthetic control method allows for the measure of aggregate effects. Since mental health and criminal justice policies are matters of state policy (in part), it is appropriate to conduct an analysis at the state level.

As federal and state governments increasingly focus priorities on addressing mental illness and improving the criminal justice system, measuring the aggregate effects of mental health court interventions can help to facilitate meaningful policy initiatives and fiscal investments. By using the synthetic control method, this study offers a superior framework for assessing the suitability of the chosen control group and a means of producing quantitative inference.

² The principle of clinical equipoise requires the general uncertainty within the expert medical community about the preferred treatment remains the minimum ethical standard required for randomized trials. Given the great body of research explicating the harms and risks associated with incarcerating mentally ill offenders, it is unlikely that anyone could claim community-based treatment facilitated by mental health court participation is equally preferable to incarceration.

4.3 Study design

4.3.1 Basic requirements

In order to conduct an empirically rigorous study using the synthetic control method to isolate the impact of an intervention, certain criteria must hold [102]:

1) Significant intervention: The intervention must be significant at the level of the unit of treatment, which can be the country, state, city, or other unit in which aggregate data is evaluated. For example, researchers used a large-scale tobacco control program established in California to evaluate the legislation's effect on tobacco consumption (compared to the counterfactual estimates of cigarette sales in California in the absence of the legislation) [100]. Similarly, in the study that originated the synthetic control method, researchers estimated the economic growth the Basque Country would have experienced absent widespread terrorism [99]. The aggregate level of terrorism functioned as the intervention [99].

2) Absence of significant exclusive shocks: The effect of the intervention can only be accurately estimated if the period of intervention was not characterized by any significant shocks exclusively affecting the treated unit. For example, if a country adopted anti-corruption laws and simultaneously a civil war broke out inside the country, it would not be feasible to isolate the effects of the anti-corruption program given that the civil war affects the production and allocation of resources as well.

However, cyclical shocks are not problematic if they affect the treated and control groups similarly.

3) Non-interference across units: The effect of the intervention cannot have an effect on the untreated units or the units will fail to proxy for the counterfactual scenario.

4) Significant pre-treatment period: The synthetic control approach uses the variation in the pre-treatment period across the treatment pool to create a synthetic control unit that mimics the treated unit pre-intervention. The longer the pre-treatment period, the less likely possible biases accrue due to unobservable time-variant characteristics.

5) Bounding criteria: For this approach to work, there must be a weighted combination of untreated units that closely mimics the treated unit before the intervention. If a unit is very far from other units in terms of the observed variables of interest, then the synthetic control method cannot give accurate predictions for the counterfactual.

4.3.2 Selected intervention: CA's Public Safety Realignment Act

The current state of mental health courts in the United States does not constitute a significant intervention for the purposes of a synthetic control study. Mental health courts have developed sporadically and in an ad hoc manner since 1997, and although there are now 300 that exist around the country, their relative impact is minimal

(averaging only 36 clients per year) compared to the overall processing of mentally ill offenders in the criminal justice system [71]. Even at an individual county level, mental health courts do not have significant contact with the total population of mentally ill criminal offenders to allow for aggregate level data and inferences [71].

Thus, it is necessary to use a proxy intervention that will impact mentally ill criminal offenders to evaluate trends in recidivism rates for mentally ill criminal offenders. The intervention to be used is statewide legislation in California's Assembly Bill 109: Public Safety Realignment Act.³

In April 2011, the California legislature passed the Public Safety Realignment Act, triggering a historic shift in corrections policy in California. The priority status and swift allocation of resources devoted to the implementation of this legislation was driven by budgetary and operational issues, and most notably, by a judicial mandate from the United States Supreme Court [103]. In *Brown v. Plata*, the Court affirmed the lower court's order to reduce California's prison population from 200 percent to 137 percent of design capacity. This amounted to the required removal of 30,000-40,000 state prisoners out of the system within two years [67, 100].

The case was the consolidation of two class action lawsuits filed against California officials for indifference to inmate medical and mental health needs[67]. The

³ See A.B. 109, 2011-12 Reg. Sess. (Cal. 2011), available at http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0101-0150/ab_109_bill_20110329_enrolled.html (effective date Oct. 1, 2011); 2011 Public Safety Realignment Fact Sheet, Cal. Dep't Corrections & Rehabilitation (Dec. 16, 2011), available at: <http://www.cdcr.ca.gov/realignment/docs/Realignment-Fact-Sheet.pdf>.

Court held that California's prison conditions amounted to "cruel and unusual punishment" and highlighted the issue of mental illness and the special treatment mentally ill offenders require and are constitutionally entitled to receive [67]. The record demonstrated that transferring prisoners between facilities would be inadequate to reduce overcrowding. Given California's budgetary crisis, new prisons were deemed unlikely to be built [67]. Thus, mass incarceration officially became an untenable policy, and a new approach to handling criminal offenders was mandated by judicial fiat.

In response to the Supreme Court's order, Assembly Bill 109 was passed and signed into law by Governor Jerry Brown, now commonly referred to as "realignment." Realignment tasks counties with implementing the most significant changes in California's criminal justice system in decades: realignment shifts to counties the responsibility for monitoring, tracking, incarcerating, and caring for low-level offenders previously housed or bound for state prison. In addition to the 30,000-40,000 state prisoners that will transition from state corrections to California's 58 counties, local jurisdictions will take on the supervision of roughly 60,000 offenders on Post-Release Community Supervision by the end of 2013 [148].

In enacting realignment, the legislature explicitly encouraged counties to use evidence-based alternatives to incarceration, recognizing that "building and operating more prisons to address community safety concerns [is] not sustainable, and will not

result in improved public safety.”⁴ In large part, realignment was intended to focus on addressing the mentally ill criminal offender population. The population shift in county jails and local supervision agencies will require a new commitment to effectively managing mentally ill offenders. Currently, many counties are ill equipped to do so because of inadequate resources and funding shortages. With prison no longer an option for most offenders cycling through local courts, counties will have to develop functional alternatives, particularly for mentally ill offenders [103].

Mental health courts have been explicitly identified as a crucial model to be replicated across the state because of their ability to divert mentally ill offenders from the criminal justice system and free up resources in county jails. The legislature emphasized collaboration as a necessary prerequisite in removing mentally ill people from harmful incarceration and instructed communities to seek alternative measures [68]. The anticipated result is a vast increase in mental health courts and the number of offenders processed through that system [103].

⁴ See Cal. Penal Code § 17.5, codifying legislative findings: “California must reinvest its criminal justice resources to support community-based corrections programs...to facilitate their reintegration back into society. Community-based corrections programs require a partnership between local public safety entities and the county to provide and expand the use of community-based punishment for low-level offender populations.” Section 17.5 defines “community-based punishment” as “correctional sanctions and programming encompassing a range of custodial and noncustodial responses to criminal or noncompliant offender activity.”

4.3.3 Research question

Part 1 - Policy impact: In California, what is the effect of Assembly Bill 109 (realignment) on recidivism rates for mentally ill criminal offenders?

Part 2 - Mechanism: If outcome measures show a change in recidivism rates among mentally ill criminal offenders, was it associated with an increase in the use of mental health courts or other diversionary programs?

4.3.4 Data

Synthetic control methods involve the construction of synthetic control units as convex combinations of multiple control units. The weights that define the synthetic control unit are chosen such that the synthetic control unit best approximates the relevant characteristics of the treated unit during the pre-intervention period. The post-intervention outcomes for the synthetic control unit are then used to estimate the outcomes that would have been observed for the treated unit in the absence of the intervention.

This study will use annual state-level data for the period 1995-2018. Assembly Bill 109, establishing realignment, was passed and went into effect in October 2011. This gives the study 16 years of pre-intervention data. The sample period begins in 1995 because it is one of the first years for which multi-variable data on criminal offenders was systematically kept in California and most other states. It ends in 2018 in order to give policymakers a five-year reflection point for the effects of realignment and the

potential status and impact of mental health courts and other diversionary programs. Although unlikely, it is possible that other control states adopt and implement legislation mirroring the key elements of Assembly Bill 109. To the extent that this occurs, such states will be invalid as potential control units. Moreover, while realignment must be completed by 2013, the reactive criminal justice reforms began in 2011, and thus the plausible prediction of the effect of this legislation provides a seven-year period, which should be sufficient for observation.

The theory behind the synthetic control method is to construct the best counterfactual from the control pool in the absence of the intervention. Thus, the creation of the synthetic California should be constructed using the weighted average of potential control states so that the resulting synthetic California best reproduces the values of a set of predictors of recidivism of mentally ill offenders in California before realignment. A data-driven search for comparison states on pre-realignment characteristics should inform this process. For example, New York should likely be discarded from the donor pool given recent legislation, funding, and stakeholder investment in mental health courts and interventions. States with similar levels of existing mental health courts as California do not need to be discarded because these courts do not impact aggregate level data and they mimic California's pre-intervention status on this element.

The state-level outcome measure of interest is the recidivism rates of mentally ill offenders. Recidivism rates will be defined as new charges, new convictions, and returns to incarceration or court supervision. Re-arrest is sometimes used as a measure of recidivism but is excluded from this study for two main reasons: 1) statistics on included measures are readily available at the state level whereas re-arrest data is published to a less reliable degree; and 2) re-arrest is a less pure measure of additional criminal activity. As described above, there are several reasons mentally ill offenders may be arrested that have little connection to a repeated criminal behavior.

Recidivism rates are a function, in part, of state-level measures of: unemployment; education (and drop out rates); income inequality; minimum wage; poverty levels; crime rates (across several indicators, e.g. severity, type, registration requirements, previous incarcerations); population density; incarceration rates (and associated factors: e.g., average length of stay); demographic composition (e.g. race, sex, age); health status (physical and mental); and homelessness rates [see, e.g. 104].

These variables have been identified based on research that exists today. This is likely an incomplete set of variables to measure. Additionally, the state of knowledge with regard to mental health and its underlying influences will surely have advanced by the time this study is conducted in 2018. To safeguard against creating an inaccurately weighted or incomplete model, the identified factors predicting recidivism rates should be updated and expanded accordingly.

The state level data that the study will use will be collected from several different sources [see Appendix G for data sources]. Observed covariates will be averaged over the entire pre-intervention period, and moreover, for the outcome of interest.

4.3.5 Data analysis

Using the techniques outlined above, a synthetic California will be created that mirrors the values of the predictors of recidivism for mentally ill offenders in California before the implementation of realignment. Based on existing literature and theory, it is estimated that the effect of realignment on recidivism rates for mentally ill criminal offenders will be the difference in levels between California and its synthetic versions in the years after Assembly bill 109 was passed. Using a statistical computational program such as STATA, an in-depth statistical analysis of the difference in outcome measures observed between the synthetic model and real California data can be evaluated.⁵

To check the statistical significance of the resulting estimates and confirm they are not driven by random chance, a placebo test should be conducted [99,105]. Abadie and Garbeazabal (2003) put forth a model for running a placebo study by applying the synthetic control method to states that did not implement a large-scale criminal justice reform similar to realignment during the study sample period [99]. When applying the

⁵ Sample STATA program code and data files are published and available for free online. See Abadie, A., Diamond, A., and Hainmueller, J. 2011. SYNTH: STATA module to implement synthetic control methods for comparative case studies: <http://econpapers.repec.org/software/bocbocode/s457334.htm>. Code for implementing this method using Matlab and R are available: <http://www.mit.edu/~jhainm/synthpage.html>.

synthetic control method to each control units as if they were exposed to the intervention and comparing the actual estimated effect with that of each control unit, if the realignment had an impact, the actual estimate should be large relative to the distribution of the placebo estimates.

Finally, once it has been determined that recidivism rates changed in some direction, the mechanisms by which they changed should be evaluated.⁶ This will tie the research back to mental health courts and evaluate how the shift in recidivism rates among mentally ill criminal offenders occurred.⁷

4.3.6 Anticipated outcomes and limitations

The body of research on mental health courts is limited, but enough support exists in broader studies and theoretical models of criminal justice and mental illness to anticipate study results will correspond with a greater reduction in recidivism rates for mentally ill offenders in post-realignment California compared to its synthetic counterpart. As discussed in the literature review above, criminalizing mental illness only exacerbates challenges mentally ill individuals face. While incarcerated, a mentally ill offender typically struggles to maintain medication and treatment regimens, housing, and a job, psychiatric symptoms worsen and he returns to the community in worse

⁶ See Appendix G for data to be sourced and used in the analysis.

⁷ Note: the effect of realignment on prevalence of mental illness in prisons, jails and under general correctional supervision as well as the effects of realignment on costs can also be evaluated through this study design.

condition than at the time of arrest. Realignment likely halts this “revolving door phenomenon” because it requires a novel approach to handling this specific category of offenders – with the explicit goal of facilitating decarceration.

Realignment’s forced reduction of prison inmates, particularly the adoption of a rule excluding low level offenders from serving time in prison, also means that mentally ill offenders can avoid the trauma of prison-related victimization and isolation and participate in alternative programs. Communities have committed to developing mental health courts and other collaborative programs grounded in evidence-based practices, so to the extent that this has materialized, mentally ill offenders’ health and criminal justice involvement should be improved. Additionally, with fewer individuals under correctional control, mentally ill offenders who do enter the system (e.g. for violent crimes) are more likely to access mental health care and program assistance for the duration of their sentence.

In light of the rationale laid out in the first portion of this paper, researchers should feel confident that realignment has had a positive effect on recidivism rates if the results yield a clean divergence in trend lines between California and synthetic California. If this effect is seen, the implication is that California’s differential occurred as a result of its exposure to realignment. Researchers should feel confident the model worked and the differential was not due to random error, confounding, or bias.

If the study shows a negative effect (an increase) of recidivism rates for mentally ill offenders, or, if no meaningful effect is measured between California and synthetic California, it does not necessarily mean the hypothesis is null. There are several potential explanations. First, the model is only as strong as the extent to which relevant variables are correctly identified and measured. Until the analysis is run, it is difficult to determine the comprehensiveness of included variables. Investing in the development of an appropriate weighting matrix and an over-inclusive list of variables before running the model is recommended. To go back and add missed variables as a later fix presents an air of data manipulation. Consequently, to safeguard against an incomplete or inaccurate model, the factors predicting recidivism rates should be rigorously analyzed and updated when the study is conducted. Similarly, a null result may indicate a misalignment between the weighting of measured control unit variables and unknowable, unmeasured control unit variables given the same relative weight in the model. Both the absence of key variables in the model and the disproportionate capture of unknowable variables are model deficiencies that may explain the lack of effect.

When interpreting results in this model, it is also important to make sure an inferential leap between macroeconomic events and individual symptomatology is avoided. This error in interpretation of statistical data is known as the ecological fallacy [149]. The ecological fallacy is evident when correlations among measures of individual characteristics are directly inferred from aggregate-level relationships [149]. For

example, there may be a greater reduction in recidivism rates for the aggregate group of mentally ill offenders at the state level compared to the reduction in recidivism rates witnessed by a given individual county court or by individuals within the court.

Study limitations may also stem from possible inadequacies of any the five criteria for the synthetic control method described above. It is possible that realignment does not rise to the level of “significant intervention” in practice. Despite political claims to the contrary, realignment may not effect change in overcrowding, sentencing, or access to services for mentally ill offenders. County jails were built to accommodate offenders with shorter-term sentences; before realignment a person could not be sentenced to county jail for more than one year [148]. Sentences longer than one year had to be serviced in state prison regardless of the nature of the crime. Since county jails were established for shorter-term stays, they traditionally lacked many of the educational, treatment, and group programming available to prison inmates. Moreover, they have less outdoor and visitor space for inmates, and are less capable of managing serious or long-term medical conditions compared to prisons [148]. As prisoners shift to county jails, the problems of state-level incarceration may follow them to this new jurisdiction. It is possible that counties do not invest in diversionary programs for budgetary reason, or may fail to for political reasons (e.g. a desire to appear “tough on crime”), and the issues that currently exist at the state level is replicated at the county level. In such a situation, realignment may have no effect or may worsen conditions for

mentally ill individuals.

Another confounding scenario is if an event representing a significant exclusive shock renders the second criteria null. The effect of realignment can only be estimated if the study period is not marked by independent events also impacting recidivism rates. For example, the passage of a law legalizing marijuana may constitute a significant shock because it would likely affect measures of recidivism among mentally ill individuals (and is wholly disconnected from the policy of realignment). Mentally ill individuals commit low-level drug offenses at high rates and are at greater risk of being prosecuted for marijuana-related charges than the general population. Thus, the legalization of marijuana could reduce recidivism rates significantly and skew study estimates. On the other hand, if the marijuana law was adopted in response to realignment as a mechanism for limiting the number of criminal offenders in the system (thus, a policy choice about what types of behavior to criminalize), then the law and its effects could be characterized as part of the larger policy and effects of realignment. Thus, it would not necessarily be a detriment to study validity.

A different type of exclusive shock that would impede causal conclusions of this study is if a significant health-related intervention affects the mentally ill offender population. For example, innovation in antipsychotic medications may independently reduce likelihood of criminal behavior. Again, however, if correctional system

programs established in the wake of realignment provide access to the new medication, it may still be possible to make an argument for causal estimates.

Additionally, interference across untreated units could violate the third criteria for modeling causal estimates. If the states comprising the synthetic California (weighted according to relevant variables) also implement policies analogous to realignment, there is no longer a viable counterfactual scenario because all (or some) experienced exposure to the intervention. Results may be contaminated to the extent that states adopt partial similar policies or have crossover effects, as well.

One of the benefits of the synthetic control method is that aggregate level data is published more frequently and can be obtained at lower cost compared to individual unit data. For this study, statistics for identified relevant variables have been collected for decades. Despite the availability of a long period of state-level data, however, data collection may be tainted by non-uniform collection and reporting procedures. If important variables are captured differently throughout the pre-treatment and post-treatment period, or if donor states use divergent methods to collect or calculate the same statistics, model estimates may be an inaccurate measure of recidivism rates among mentally ill offenders over time.

Finally, it's possible that mental health courts do not develop further and California chooses to adopt various other alternative criminal justice options instead. If

so, the impact of realignment on recidivism can still be measured, but it would no longer implicate an analysis of the effectiveness of mental health courts.

5. Conclusion and Future Research

This paper examines the staggering number of people with mental illnesses under corrections supervision, the reasons why this population is particularly unfit for traditional punitive criminal justice schemes, and summarizes the state of mental health courts and corresponding research aimed at evaluating this new approach to criminal case processing. As communities, states and the federal government look to allocate scarce resources toward proven, evidence-based initiatives, mental health courts and alternative community-based programs have become a meaningful part of the discussion for systemic reform and outcome improvement.

Legal commands and establishments, whether judicial, legislative, or executive, emanate from social conditions, affect them, and are in turn affected by them. These interactions are not so much governed by the intentions or aspirations of the government body designing them, or even the explicit terms of the formal commands themselves, but rather by the realities of human affairs. Existing research shows insight into the question of how a formal command such as the creation of a mental health court is implemented, but its real-life impact remains opaque. The wide diversity and many permutations of mental health courts and the lack of scientific rigor with which results of some of these programs are reported do not lend themselves to using evidence-based research to guide future policy in this area.

Similarly, with the adoption of Assembly Bill 109, there are many open questions about how the commands of realignment will be implemented and what its consequences and effects will be on communities and the state of California. Will realignment reduce criminal recidivism rates for mentally ill adults? Will the mechanism for change be an increase in mental health courts or other diversionary programs? This paper lays the foundation for the provision of sound data points that can inform the development and implementation of effective interventions for mentally ill criminal offenders. By using the results of the proposed study design, policymakers can base decision-making and funding allocations on aggregate level data about recidivism rates.

Next steps should begin to answer open questions presented above and introduced by study results. With regard to the study proposed here, an evaluation of why a change in recidivism rates is observed should be explored by examining county and community level heterogeneity. An empirical study should exploits the differences in realignment reform on county-specific incarceration rates and the county-specific programmatic adoptions in light of realignment. Similar analyses can delve deeper and evaluate other mechanisms that may be related to contextual factors.

Future research should also analyze court processing. Current gaps in the literature include a lack of detail for the personal qualifications and experience of mental health court actors, why certain individuals choose not to participate in a court, how

various levers are used by court to achieve results, and the types of treatment mental health courts link participants to and their associated outcomes. Depending on the location of the court (e.g. rural or urban), the amount of funding they have in place to operate day-to-day, and other related factors, treatments likely vary from court to court. There should be an effort to examine what types of services mental health court participants are being referred to, who are the providers of these services, and how they are paid for, as well as linkage rates post-court completion. Mental health courts do not have control over the service providers and existing treatment options. Holding providers accountable for the services they provide is just on hurdle mental health courts cannot jump. Communication between court staff and services providers is essential to provide the best possible outcomes for success of the participant.

Therefore, the real question becomes not are mental health courts effective, but for whom and by what means? Questions for future questions should include: 1) Are there certain participant characteristics associated with specific outcomes? 2) Are there differences between those offenders who chose to participant and those who do not? 3) Which of the key elements are most effective? 4) What specific types of treatment have the most positive outcome for participants? 5) To what extent are evidence-based treatment grounded in psychological theory and principles of behavior being utilized? 6) What types of offenses correspond tot he most positive outcomes? 7) What happens when individuals are no longer under court supervision?

Answering these questions will help strengthen the mental health court model and facilitate targeted improvements that can lead to better outcomes for participants.

Appendix A: Diagnostic Information (DSM-IV)

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability.

5-Axis Diagnosis

Axis I: clinical disorders, including major mental disorders, as well as developmental and learning disorders. Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, and schizophrenia.

Axis II: underlying pervasive or personality conditions, as well as mental retardation. Common Axis II disorders include borderline personality disorder, schizotypal personality disorder, antisocial personality disorder, narcissistic personality disorder, paranoid personality disorder and mild mental retardation.

Axis III: Acute medical conditions and physical disorders. Common Axis III disorders include brain injuries and other medical/physical disorders, which may aggravate existing diseases or present symptoms similar to other disorders

Axis IV: psychosocial and environmental factors contributing to the disorder

Axis V: Global Assessment of Functioning or Children's Global Assessment Scale for children under the age of 18 (on a scale from 100 to 0).

Personality Disorder

An enduring pattern of inner experience and behavior that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances. Personality disorders are characterized by the chronic use of mechanisms of coping in an inappropriate, stereotyped, and maladaptive manner. Ten personality disorders, grouped into 3 clusters, are defined in the DSM-IV:

Cluster A: Odd or eccentric behavior. Includes:
Paranoid personality disorder

Schizoid personality disorder

Cluster B: Dramatic, emotional or erratic behavior. Includes:

Antisocial personality disorder
Borderline personality disorder
Histrionic personality disorder
Narcissistic personality disorder

Cluster C: Anxious fearful behavior. Includes:

Avoidant personality disorder
Dependent personality disorder
Obsessive-compulsive personality disorder

Dual-Diagnosis

A diagnosis of both mental illness and substance abuse.

Triple-Diagnosis

A diagnosis of mental illness, substance abuse and HIV/AIDS

Appendix B: Rates of Incarceration and Mental Illness¹

Percent of inmates with mental health problems²

| Mental health problem | State prison | Federal prison | Local jail |
|------------------------------------------|--------------|----------------|------------|
| Total | 56.2 | 44.8 | 64.2 |
| Symptoms in 12 months prior to interview | 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 |

Percent of inmates with mental health problems, by selected characteristics

| Selected characteristics | State prison | | Local jail | |
|---------------------------------------|----------------|---------|----------------|---------|
| | Mental problem | Without | Mental Problem | Without |
| Criminal record | | | | |
| Current or past violent offense | 61 | 56 | 44 | 36 |
| 3 or more prior incarcerations | 25 | 19 | 26 | 20 |
| Substance dependence or abuse | 74 | 56 | 76 | 53 |
| Drug use in month before arrest | 63 | 49 | 62 | 42 |
| Family background | | | | |
| Homelessness in year before arrest | 13 | 6 | 17 | 9 |
| Past physical or sexual abuse | 27 | 10 | 24 | 8 |
| Parents abused alcohol or drugs | 39 | 25 | 37 | 19 |
| Charged with violating facility rules | 58 | 43 | 19 | 9 |
| Physical or verbal assault | 24 | 14 | 8 | 2 |
| Injured in a fight since admission | 20 | 10 | 9 | 3 |

¹ Data sourced from Survey of Inmates in State and Federal Correctional Facilities, 2004, and Survey of Inmates in Local Jails, 2002 [21].

² Sources on measuring symptoms of mental disorder based on a Structured Clinical Interview for the DSM-IV [see 118, 119, 120].

Percent of inmates with mental health problems, by demographics³

| Demographics | | State prison | Federal prison | Local jail |
|--------------|---------------|--------------|----------------|------------|
| Gender | All inmates | 56.2 | 44.8 | 64.2 |
| | Male | 55 | 43.6 | 62.8 |
| | Female | 73.1 | 61.2 | 75.4 |
| Race | White | 62.2 | 49.6 | 71.2 |
| | Black | 54.7 | 45.9 | 63.4 |
| | Hispanic | 46.3 | 36.8 | 50.7 |
| | Other | 61.9 | 50.3 | 69.5 |
| Age | 24 or younger | 62.6 | 57.8 | 70.3 |
| | 25-34 | 57.9 | 48.2 | 64.8 |
| | 35-44 | 55.9 | 40.1 | 62 |
| | 45-54 | 51.3 | 41.6 | 52.5 |
| | 55 or older | 39.6 | 36.1 | 52.4 |

Substance dependence or abuse among inmates, by mental health status⁴

| | State prison | | Federal Prison | | Local jail | |
|----------------------|----------------|---------|----------------|---------|----------------|---------|
| | Mental problem | Without | Mental problem | Without | Mental problem | Without |
| Any alcohol or drugs | 74.1 | 55.6 | 63.6 | 49.5 | 76.4 | 53.2 |
| Dependence | 53.9 | 34.5 | 45.1 | 27.3 | 56.3 | 25.4 |
| Abuse only | 20.2 | 21.1 | 18.5 | 22.2 | 20.1 | 27.8 |
| Alcohol | 50.8 | 36 | 43.7 | 30.3 | 53.4 | 34.6 |
| Dependence | 30.4 | 17.9 | 25.1 | 12.7 | 29 | 11.8 |
| Abuse only | 20.4 | 18 | 18.6 | 17.7 | 24.4 | 22.8 |
| Drugs | 61.9 | 42.6 | 53.2 | 39.2 | 63.3 | 36 |
| Dependence | 43.8 | 26.1 | 37.1 | 22 | 46 | 17.6 |
| Abuse only | 18 | 16.5 | 16.1 | 17.2 | 17.3 | 18.4 |

³ Note: statistics calculated using the following definitions: White excludes persons of Hispanic Origin; Black includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and inmates who specified more than one race; and Other excludes persons of Hispanic origin; includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and inmates who specified more than one race.

⁴ Substance dependence or abuse was measured based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition [118].

Appendix C: Relevant Federal Legislation

C.1 America's Law Enforcement and Mental Health Project¹

PL 106–515, November 13, 2000, 114 Stat 2399

UNITED STATES PUBLIC LAWS
106th Congress - Second Session
Convening January 24, 2000

PL 106–515 (S 1865)
November 13, 2000

AMERICA'S LAW ENFORCEMENT AND MENTAL HEALTH PROJECT

An Act to provide grants to establish demonstration mental health courts.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “America's Law Enforcement and Mental Health Project”.

SEC. 2. FINDINGS.

Congress finds that—

- (1) fully 16 percent of all inmates in State prisons and local jails suffer from mental illness, according to a July, 1999 report, conducted by the Bureau of Justice Statistics;
- (2) between 600,000 and 700,000 mentally ill persons are annually booked in jail alone, according to the American Jail Association;
- (3) estimates say 25 to 40 percent of America's mentally ill will come into contact with the criminal justice system, according to National Alliance for the Mentally Ill;
- (4) 75 percent of mentally ill inmates have been sentenced to time in prison or jail or probation at least once prior to their current sentence, according to the Bureau of Justice Statistics in July, 1999; and
- (5) Broward County, Florida and King County, Washington, have created separate Mental Health Courts to place nonviolent mentally ill offenders into judicially

¹ Relevant portions of the legislation are included here.

monitored inpatient and outpatient mental health treatment programs, where appropriate, with positive results.

SEC. 3. MENTAL HEALTH COURTS.

(a) AMENDMENT.— Title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended by inserting after part U (42 U.S.C. 3796hh et seq.) the following:

“PART V—MENTAL HEALTH COURTS

‘SEC. 2201. GRANT AUTHORITY.

“The Attorney General shall make grants to States, State courts, local courts, units of local government, and Indian tribal governments, acting directly or through agreements with other public or nonprofit entities, for not more than 100 programs that involve—

- (1) continuing judicial supervision, including periodic review, over preliminarily qualified offenders with mental illness, mental retardation, or co-occurring mental illness and substance abuse disorders, who are charged with misdemeanors or nonviolent offenses; and
- (2) the coordinated delivery of services, which includes—
 - (A) specialized training of law enforcement and judicial personnel to identify and address the unique needs of a mentally ill or mentally retarded offender;
 - (B) voluntary outpatient or inpatient mental health treatment, in the least restrictive manner appropriate, as determined by the court, that carries with it the possibility of dismissal of charges or reduced sentencing upon successful completion of treatment;
 - (C) centralized case management involving the consolidation of all of a mentally ill or mentally retarded defendant's cases, including violations of probation, and the coordination of all mental health treatment plans and social services, including life skills training, such as housing placement, vocational training, education, job placement, health care, and relapse prevention for each participant who requires such services; and
 - (D) continuing supervision of treatment plan compliance for a term not to exceed the maximum allowable sentence or probation for the charged or relevant offense and, to the extent practicable, continuity of psychiatric care at the end of the supervised period.

* * *

“SEC. 2204. APPLICATIONS.

“To request funds under this part, the chief executive or the chief justice of a State or the chief executive or chief judge of a unit of local government or Indian tribal government shall submit to the Attorney General an application in such form and containing such

information as the Attorney General may reasonably require.

“SEC. 2205. FEDERAL SHARE.

“The Federal share of a grant made under this part may not exceed 75 percent of the total costs of the program described in the application submitted under section 2204 for the fiscal year for which the program receives assistance under this part, unless the Attorney General waives, wholly or in part, the requirement of a matching contribution under this section. The use of the Federal share of a grant made under this part shall be limited to new expenses necessitated by the proposed program, including the development of treatment services and the hiring and training of personnel. In-kind contributions may constitute a portion of the non-Federal share of a grant.

“SEC. 2206. GEOGRAPHIC DISTRIBUTION.

“The Attorney General shall ensure that, to the extent practicable, an equitable geographic distribution of grant awards is made that considers the special needs of rural communities, Indian tribes, and Alaska Natives.

* * *

“SEC. 2208. TECHNICAL ASSISTANCE, TRAINING, AND EVALUATION.

- (a) TECHNICAL ASSISTANCE AND TRAINING.—The Attorney General may provide technical assistance and training in furtherance of the purposes of this part.
- (b) EVALUATIONS.—In addition to any evaluation requirements that may be prescribed for grantees, the Attorney General may carry out or make arrangements for evaluations of programs that receive support under this part.
- (c) ADMINISTRATION.—The technical assistance, training, and evaluations authorized by this section may be carried out directly by the Attorney General, in collaboration with the Secretary of Health and Human Services, or through grants, contracts, or other cooperative arrangements with other entities.”.

* * *

“(20) There are authorized to be appropriated to carry out part V, \$10,000,000 for each of fiscal years 2001 through 2004.”

Approved November 13, 2000.

C.2 Mentally Ill Offender Treatment and Crime Reduction Act²

PL 108–414, October 30, 2004, 118 Stat 2327

UNITED STATES PUBLIC LAWS
108th Congress - Second Session
Convening January 7, 2004

MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2004

An Act To foster local collaborations which will ensure that resources are effectively and efficiently used within the criminal and juvenile justice systems.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Mentally Ill Offender Treatment and Crime Reduction Act of 2004”.

SEC. 2. FINDINGS.

Congress finds the following:

- (1) According to the Bureau of Justice Statistics, over 16 percent of adults incarcerated in United States jails and prisons have a mental illness.
- (2) According to the Office of Juvenile Justice and Delinquency Prevention, approximately 20 percent of youth in the juvenile justice system have serious mental health problems, and a significant number have co-occurring mental health and substance abuse disorders.
- (3) According to the National Alliance for the Mentally Ill, up to 40 percent of adults who suffer from a serious mental illness will come into contact with the American criminal justice system at some point in their lives.
- (4) According to the Office of Juvenile Justice and Delinquency Prevention, over 150,000 juveniles who come into contact with the juvenile justice system each year meet the diagnostic criteria for at least 1 mental or emotional disorder.
- (5) A significant proportion of adults with a serious mental illness who are involved with the criminal justice system are homeless or at imminent risk of homelessness, and many of these individuals are arrested and jailed for minor, nonviolent

² Relevant portions of the legislation are included here.

offenses.

- (6) The majority of individuals with a mental illness or emotional disorder who are involved in the criminal or juvenile justice systems are responsive to medical and psychological interventions that integrate treatment, rehabilitation, and support services.
- (7) Collaborative programs between mental health, substance abuse, and criminal or juvenile justice systems that ensure the provision of services for those with mental illness or co-occurring mental illness and substance abuse disorders can reduce the number of such individuals in adult and juvenile corrections facilities, while providing improved public safety.

SEC. 3. PURPOSE.

The purpose of this Act is to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems. Such collaboration is needed to—

- (1) protect public safety by intervening with adult and juvenile offenders with mental illness or co-occurring mental illness and substance abuse disorders;
- (2) provide courts, including existing and new mental health courts, with appropriate mental health and substance abuse treatment options;
- (3) maximize the use of alternatives to prosecution through graduated sanctions in appropriate cases involving nonviolent offenders with mental illness;
- (4) promote adequate training for criminal justice system personnel about mental illness and substance abuse disorders and the appropriate responses to people with such illnesses;
- (5) promote adequate training for mental health and substance abuse treatment personnel about criminal offenders with mental illness or co-occurring substance abuse disorders and the appropriate response to such offenders in the criminal justice system;
- (6) promote communication among adult or juvenile justice personnel, mental health and co-occurring mental illness and substance abuse disorders treatment personnel, nonviolent offenders with mental illness or co-occurring mental illness and substance abuse disorders, and support services such as housing, job placement, community, faith-based, and crime victims organizations; and
- (7) promote communication, collaboration, and intergovernmental partnerships among municipal, county, and State elected officials with respect to mentally ill offenders.

SEC. 4. DEPARTMENT OF JUSTICE MENTAL HEALTH AND CRIMINAL JUSTICE COLLABORATION PROGRAM.

- (1) IN GENERAL.—The Attorney General, in consultation with the Secretary, may

award nonrenewable grants to eligible applicants to prepare a comprehensive plan for and implement an adult or juvenile collaboration program, which targets preliminarily qualified offenders in order to promote public safety and public health.

(2) PURPOSES.—Grants awarded under this section shall be used to create or expand—

- (A) mental health courts or other court-based programs for preliminarily qualified offenders;
- (B) programs that offer specialized training to the officers and employees of a criminal or juvenile justice agency and mental health personnel serving those with co-occurring mental illness and substance abuse problems in procedures for identifying the symptoms of preliminarily qualified offenders in order to respond appropriately to individuals with such illnesses;
- (C) programs that support cooperative efforts by criminal and juvenile justice agencies and mental health agencies to promote public safety by offering mental health treatment services and, where appropriate, substance abuse treatment services for—
 - (i) preliminarily qualified offenders with mental illness or co-occurring mental illness and substance abuse disorders; or
 - (ii) adult offenders with mental illness during periods of incarceration, while under the supervision of a criminal justice agency, or following release from correctional facilities; and
- (D) programs that support intergovernmental cooperation between State and local governments with respect to the mentally ill offender.

Approved October 30, 2004.

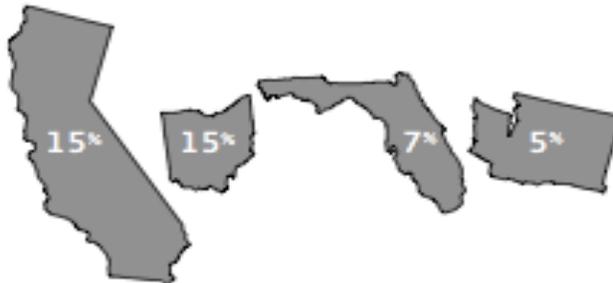
Appendix D: Mental Health Court Snapshot³

Distribution across the United States



States with greatest presence of courts

Over 40 percent of all existing adult mental health courts are located in California, Ohio, Florida, and Washington.



³ Note: this selection of aggregate mental health court data comes from self-reported survey responses and is neither conclusive or exhaustive; 90 mental health courts across 30 states provided details about their history, community, program, processes, and data collection strategies [69].

Instructions for referral: If yes to item 7 OR yes to item 8 OR yes to two or more of items 1 through 6 this inmate should be referred for further evaluation of mental health symptoms.

Other instructions:

Section 2

Items 1-6: Place a check mark in the appropriate column (for "NO" or "YES" response). If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES". Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

Item 7: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital.

Item 8: This refers to any prescribed medication for any emotional or mental health problems. If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES". Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

General Comments Column: As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES". Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question. All "YES" responses require a note in the General Comments section to document:

- (1) Information about the detainee that the officer feels relevant and important
- (2) Information specifically requested in question

Section 3

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problems occurred, please check OTHER, and note what it was.

E.2 Sample case presentation form

The following case presentation form serves as the template used in the San Francisco Behavioral Health Court [140].

| Behavioral Health Court: Case Presentation | | Date: _____ |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| Name | _____ | |
| Date of Arrest | _____ | |
| Referral Source | _____ | |
| Attorney | _____ | |
| SF# | _____ | |
| DOB/Age | _____ | |
| Gender | <input type="checkbox"/> M | <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM |
| Ethnicity/ Language | <input type="checkbox"/> White (non Latino) | <input type="checkbox"/> English <input type="checkbox"/> Cantonese |
| | <input type="checkbox"/> Native American | <input type="checkbox"/> Tagalog <input type="checkbox"/> Asian/Pacific Islander |
| | <input type="checkbox"/> African American (non Latino) | <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Latino/a | <input type="checkbox"/> Russian |
| Source of Income | <input type="checkbox"/> None <input type="checkbox"/> GA, CAAP, TANF <input type="checkbox"/> SSI/SSDI | |
| | <input type="checkbox"/> Employed | <input type="checkbox"/> Other _____ |
| Prior Housing Status | <input type="checkbox"/> Homeless/street/shelter | <input type="checkbox"/> With Roommate |
| | <input type="checkbox"/> Independent apartment/house | <input type="checkbox"/> (shared expenses) |
| | <input type="checkbox"/> Hotel/SRO | <input type="checkbox"/> With Roommate |
| | <input type="checkbox"/> With Parent/Guardian/Relative | <input type="checkbox"/> (no shared expenses) |
| | Will client have this same housing upon release? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Current Charge(s) | _____ | |
| Diagnosis | _____ | |
| Current Providers | _____ | |
| History of Mental Illness (symptoms) and Treatment | _____ | |
| History of Dangerous Behaviors (suicide attempts/violence) | _____ | |
| Treatment Plan (how will BHC facilitate this) | _____ | |
| Treatment Goals | _____ | |
| Barriers to Treatment | _____ | |
| Dependency court involvement? | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many children: <input type="text"/> | |

Appendix F: Comparison of Five Mental Health Courts

Since 2006, the U.S. Justice Department's Bureau of Justice Assistance has worked to identify and highlight agencies from across the country with comprehensive mental health court programs willing to share their expertise with jurisdictions seeking to develop or improve existing mental health courts. Representing a diverse cross-section of perspectives, interests, locations, and community resources available, the following five “learning sites” were selected as centers for peer-to-peer learning.¹

F.1 Bronx County Mental Health Court, New York

Established in 2001, approximately 225 mentally ill offenders are under court supervision on any given day. Notable features include:

- Targets individuals with serious charges and lengthy criminal records²
- Emphasizes linguistic, cultural, and clinical competency for large Hispanic/Latino and African American populations in the community
- Operates in a large urban center in which 31 percent of the population lives below federal poverty guidelines
- Collects and analyzes comprehensive process and outcome data; a full-time researcher/evaluator and grant writer is a member of the court team
- Works closely with over 30 treatment and other service providers
- Incorporates consumers on case management and advocacy staff
- Received funding through the Bureau of Justice Assistance Mental Health Courts Grant Program

F.2 Daugherty Superior Court, Georgia

Established in 2002, approximately 40 mentally ill offenders are under court supervision on any given day. Notable features, include:

¹ Bureau of Justice Assistance. Undated. Learning Sites. New York, New York: Consensus Project. A snapshot of each court’s functioning in key areas is provided here. A more detailed analysis of court functioning across the spectrum of variability described above (including screening process, eligibility requirements, types of treatment provided) can be found at: <http://consensusproject.org/learningsites>.

² While the Bronx mental health court recently expanded to include broader misdemeanor offenders, as a learning site, the Bronx mental health court is focused on providing assistance for felony offender processing.

- Operates a dual mental health and drug court (court refers to itself as the Dougherty Superior Court Mental Health and Substance Abuse Division)
- Targets people who cycle in and out of jail and who routinely appear on the court calendar as defendants charged with “quality of life” offenses; the majority of participants enter the program after their second or third probation violation
- Operates in a rural jurisdiction that has been designated as a “Health Professional Shortage Area” by the U.S. Department of Health and Human Services
- Sits in the county with the highest incarceration rate in Georgia (and at times has had the highest incarceration rate of any county in the country)
- Conducted an evaluation of participant performance which indicated that program participation reduces arrests, jail stays, and hospitalizations

F.3 Washoe County Mental Health Court, Nevada

Established in 2001, approximately 200 mentally ill offenders are under court supervision on any given day. Notable features, include:

- Targets people with multiple offenses across a range of criminal charges in an effort to reduce jail overcrowding and recidivism
- Operates in a mid-sized jurisdiction that also has a adult criminal drug court, a family drug court, a homelessness court, an alternative sentencing department, a post-booking diversion program, and a crisis intervention team (CIT), but the availability of treatment and other services in the community are lacking
- Collects comprehensive data as part of regular operations
- Works closely with the local jail and pre-trial services agency, enabling early participant identification and diversion
- Provides formal training on mental health issues to probation and pre-trial services officers
- Received funding from the Bureau of Justice Assistance Mental Health Courts Program

F.4 Bonneville County Mental Health Court, Idaho

Established in 2002, approximately 35 mentally ill offenders are under court supervision on any given day. Notable features, include:

- Targets individuals with more serious charges and lengthy criminal records
- Operates in a small rural jurisdiction where intensive, evidence-based services are available and a misdemeanor diversion project has been established

- Assigns all participants to an Assertive Community Treatment (ACT) team
- Collaborates with the jail so that any MHC participant who is re-incarcerated can receive (or continue to receive) medications prescribed by the psychiatrist on the MHC team
- Employs a wide range of individually tailored sanctions, treatment modifications, and incentives
- Received funding from the Bureau of Justice Assistance Mental Health Courts Grant Program

F.5 Akron Mental Health Court, Ohio

Established in 2001, approximately 100 mentally ill offenders are under court supervision on any given day. Notable features, include:

- Targets only people whose offenses are serious enough to warrant at least 60 days in jail
- Operates in a medium-sized jurisdiction that also has a Crisis Intervention Team (CIT)
- Works with Kent State University to collect data and evaluate the program; findings due in 2007
- Collaborates with a small number of community mental health and substance abuse service providers, one of which is directly involved in program management
- Provides mandatory “cross-system training” to all MHC personnel twice per year
- Maintains separate mental health and criminal justice files for participants
- Allows for the possibility of vacating guilty pleas/sentences and dismissing cases upon successful program completion

F.6 Side-by-side comparison of key court features

F.6.1 Planning

| | |
|------------|-------------------------------------------------------------------------------------------------------------|
| Bronx | Designed by a committee representing 41 agencies through a consensus process |
| Dougherty | Designed by a planning committee convened to discuss a broad range of criminal justice/mental health issues |
| Washoe | Designed over a year-long planning process before accepting participants |
| Bonneville | Designed by a committee comprising a wide array of criminal justice |

| | |
|-------|--------------------------------------------------------------------------------------------|
| | and mental health stakeholders |
| Akron | Designed by a “criminal justice forum” that was also involved with the creation of the CIT |

F.6.2 Ongoing oversight

| | |
|------------|------------------------------------------------------------------------------------------------------------------------------------|
| Bronx | Advised by a committee that meets semiannually, and more frequently when the program considers modifying or growing its operations |
| Dougherty | Advised by a committee, which is collecting data to determine whether the program is achieving its goals |
| Washoe | Advised by a committee that meets once per month |
| Bonneville | Advised by a committee that meets quarterly and includes a graduate of the program |
| Akron | N/A |

F.6.3 Mental health court team

| | |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bronx | <p>Comprises a clinical team, coordinating staff, and criminal justice personnel</p> <ul style="list-style-type: none"> - Clinical team: Five pre-placement case managers, seven post-placement case managers/peer specialists, one clinical director, and three part-time psychiatrists - Coordinating staff: One project director and two co-directors (one of whom is a full-time researcher/evaluator and one of whom is the medical director and a part-time psychiatrist on the clinical team) - Criminal justice personnel: A judge, two court attorneys, three rotating assistant district attorneys, and court-assigned defense counsel |
| Dougherty | Comprises a judge, a court coordinator (who is a registered nurse and also the mental health screener) three probation officers, two caseworkers (specializing in mental health and substance abuse, respectively), two public defenders, and two district attorneys |
| Washoe | Comprises a judge, a private contract defense attorney, two pre-trial services officers, state mental health liaison, and probation officer. Meets weekly to discuss cases as well as treatment plans, sanctions, and incentives. |
| Bonneville | Comprises a judge, a court coordinator, two probation officers (one felony and one misdemeanor), a vocational rehabilitation specialist, a |

| | |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | graduate of the MHC, NAMI representative, prosecuting attorney, child support specialist, jail clinician, representative from inpatient substance abuse and mental health treatment facility, ACT team representatives, and the court clerk. Meets weekly to discuss cases as well as treatment plans, sanctions, and incentives. |
| Akron | Comprises a municipal court judge, a program manager (who is also the chief probation officer for the Akron Municipal Court), a court liaison, a clinical director (who is a psychiatrist), a treatment manager, and five “community living specialists”. Meets extensively on a weekly basis to discuss cases and make decisions about program participant. |

F.6.4 Eligibility

| | |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bronx | Accepts individuals charged violent or nonviolent felonies (excluding current charges of murder, sex offenses, and arson) who have a severe and persistent mental illness with or without co-occurring substance use |
| Dougherty | Accepts individuals charged with non-violent felonies who have mental illness, co-occurring mental illness and substance abuse disorders, or a primary substance abuse disorder |
| Washoe | Accepts participants with misdemeanors or low-level felony charges and a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depression |
| Bonneville | Accepts individuals charged with felonies or serious misdemeanors who have an Axis I serious and persistent mental illness and for whom community-based treatment would be appropriate and beneficial |
| Akron | Accepts participants with misdemeanor charges and an Axis I diagnosis of bi-polar disorder, schizoaffective disorder, or schizophrenia. Screens potential participants for competency before acceptance to the program, and when necessary, restores competency before entrance into the program. |

F.6.5 Treatment and other services

| | |
|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bronx | Draws on various specialized treatment providers in the community for crisis, intermediate, residential, outpatient, and hospital care who address mental health, substance abuse, medical, educational, and vocational needs |
| Dougherty | Draws on the following community-based services: crisis stabilization unit for individuals with mental illness and substance abuse disorders; a |

| | |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | 28-day residential program for individuals with dual diagnoses; a detoxification center; a Transitional Aftercare for Probationers and Parolees program which provides transportation assistance, case management, and assistance applying for benefits and entitlements; psychoeducation; dual diagnosis groups; and a peer support program run by a consumer of mental health services. Supplements community resources with group therapy for participants who abuse substances. |
| Washoe | Provided primarily through Northern Nevada Adult Mental Health Services. Includes development of individual treatment plans that are reviewed (and if necessary, adjusted) every 90 days, case management, physical and mental health medical appointments, access to medications, supported housing, rehabilitation classes, vocational assistance, group therapy, and outpatient and inpatient dual-diagnosis treatment. |
| Bonneville | Employs a participant-centered, evidence-based program of treatments and services delivered by a multidisciplinary ACT team. Includes case management, medications, group therapy (including groups on moral reconnection therapy (MRT) and co-occurring disorders), individual psychotherapy sessions with social workers, assistance with rent, childcare, benefits applications, transportation, housing, legal advocacy, vocational rehabilitation, educational assistance, job searches, and transportation to appointments. Emphasizes securing basic needs like housing, medical care, and medications. Ensures that participants utilize community supports and self-help resources. |
| Akron | Uses Community Support Services (CSS), a mental health treatment and social services agency (which is directly involved in program management) and Oriana House, a chemical dependency treatment and community corrections agency (which is not directly involved in program operations) as its primary community-based treatment providers. Brokers services that include psychiatric counseling, case management, vocational training, assistance with housing, medical benefits, and residential support. |

F.6.6 Funding and sustainability

| | |
|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bronx | Conducts outcome evaluations as part of grant reporting requirements and has used these evaluations to seek new funding sources. Secured city, state, and federal funding for planning, implementation, and expansion of the program. |
| Dougherty | Funded by the Community Service Board (the state agency in charge of |

| | |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | providing mental health services), for the court coordinator and two caseworker positions. Supported by the local criminal justice system, which donates the staff time of probation officers, public defenders, and prosecutors. Uses operations data to justify continued funding. |
| Washoe | Engaged the state legislature to appropriate funds for their MHC and the Clark County (Las Vegas) MHC, and to increase the state's service capacity (Assembly Bill 175). Invites legislators to visit the MHC and routinely sends legislators information about the program. Collects data to inform operational decisions. Involved in a National Science Foundation study, to be completed in 2008, examining the voluntary nature of the court. |
| Bonneville | Secured state legislation that funded the MHC coordinator's position and other resources for the development of new mental health courts within the state. Receives significant support from elected officials who are interested in making the MHC part of a more system-wide response to people with mental illness involved with the criminal justice system. |
| Akron | Secured the support of community service providers and municipal agencies, who provide treatment and services to participants. Receives funding annually from the county's Alcohol Drug and Mental Health Board. |

Appendix G: Data Sources

There are several existing databases and entities that collect and store the data needed to conduct the proposed synthetic control method study. In addition to state and national databases identified in the literature, key informant interviews can be used to further ascertain sources for vital statistics to measure outcomes at the county and state population level. To be included, each database must contain data relevant to a covariate or outcome being measured and the data has to have been collected at more than a single point in time to allow for comparison over time (pre-intervention period and post-intervention period). Data is available at the state and county level.

Publicly Available Data Sources

Behavioral Risk Factor Surveillance System.

Board of State and Community Corrections, Jail Profile Survey.

Bureau of Justice Statistics, U.S. Department of Justice, Federal Justice Statistics.

Bureau of Justice Statistics, U.S. Department of Justice, Prisoner Recidivism.¹

Bureau of Justice Statistics, U.S. Department of Justice, State Court Processing Statistics.

¹ Recidivism statistics were first reported in a Bureau of Justice Statistics Special Bulletin entitled Recidivism of Prisoners Released in 1994 by Patrick A. Langan and David J. Levin and published in June 2002 [<http://www.bjs.gov/index.cfm?ty=pbdetail&iid=1134>]. The bulletin presents a detailed description of the study's data collection procedures. Information collected federally and reported by states and compiled here include: name, date of birth, sex, race, department of corrections identification number, state identification number, FBI identification number, offense committed, sentence length, date prisoner entered prison, month and day prisoner was released, total number of offenses person charged with on each day of arrest, what each offense was, the level of each offense, any resulting court adjudication, result of court adjudication, original sentence for each offense (e.g. prison, jail, probation, sentence length), and other details about each offense.

California Census Bureau, State and County Facts.

California Consumer Perception Survey and Mental Health Statistics Improvement Program (part of the Uniform Reporting System).

California Department of Corrections and Rehabilitation, Commitment status: Total felony admissions by month.

California Department of Corrections and Rehabilitation, Weekly Population Report.

California Department of Corrections and Rehabilitation, Post Release Community Service and 1170(h) populations.

California Department of Corrections and Rehabilitation, Weekly Report: Offender information.

California Department of Corrections and Rehabilitation, Weekly Wednesday Total Parole Population.

California Health Interview Survey.

California Quality of Life Survey.

California State Controller, Counties Annual Reports.

Client and Services Information System.

Criminal Justice Statistics Center, Crime in California [by year].

Data Collection and Reporting System.

Federal Bureau of Investigation, U.S. Department of Justice, Federal Bureau of Investigation Uniform Crime Reporting Handbook and Statistics.²

Involuntary Detention Reports.

Jail Profile Survey.

² Data is compiled by the Federal Bureau of Investigation through the Uniform Crime Reporting Program. On a monthly basis, law enforcement agencies report the number of offenses that become known to them in several crime categories. An arrest is counted each time a person is taken into custody, notified, or cited for criminal infractions other than traffic violations.

National Alliance on Mental Illness.

National Death Index.

National Health Interview Survey.

National Institute of Corrections.

National Institute of Health and Substance Abuse and Mental Health Services Administration.

National Institute of Mental Health.

National Outcome Measures Survey.

National Profile of Local Health Departments.

National Survey on Drug Use and Health.

Office of Statewide Health Planning and Development.

Point-in-Time Homeless Persons Count.

Population of California: California Department of Finance³

State of California Department of Justice, Office of the Attorney General, California Criminal Justice Profile.

Survey of Inmates in Federal Correctional Facilities and Survey of Inmates in State Correctional Facilities.

Survey of Inmates in Local Jails.

Uniform Reporting System.

U.S. Department of Health and Human Services.

³ Tracking both current population statistics and projections for California and its counties through 2050. See California Department of Finance. 2012. Interim Population Projections for California and Its Counties 2010-2050. Available, <http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php>.

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