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THE SECOND GENERATION OF MENTAL HEALTH COURTS

Allison D. Redlich and Henry J. Steadman
Policy Research Associates, Inc.

John Monahan
University of Virginia School of Law

John Petrila
University of South Florida, Florida Mental Health Institute

Patricia A. Griffin
National GAINS Center for People With Co-Occurring Disorders in the Justice System

Mental health courts (MHCs) generally began to appear in 1997. Today, more than 80 courts exist in the United States. In the present article, the authors argue that the 2nd generation of MHCs has arrived. The authors compare 8 previously described courts (P. A. Griffin, H. J. Steadman, & J. Petrila, 2002) with 7 newer courts that have not been previously described in the psycholegal literature. The authors identify 4 dimensions distinguishing 1st- from 2nd-generation courts: (a) the acceptance of felony versus misdemeanant defendants, (b) pre- versus postadjudication models, (c) the use of jail as a sanction, and (c) the type of court supervision. The 4 dimensions are interdependent in that the acceptance of more felony cases contributes to the rise in processing cases postadjudication, using jail as a sanction and more intensive supervision. Potential reasons for the evolution of a 2nd generation are discussed.

Keywords: mental health courts, diversion

Between 1998 and 2003, the number of mental health courts (MHCs) in the United States increased from fewer than 10 to more than 80 (National GAINS Center for People With Co-Occurring Disorders in the Justice System, 2003). Empirical data, both evaluative and outcome, remain sparse despite their growth. Informative articles have been written on individual courts (e.g., Petrila, Poythress, McGaha, & Boothroyd, 2001; Cosden et al., 2003) and on the comparison of multiple courts (Bazelon Center for Mental Health Law, 2003; Trupin & Richards, 2003), but nondescriptive studies are generally lacking.

One issue relates to defining MHCs. Previously, MHCs have been described as those that (a) are criminal courts, (b) have separate dockets exclusive to persons with mental illness, (c) divert defendants from jail or prison into community mental health treatment, and (d) monitor mental health treatment and potentially impose sanctions for noncompliance (Steadman, Davidson, & Brown, 2001).

Allison D. Redlich and Henry J. Steadman, Policy Research Associates, Inc., Delmar, NY; John Monahan, University of Virginia School of Law; John Petrila, Department of Mental Health Law and Policy, Florida Mental Health Institute, University of South Florida; Patricia A. Griffin, National GAINS Center for People With Co-Occurring Disorders in the Justice System, Delmar, NY.

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Correspondence concerning this article should be addressed to Allison D. Redlich, Policy Research Associates, 345 Delaware Avenue, Delmar, NY 12054. E-mail:aredlich@prainc.com

Based on the MHCs described by Goldkamp and Irons-Guynn (2000) and Griffin et al. (2002), a number of MHCs fit these common descriptions. However, we propose that a second generation of MHCs is developing, based on notable differences between the descriptions of older courts and those developed within the past 3 years. We support this observation by comparing eight established MHCs ("first generation") previously addressed by Griffin et al. (2002) with seven newer MHCs ("second generation") that we evaluated as part of the 2002 Bureau of Justice Assistance (BJA) Mental Health Court Program.

One definition of the word *generation* is descent from a common ancestor. Clearly, the first and second generations of MHCs descend from similar sources and because of this, they have numerous overlapping characteristics. There are also important differences, however, that we believe warrant the title of second generation. We are not claiming that the second generation of courts is superior to or an improvement on the first. There are no empirical data to support such a claim. Rather, we assert that the second generation of MHCs differs from the first on four meaningful dimensions that must be considered in planning needed research: (a) type of charges the court accepts (felony vs. misdemeanor), (b) type of adjudicative model the courts follow (pre- vs. postadjudication), (c) sanctions used in the court (specifically the expressed willingness to use jail as a sanction), and (d) supervision of MHC participants (mental health vs. criminal justice professionals). Because of these differences, the conceptualization of what is an MHC should be fundamentally altered.

For the work reported here we did not reevaluate the eight first-generation courts. It is possible that one or more of these eight courts have evolved over time in their procedures, eligibility criteria, sanctions used, and so forth and may have shifted into a court we consider a second-generation court. Our intent is to depict two cohorts of courts based on previous descriptions provided in the literature and on data we have collected and to support the idea that there is a new generation of MHCs that is distinguishable from the original cohort of courts.

First-Generation MHCs

Griffin et al. (2002) examined eight well-established MHCs. The first four were formerly investigated by Goldkamp and Irons-Guynn (2000) and are located in Broward County, FL; King County, WA; San Bernardino, CA; and Anchorage, AK. Griffin et al. then "identified the four longest-running MHCs other than those studied by Goldkamp and Irons-Guynn" (p. 1286) as MHCs in Santa Barbara, CA; Clark County, WA; Seattle, WA; and Marion County, IN. These eight courts began in the mid- to late-1990s.

Table 1 lists characteristics of the eight first-generation courts as described by Griffin et al. (2002). At the time, six of the eight only accepted defendants with misdemeanor charges, and often restrictions were placed on the misdemeanors these courts were willing to accept. For example, four of the courts excluded defendants with charges of driving under the influence. However, since the Griffin et al. article was published, four of the six courts that had previously only accepted persons charged with misdemeanors now consider persons charged with felonies on a case-by-case basis (see National GAINS Center for People With Co-Occurring Disorders in the Justice System, 2003).

Table 1
Characteristics of First-Generation Mental Health Courts

Court	Cases accepted	Adjudication model	Jail as a sanction?	Supervision
Broward County, FL	Misdemeanors	Mostly preplea	Extremely rare	Community treatment providers; Type I
King County, WA	Misdemeanors	Mostly postplea	Sparingly	Probation (special); Type II
San Bernardino, CA	Misdemeanors and low-level felonies	Postplea	Used liberally	Team: Probation and mental health staff; Type III
Anchorage, AK	Misdemeanors	Mostly postplea	After repeated attempts and still noncompliant	Court monitor; Types I, II
Santa Barbara, CA	Misdemeanors and some felonies	Mostly postplea	Occasional	Team: probation and mental health staff; Type III
Clark County, WA	Misdemeanors	Pre- and postplea (depending on jurisdiction)	Avoids unless new violent charge	Community treatment providers (most cases); Type I
Seattle, WA	Misdemeanors	Mostly preplea	Rarely and conditional	Probation (special); Type II
Marion County, IN	Misdemeanors	Preplea	Rarely	Community treatment providers; Type I

In terms of the type of adjudication model the eight courts followed, Griffin et al. (2002) described three models: preadjudication, postplea based, and probation based. The second and third models are postadjudication models in that convictions are in place but sentences may or may not be imposed. Four of the eight used a preadjudication model for most or all of their cases. Under this agreement, a plea of guilty may be required but the case is not adjudicated. Often the prosecutor holds the charges in abeyance, and this is what is used as leverage to motivate the participant to comply with mental health treatment and other orders of the court. Three of the courts used postadjudication for most or all of their cases, and for one court (Clark County, WA) the use of the pre- and postadjudication models depended on where in the county the crime was committed.

All of the eight MHCs reported using a variety of sanctions when compliance with court-ordered conditions was less than perfect. Sanctions included hearings before the judge (in which participants usually receive reprimands from the judge), changes in treatment plans, and community service. Jail was available as a sanction, but most courts reported using it very rarely. One court, San Bernardino, CA, however, indicated more liberal use of jail as a sanction.

As reported in Griffin et al. (2002), the eight courts follow one of three supervision models. In this context, supervision refers to the responsibility of ensuring that MHC participants stay engaged in community treatment (e.g., go to therapy sessions, take their medication) and otherwise follow the court's orders. Type I is a model in which community treatment providers are primarily responsible for MHC participant supervision but also report back to the court on a regular basis and/or when difficulties arise. In the Type II model, recurring supervision is provided by court staff or probation–parole officers. Sometimes the court staff person or probation officer has a dedicated position or caseload and works exclusively with MHC participants. In the Type III model, mental health staff and probation work together. Four of the first-generation courts followed the Type I supervision model, three followed Type II, and two courts followed Type III. (Note that the Anchorage MHC used both Types I and II depending on which court program the participant was in.)

Overall, based on descriptions provided by Goldkamp and Irons-Guynn (2000) and Griffin et al. (2002), the majority of first-generation MHCs focused on misdemeanants. As such, the courts were in a better position to accept cases without requiring convictions and to rely more heavily on supervision external to the MHC (i.e., community mental health providers).

Second-Generation MHCs

In 2002, the BJA announced their first round of funding for MHCs. Of those that applied, 23 courts were funded. Under National Institute of Justice support, we conducted a process evaluation of the seven operational courts. (The remainder of the courts used the BJA funds to initiate their MHCs and thus were not suitable for evaluation.) Over a 3-month period in 2003, two-person teams (composed of the authors) conducted site visits of the courts. A set of 50 questions was developed a priori building from the previous MHC comparison work of

Goldkamp and Irons-Guynn (2000) and Griffin et al. (2002), and answers were obtained during the site visits. The seven courts are described below.

1. Santa Clara County, CA. Santa Clara County is a large county both in terms of population (1,682,000 residents) and geography. The major city is San Jose, a hub of Silicon Valley. The Santa Clara County MHC grew directly from the county's Drug Treatment Court, and the MHC is a dual-diagnosis court. That is, the MHC in this county focuses on clients who have mental health issues as well as substance abuse issues. However, the court does not restrict eligibility to only those with co-occurring problems. Rather, the court casts a broad net and accepts nearly all referrals. It is one of the largest MHCs we have seen, with over 600 participants and a calendar that meets a full day and a half per week.

2. Orange County, NC. This court, named the Community Resource Court, originated in May 2000. The idea for the court was initiated by a local National Alliance on Mental Illness member. Orange County has 118,000 residents and is home to Chapel Hill and Hillsborough. Court is held twice a month in two locations. When we visited the court in August 2003, there were 65 cases combined for the two dockets.

3. Allegheny County, PA. Allegheny County, whose major city is Pittsburgh, has nearly 1.3 million residents. The first referral to the court was in July 2001. The court holds both plea and reinforcement hearings, which are held alternately once a week. The plea hearings are the first-time appearances for new defendants. The reinforcement hearings, which are characterized by MHC personnel as positive (e.g., praise for treatment adherence) or negative (e.g., threat of sanctions for treatment nonadherence) and are dependent on progress and compliance, are first held every 30 days and later every 90 days as participants advance through the MHC process. At the time of our site visit to the court, there were 120 active cases and 36 people who had successfully graduated.

4. Washoe County, NV. Washoe County is in northern Nevada. The larger cities there are Reno and Sparks, and the county is home to nearly 500,000 residents. The MHC began accepting referrals in November 2001; since its inception, approximately 225 participants have enrolled in the court. At the time of our visit, there were 37 cases on the docket. The court meets weekly and is one of several specialty courts in the county.

5. Brooklyn, NY. Brooklyn is home to 2.5 million people. This court started as a pilot program in March 2002, and to date approximately 40 to 50 people have participated (36 are currently enrolled). The court meets weekly and status hearings are held with decreasing frequency as the participant progresses through the court. Like many MHCs, Brooklyn's court was sparked by its Drug Treatment Court. This MHC is part of a larger array of forensic programs for persons with mental illness.

6. Bonneville County, ID. The hub of Bonneville County, which is home to approximately 85,000 residents, is Idaho Falls. Its MHC began in August 2002 and is small relative to other MHCs. One reason for its small size is the court's integration with an Assertive Community Treatment (ACT) team. All MHC clients are served by the ACT team. By their nature, ACT programs are intensive and the ratio of clients to staff is low. In this MHC, no more than 20 clients can participate at a time; at the time of our visit, there were 13 active clients. Court is held once a week.

7. Orange County, CA. Orange County is a large county in the southern part of California. Although the county has 2.8 million residents, the MHC serves only a specific region of the county, which has a population of 800,000 people. Like the Santa Clara County MHC, this MHC is a dual-diagnosis court. All participants must be enrolled under the California Proposition 36 track, which is the Substance Abuse and Crime Prevention Act. This initiative allows for treatment alternatives to incarceration for first-time and second-time nonviolent drug possession offenders and is the primary funding mechanism for the Orange County MHC. Currently, 47 active participants are enrolled.

Table 2 describes the seven second-generation MHCs using the same variables as in Table 1. As discussed later in detail, (a) all of the courts accept felony cases, (b) all but one utilize postadjudication models, (c) the majority are comfortable placing persons in jail as a sanction when necessary, and (d) there is a preponderance of reliance on internal supervision (i.e., internal to the criminal justice system).

Similarities and Differences Between First- and Second-Generation MHCs

As stated earlier, first- and second-generation MHCs have clearly descended from the same ancestors. Indeed, there are likely to be more similarities between the generations than differences. For example, all of the courts we evaluated are problem-solving courts and are based on the premise of therapeutic jurisprudence (Winick & Wexler, 2003). In addition, court processes are generally informal and nonadversarial.

Goldkamp and Irons-Guynn (2000) described three common factors of early MHCs. First, the courts are designated as specialty courts; that is, they that have special dockets and, in the case of MHCs, only accept participants with mental health problems or diagnoses. Of the eight examined by Griffin et al. (2002), this was clearly the case. Of the seven more recent courts presented here, at least one accepts clients without mental health problems and includes those with physical health problems, such as AIDS or hepatitis C. This is most likely an exception to the rule, however. We still generally describe the second generation of MHCs as those that primarily serve persons with mental illness.

The second common feature of MHCs noted by Goldkamp and Irons-Guynn (2000) is that most have dockets restricted to nonviolent misdemeanants. Although we discuss this more in depth later, we did not find this standard across the newer courts. The third common feature was that MHCs attempt to divert people into community treatment instead of jail or prison. This was also a goal of the seven more recent courts, a goal that is unlikely to change over time and with the creation of even newer courts. Indeed, the first and third features are integral to the definition of MHCs, whereas the second feature serves better as a description of individual courts. MHCs, as generally understood, are specialty courts for persons with mental illnesses charged with crimes (the first feature) and are designed to mandate people into treatment instead of incarceration (the third feature). The second feature—restriction to nonviolent misdemeanants—is a feature that is alterable without necessarily changing the definition of an MHC. This second

Table 2
Characteristics of Second-Generation Mental Health Courts

Court	Cases accepted	Adjudication model	Jail as a sanction?	Supervision
Santa Clara County, CA	Mostly felonies	Postplea	Comfortable using it, but used with discretion	Team; Type III
Orange County, NC	Misdemeanors and felonies	Mostly preplea	Comfortable using it, but used with discretion	Treatment staff (most cases); Type I
Allegheny County, PA	Misdemeanors and some property felonies	Postplea	Rarely used	Probation; Type II
Washoe County, NV	Misdemeanors and felonies	Postplea	Comfortable using it, but used with discretion	Team; Type III
Brooklyn, NY	Nonviolent felonies; few misdemeanors	Postplea	Rarely used	Court case managers; Type II
Bonneville County, ID	Misdemeanors and felonies	Postplea	Comfortable using it, but used with discretion	ACT team and probation; Type III
Orange County, CA	Felony–substance	Postplea	Comfortable using it, but used with discretion	Probation; Type II

feature is also our first dimension distinguishing first- from second-generation courts.

Dimension 1: Type of Charges Accepted

In the Griffin et al. (2002) study, seven of the eight first-generation courts focused on misdemeanor crimes, and only two courts (San Bernardino and Santa Barbara) included felony crimes. Updated information (National GAINS Center for People With Co-Occurring Disorders in the Justice System, 2003) on these eight courts informs us that now only two courts will not consider felony defendants. Of the seven second-generation courts, all accept felonies. Three of the seven can be described as focusing on felonies or those that only accept felonies. Of the four that accept both misdemeanants and felonies, we describe only one (Allegheny County) as focusing on misdemeanor crimes with an occasional acceptance of persons charged with felonies on a case-by-case basis (see Tables 1 and 2).

A related feature is whether courts will accept offenders charged with violent offenses or those with violent histories. From our observations, the seven second-generation courts were also more relaxed on this issue, although this is not to say that these courts were unconcerned with public safety, as they clearly made it a priority. In the eight first-generation courts, two courts allowed for charges of domestic violence or battery and sometimes only with the victims' consent. Of the seven second-generation courts, restrictions concerning violent charges and histories still exist, but most courts were also willing to apply a "totality of the circumstances" approach and examine the circumstances surrounding the crime, the person, and the overall situation before making a decision of acceptance or rejection. For example, one of the courts accepted two women with mental illness accused of killing their children. Another court enrolled a person charged with taking a saw to a female neighbor's door. In this latter case, an exception was made because court-related personnel were familiar with the potential client and believed the MHC was in the participant's and society's best interests. Similarly, in its analysis of 20 MHCs, the Bazelon Center for Mental Health Law (2003) reported that 80% of courts were willing to consider persons charged with violent acts.[1]

Dimension 2: Type of Adjudication Model

Of the eight courts studied by Griffin et al. (2002), although six have mechanisms for postplea adjudication, four of the eight relied primarily on preplea models. Using information from the National GAINS Center for People With Co-Occurring Disorders in the Justice System (2003) report, it seems that, with one exception, the courts have not changed their adjudication procedures. The Marion County court appears to have changed to a deferred-sentence model and thus processes cases postadjudication. In contrast to some of the first-generation courts, of the seven second-generation courts, six only allow for postplea enroll-

[1]The Bazelon Center for Mental Health Law did not provide a list of the 20 MHCs that they studied; thus, the proportion of the courts that are newly established versus older courts (e.g., pre-2000 vs. post-2000) is unknown.

ment. The seventh (Orange County, NC) is primarily deferred prosecution (preplea), but approximately 25% of their cases are postplea–postconviction.

An ancillary component to the more frequent utilization of postplea adjudication models in the second-generation courts is that potential MHC participants are being referred much further down the criminal justice pipeline. For the eight first-generation courts, Griffin et al. (2002) wrote that "each court identifies possible participants within the first 24 to 48 hr of arrest" (p. 1286). Generally, we did not find this to be the case for the seven second-generation courts. Persons are either not being identified shortly after arrest during initial detention or, if they are identified shortly after arrest, are not enrolled in the MHC until much further into the adjudication process. Time from referral to first MHC appearance ranged from 0 to 129 days, with an average of 28 days across the second-generation courts (Steadman, Redlich, Griffin, Petrila, & Monahan, 2005). Potential referents are often identified by other judges and court personnel later in the criminal justice process. For example, in one of the seven newer courts, participants are convicted and sentenced before MHC consideration. The original sentencing judge is the final decision maker of whether persons are allowed to enter the MHC and if they replace their sentences with mandated community treatment.

Dimension 3: Type of Sanctions Used

Within this dimension, we focus on the use of jail as a sanction. All of the first- and second-generation courts utilize a cadre of sanctions, such as mandating community service and reprimands from the judge. Griffin et al. (2002) noted that six of the eight first-generation courts reported rarely using jail as a sanction for noncompliance with the courts' orders. Of the second-generation courts, our impression was that jail appeared to be used with more regularity. At least five of the seven seem to be comfortable using jail as a sanction, although all reported using jail as a later (but not necessarily last) resort when earlier, less punitive sanctions had not induced treatment engagement. Moreover, all of the seven courts reported some flexibility in regard to noncompliance; that is, perfect performance was recognized as a futile goal. Many of the courts also acknowledged that, whereas jail was an effective solution to gaining compliance for some participants, for others, jail had a detrimental and opposite effect. Thus, jail as a sanction was used with discretion.

Nevertheless, from what we observed, our perception was that the second-generation courts were more willing to place people in jail than previously studied MHCs, a consequence perhaps of the fact that these more recent courts accept persons charged with felonies. For example, one MHC reported being comfortable using jail under the following circumstances: (a) as a "wake-up" call, (b) for medical detoxification, (c) as a result of new charges, or (d) for failure to keep appointments with their probation officers. Another common mechanism for jail time among several of the courts was "dirty" urinalyses, which is similar to their predecessors, Drug Treatment Courts. In its report on 20 MHCs, the Bazelon Center for Mental Health Law (2003) found that 64% were willing to place people in jail for noncompliance, but the frequency of use was not specified. Empirical data are sorely lacking on the use of jail as a sanction (such as average numbers of jail days) as well as on all types of MHC sanctions.

Dimension 4: Type of Supervision

As described previously, Griffin et al. (2002) denoted three types of supervision models for their eight first-generation courts. Type I was supervision by existing community mental health providers, who reported back to the MHC either when there are difficulties or on a regular basis. Type II was regular supervision by dedicated MHC staff (e.g., court monitor, mental health staff) or probation–parole officers. Type III was regular supervision from a combination of probation officers and community or court mental health workers. For the second-generation courts, we found that the courts fit one of these three models but the majority of MHCs relied on supervision by personnel directly linked to the court.

As shown in Table 2, four of the courts rely on either probation solely or MHC staff (Type II model) to supervise clients in the community. Two courts utilize a team approach (Type III) in that probation officers jointly supervise clients with either court staff or community mental health providers. Only one court—Orange County, NC—relies primarily on community mental health staff (Type I), who then report back to the MHC. Although this court does have the option of probation supervision, it is not commonly used because, in most circumstances, it does not apply (i.e., 75% of their clients are diverted preadjudication and are, therefore, not subject to probation). Thus, whereas the types of supervision used by the first- and second-generation courts are similar, the frequency with which they are used differs. That is, whereas four of the first-generation courts relied solely on community treatment providers for supervision of participants, only one second-generation court did so. For the newer courts, it was more common to see court personnel and/or probation responsible for supervision.

It is clear that these four dimensions distinguishing first- from second-generation courts are related to one another. That is, because the courts now accept more felony defendants, the number of courts relying on postplea adjudication models increased, as did the use of jail as a sanction and the use of criminal justice mechanisms of supervision. Because felony crimes, by definition, are more serious than misdemeanor crimes, prosecutors and others involved in the MHC more often require that potential participants plead guilty (with or without a conviction) to enroll in the MHC. This is also true for the increased use of jail as a sanction. In their report, the National Drug Court Institute (2000) noted that the leverage of jail is commonly used in Drug Treatment Courts, which tend to handle felonies.

Moreover, the first three dimensions are relevant to the front end of MHC operations. The day-to-day, back-end operations after participant enrollment have changed little. After enrollment dispositions are made, participants attend hearings in front of a judge, treatment mandates are issued, and some level of supervision is rendered. As noted previously, because these courts accept defendants charged with felonies, the supervision is more likely to involve probation officers rather than be left solely to community mental health providers. Rather, what has seemingly changed is how potential persons are selected for enrollment, the front end of the court.

The precise reasons for the changes in how MHCs refer and select participants for inclusion in the courts are not known. We have several suppositions, however.

One has to do with funding mechanisms for the courts. The two California courts, Santa Clara and Orange Counties, are linked to Proposition 36 funds. As noted earlier, this initiative allows first- and second-time, nonviolent, simple drug possession offenders the opportunity to receive substance abuse treatment in the community instead of incarceration. As a result, both are dual-diagnosis courts and focus on felony defendants. One aim of Proposition 36 is to divert people from state prisons rather than local jails (a goal of many misdemeanor MHCs), and, as such, felons are a more appropriate target for these courts. It is also possible that localities have made policy decisions to not focus on misdemeanants because of uncertainty regarding the effectiveness of such a focus and reliance on alternative strategies for diversion. The Bazelon Center for Mental Health Law (2003) acknowledged that MHCs were becoming increasingly likely to accept felony defendants but argued that misdemeanants are ill suited for MHCs because they should be diverted from the criminal justice system entirely (e.g., prebooking diversion programs). As the center's report states, "To avoid becoming the entry point for people abandoned by the mental health system, MHCs should close their doors to people charged with misdemeanors" (p. 7). If the trends we have noted from the first- to second-generation courts continue, third- or fourth-generation courts may indeed be exclusive to felony defendants. In addition, with an increase in the number of pretrial–prearrest diversion and crisis intervention training programs for persons with mental illness (Naples & Steadman, 2003), it may be that the need has diminished for MHCs to accept misdemeanants in localities with alternative forms of diversion. Some local jails will not accept misdemeanants (primarily because of overcrowding) regardless of mental health status.

Conclusions

The current article is meant to generate thought and discussion concerning the differences between well-established and newly established MHCs. It is not intended as an exhaustive catalogue of all of the current U.S. MHCs. We have only examined 15 courts over two studies, which is approximately one fifth of the MHCs that exist in the United States. Furthermore, we did not directly reevaluate the eight first-generation courts; thus, their current practices may not match exactly what was described in the literature reporting on their operations up to 2002. We must also emphasize that we did not compare the efficacy of what we have labeled first- and second-generation courts and are not suggesting that second-generation courts are superior to first-generation courts. Finally, we use the term *generation* to represent a cohort of courts, but, of course, there are some exceptions to the rule. That is, there were first-generation courts that may today have many of the characteristics of second-generation courts and vice versa. However, our goal was to describe what was common among the courts and not pigeonhole courts into any one label.

Do the four dimensions—increased acceptance of felony charges, postplea adjudication models, increased use of jail as a sanction, and increased use of criminal justice supervision—challenge the intent of therapeutic jurisprudence? Are second-generation courts an improvement on first-generation courts or simply a distinct type of MHC? In the future, will the trend we noted with second-generation courts continue, and will MHCs limit their jurisdiction to felonies?

What is the impact of the use of sanctions on compliance with court-ordered conditions? Some of these questions have been raised elsewhere (Griffin et al., 2002; Steadman et al., 2001), and as the characteristics of MHCs become more clear, it is hoped that research will begin to address these questions along with the many other substantive issues that such courts raise.

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