From the Jailhouse to Capitol Hill: Impacting Mental Health Court Legislation and Defining What Constitutes a Mental Health Court

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This article examines congressional testimony preceding the passage of legislation authorizing federal funds for mental health courts and makes the case for the importance of anecdotal evidence in the process. The magnitude of persons with mental illness in the criminal justice system is considered, as well as factors that have led to the criminalization of this population. The concept of therapeutic jurisprudence is discussed, and commonalities in the emergence of mental health courts and methods of supervision are examined. Areas of concern are addressed, and mental health courts are advocated as a commonsense approach to diverting persons with mental illness from the criminal justice system and ensuring linkages to treatment.

Keywords: *mental health courts; therapeutic jurisprudence; diversion; criminalization of the mentally ill; supervision of the mentally ill within the criminal justice system; transinstitutionalization*

At the age of 24, with a master's degree in hand, I stepped out of the ivory tower, so to speak, with a save-the-world attitude and accepted a job as administrative assistant to the warden at a maximum security, death row prison in Columbia, South Carolina. At this dismal, dreary facility that had been in existence since 1866, I dealt with disgruntled inmates filing grievances and disciplinary hearing appeals. After approximately a year on the job, I reported for in-service training. A trainer recognized me from my orientation training the previous year and remarked that I seemed to be dejected and not myself. I acknowledged that I was somewhat depressed, and he stated, "Envision, if you will, that you have a pail of water, and you swirl your hand as hard and fast as you can around in the pail of water for a solid minute.

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Upon returning to the bucket of water in one hour, what will you find?" I replied, "I guess that the water in the bucket will be motionless." He said, "Exactly, young man, and that is the impact that you are going to have on the criminal justice system—so quit looking down and stop worrying so much about your work."

Since that encounter, I have lamented many times to students in my criminology classes about how lawmaking is dictated by corporate lobbyists—citing repeatedly the example of Ford Motor Company executives knowingly putting the defective Pinto on the highway, leading to fiery crashes and deaths, while automotive industry lobbyists ensured that no legislation would be passed to make their actions criminal homicide (Dowie, 1982).

Furthermore, as noted by Samuel Walker's (1989) wedding cake analogy, certain celebrated cases within the criminal justice system draw public attention and receive heightened scrutiny. These cases, frequently sensationalized by the media, often drive policy within the criminal justice system. How many times I have complained to students about how such isolated incidents result in misinformed generalizations and have misguided policy implications. For example, the overemphasis by the media on the association between mental illness and violence has lead to public misperceptions. Unfortunately, all too often substantive policy changes for the mentally ill encountering the criminal justice system are frequently predicated on the occurrence of exceptionally tragic events.[1]

My view of the legislative process has changed after having testified before a congressional subcommittee on the topic of the impact of mentally ill offenders on the criminal justice system on September 21, 2000 (*Hearing on the Impact of Mentally Ill Offenders*, 2000). In a collaborative effort coordinated by the Council of State Governments, I testified before the congressional subcommittee along with several other individuals representing various perspectives affected by this issue.[2]

Several of the panelists, in identifying the enormity of the problem surrounding persons with mental illness who encounter the criminal justice system, related personal stories illustrating difficulties in dealing with this population. Amazingly, although we were from diverse backgrounds, we reached a general consensus in our remarks and recommendations. Although we were not specifically addressing any particular pending legislation and were unclear as to what effect our testimony would have, what ultimately emerged was passage of America's Law Enforcement and Mental Health Project Act, which authorized federal funding, albeit limited, for mental health courts (Public Law, 2000). As noted by Griffin, Steadman, and Petrila (in press), "Despite the absence of published outcome data, Congress . . . appropriated

funds for the development of new [mental health] courts, and [these] courts appear to be growing in popularity."

The use of anecdotal evidence in this process cannot be discounted, and Representative Sheila Jackson-Lee remarked to me and victims' advocate Kim Webdale at the cessation of the hearing that she considered our testimony of personal stories to be compelling (S. Jackson-Lee, personal communication, September 21, 2000).[3] Although I had published a book chapter on mental health courts (Slate, 2000) (which was included with my recommendations to the subcommittee) and Governor Jeb Bush had appointed me to Florida's Mental Health and Substance Abuse Commission,[4] I believe my personal experiences with the mental health and criminal justice systems were what proved instrumental in my selection to testify before the congressional subcommittee.

THE ESSENCE OF MY CONGRESSIONAL TESTIMONY

After 2 years of work experience at the penitentiary, I left that depressing environment to take a job as a U.S. probation officer in Columbia, South Carolina. I had interned at this probation office while in graduate school, and I perceived this to be my dream job. That promising career came to a screeching halt during my first 6 months on the job. After having encountered what I would describe as a shoot/no-shoot situation with a probationer and heading off to Miami for federal probation officer training, I experienced the first manic episode of my life (stressful events can sometimes trigger manic episodes). This manic episode evolved into contact with the police, and, although I did not consider it good fortune at the time, fortunately I was initially hospitalized in Miami and later transferred to a hospital in Columbia. Ironically, while employed at the prison, I had been responsible for ensuring the revision of our four-point restraint policy; now it was I who was placed in four-point restraints as medication was injected into my thighs to bring me down from my mania. Within a 2-week span of time, I was hospitalized and diagnosed with a mental illness (bipolar disorder); I was forced to resign my job as a federal probation officer due to my diagnosis, and while I was in the hospital, the woman whom I had dated for 7 years and been married to for 2 years left me and ultimately divorced me. Frankly, I had to make a determination whether I wanted to stick around for anymore of life's experiences. Dr. Roger Deal, at the hospital in Columbia, told me that to be manic-depressive, one had to be of above-average intelligence and that he got his kicks, his jollies, from putting people like me back together again and sending them back into the world to be successful. (How much can hang in the balance on a few

words from an authority figure on encountering someone in a position of vulnerability as myself at that particular time.) I believed him and returned to something familiar to me—education. Within 5 months of leaving my job at federal probation, stabilized on lithium—a mineral on the periodic chart—I was teaching as a part-time criminal justice instructor at a community college back in my hometown, ultimately teaching as many as five courses a quarter. Gradually gaining my confidence and self-assurance back, I began applying for admission into criminology/criminal justice doctoral programs. I was accepted for admission into the three programs to which I applied: Claremont Graduate School, Florida State University, and Michigan State University. I chose Claremont on the basis of being offered a full fellowship and a stipend for living expenses. Now divorced and approximately 1 year after the demise of my career as a federal probation officer, I set out for doctoral study in California. All the while, only those closest to me knew that I was manic-depressive. I even paid for visits to doctors and for my medication out of my pocket to avoid a paper trail as I was running from the stigma associated with mental illness.

After completing coursework at Claremont, I took a job while all-but-dissertation at the University of Maine at Augusta as a full-time assistant criminal justice professor. During my 4 years in Maine, I continued on my medication, remained in the closet regarding my mental illness, and finished my dissertation. In 1993, I accepted an assistant professor of criminology position at Florida Southern College in Lakeland, Florida. Continuing to remain in the shadows concerning my mental illness, I refrained from asking my newfound colleagues for a recommendation of a reputable psychiatrist in the area. Instead, I made the mistake of resorting to the yellow pages of the telephone directory and a local hospital's physician referral service for the selection of my doctor. This resulted in my choosing a psychiatrist who became convinced that I was not manic-depressive after all, believing that I had had a brief reactive psychosis to the previously referred to stressful shoot/no-shoot incident. He decided to discontinue my medication (lithium) in the summer of 1994, and for the first time in 8 years, I believed that I was not manic-depressive.

My new wife and I attended a college football game in Columbia, South Carolina between the South Carolina Gamecocks and the Georgia Bull Dogs on Labor Day weekend prior to classes beginning at Florida Southern College the next week. Driving at speeds as high as 100 miles per hour, we arrived at the game with me in the throes of a full-blown manic episode, believing that I was not mentally ill. Furthermore, if I wasn't manic-depressive and had been misdiagnosed back in 1986 (as indicated by my doctor), I reasoned that some sort of conspiracy against me had cost me my job at federal probation,

and, now, I was back in Columbia on a mission to right the wrong that had been perpetrated on me 8 years previously. Exacerbating the problem was the fact that, off my medication, the area of the brain that would normally allow me to recognize that I was ill was impaired.[5]

At the football game, I actually believed that I could control the players on the field like chess pieces and somehow will the Gamecocks to win. Of course, if you know much about Gamecock football prior to the arrival of Lou Holtz, this task proved too daunting, and I became frustrated with the Gamecocks's lack of responsiveness to my commands. Therefore, I insisted that my wife and I leave the game early.

As we made our way to our vehicle, my wife tried to alert a couple of emergency medical technicians (EMTs) to my condition. Unfortunately, manics can be very persuasive, and I convinced the EMTs that it was my wife who was ill, not me. As one might imagine, with her trying to deal with me in my manic state, the EMTs found her blood pressure to be extremely high. Their last words to me as they sent us on our way were for me to take care of her.

A friend's condominium was vacant for the evening, and we ultimately traveled there to spend the night. For most of the evening, I maintained a vigil in the parking lot of the condominium complex and threw my wallet and identification credentials away so the "conspirators" could not identify me. I had become obsessed with my conspiracy theory and began to believe the conspirators might be closing in on me.

During the evening, at a point that I had actually stepped inside the condominium, a law enforcement officer, who had been alerted to my bizarre behavior in the parking lot of the complex, stopped by and spoke with my wife. She explained the situation to him and asked him to intervene, but he informed her that because I did not appear to have reached a state where I was a danger to myself or to others that he had no legal authority to intervene, and he instructed her to keep me inside the condominium.

The following morning I became convinced that I needed to seek protective custody to avoid the conspirators. In my delusional state, I plotted and managed to get myself arrested by skinny-dipping in an unoccupied swimming pool at the condominium complex. On the arrival of the two law enforcement officers, I informed them of the conspiracy against me and my need for protective custody, and my wife showed them the vial containing the medication that I should be taking and told them how the doctor had mistakenly discontinued my medication. She emphasized that I was a criminology professor and had previously worked as a prison administrator and federal probation officer in Columbia. Her pleadings were to no avail: The officers took me directly to jail. There, I was placed in a holding cell with approximately 15 other detainees. And another inmate assaulted me when I invaded

his personal space while jabbering incessantly about the conspiracy against me and uninhibitedly telling him about my previous jobs in the criminal justice system in Columbia. In my state of delusion, prior to the assault, I actually thought the inmate who eventually attacked me had been planted inside the cell to make a record of the horrific conditions and abuses for future litigation efforts; I was there to assist him.

Ultimately, I appeared before a magistrate, and my bail was set at $500. However, I was unable to make bail as I had thrown my wallet away; and even if I could have made bail, where was a psychotic manic to go?

At no time while I was incarcerated did I see any medical personnel nor did I receive any medical treatment, and detention officers ultimately assaulted me as they extracted me from the holding cell and placed me in a strip cell. Ironically, I was finally extricated from my difficulty by a federal probation officer, Ronald L. Hudson, whom I had worked with previously. He came down to the jail and flashed his badge, with no authority whatsoever, and announced that I was coming with him. Ron has since informed me that, although he is not a mental health professional, when he saw me in my disheveled, psychotic state, with the stench of feces that I had smeared on like war paint, he knew that I was mentally impaired. He would tell me later that my jailers were clueless as to how to handle me, and so, with a sense of relief, they released me to his care.

Ron took me directly to a hospital emergency room, where the attending physician called in interns and other medical personnel to observe me for educational purposes so they might witness firsthand an individual in the throes of a psychotic, manic episode. I was hospitalized for 12 days. My criminal charge was dismissed and the arrest eventually expunged. Ultimately, I was able to return home, and, due to a compassionate and understanding academic community headed by Dr. Thomas Reuschling, president of Florida Southern College, I was able to resume teaching. My mental illness was no longer hidden. Since this last ordeal, I have changed doctors, resumed taking my medication, been accepted by my colleagues at work, and have now been teaching full time for 8 years, with no further manic episodes.

Why tell this story? If this could happen to me with my prior knowledge and experience within the criminal justice system, as a criminology professor and corrections official, with no criminal record—not even a speeding ticket—it can happen to anyone, and it is happening to many. I am no longer ashamed of my mental illness, but I am ashamed of the "treatment" and so-called justice that the mentally ill sometimes receive within society and the criminal justice system. Unfortunately, many of those persons with mental illness hurled into the bowels of the criminal justice system do not have the friends, the resources, or the sheer stroke of luck to extricate themselves from

such difficulties that I did; they are unable to call attention to their plight and expose the inhumanity that is being perpetrated on individuals who are not responsible for their actions by criminal justice practitioners who are ill-equipped and largely untrained to handle the mentally ill in crisis. My ordeal transpired in South Carolina's capitol city; however, it could have taken place in just about any jurisdiction in America.

PREVALENCE OF MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

"There is no more complicated or intractable a problem within criminal justice than that posed by the needs of persons with severe mental disorders, and . . . the failure to rationally respond to the issues raised by the incarceration of persons with severe mental disorders results in the unfair and disproportionate criminalization of persons with severe disorders" (Stone, 1997, p. 286). As noted in the Surgeon General's Report on Mental Health, an alarming number of persons with mental illness are improperly processed within the criminal justice system (U.S. Department of Health and Human Services, 1999). According to a Bureau of Justice Statistics study, 16% of those held in local jails, 16% of probationers, 16% of state prison inmates, and 7% of federal inmates have reported a mental illness (Ditton, 1999). A much greater incidence of severe persistent mental illnesses has been found to exist in jail and prison populations than in the general, noninmate population, with the prevalence of mental illness of those in such criminal justice system custody assessed to be anywhere from 5 to 7.5 times greater percentage makeup than that of the general population (Stone, 1997; Watson, Hanrahan, Luchins, & Lurigio, 2001). There was a reported 154% increase in the number of persons with mental illness in jails from 1980 to 1992 (Watson et al., 2001).

In 1960, more than 500,000 persons resided in state hospitals, and recent figures reflect that less than 60,000 persons with mental illness are housed in public hospitals (Sharfstein, 2000). Current data reveals that there are almost 5 times more persons with mental illness in jails and prisons across America than in all state psychiatric hospitals combined (Leifman, 2001; Lerner-Wren, 2000). In essence, the deinsitutionalization movement has resulted in a transinstitutionalization of persons from mental hospitals to the criminal justice system (Lurigio & Swartz, 2000). Jails in effect have become the asylums of the new millennium, as noted by Sharfstein (2001): "With 3,500 and 2,800 mentally ill inmates, respectively, the Los Angeles County Jail and New York Rikers Island Jail are currently the two largest psychiatric inpatient treatment facilities in the country" (p. 3).

Roughly half of all individuals with mental illness are arrested at least once, and the vast majority of these arrests are typically for minor offenses (Solomon & Draine, 1995a; Walsh & Bricourt, 1997). Those persons who are seriously and persistently mentally ill and are symptomatic in the presence of law enforcement officers have a much greater probability of being arrested and tend to stay in jail for a longer duration than those individuals who are not mentally ill (Solomon & Draine, 1995b). Without treatment, the condition of the mentally ill in jail further deteriorates (Stone, 1997), and the mentally ill in custody are prone to victimization, such as assaults and rapes, and to being disciplined, to include solitary confinement, for violation of codes of conduct that they cannot begin to understand while in crisis; suicides are not uncommon among this population (Kondo, 2000).

THE CRIMINALIZATION OF THE MENTALLY ILL

Several factors have been identified as contributors to the current quandary that has resulted in the criminalization of the mentally ill. The deinstitutionalization movement has been blamed for releasing individuals from state hospitals with the belief that community treatment programs would be put in place to meet the needs of those entering society (Kalinich, Embert, & Senese, 1991; Winfree & Wooldredge, 1991). Due to a lack of funding and a variety of other reasons, the local programs for the most part never materialized (Jerrell & Komisaruk, 1991; Sargeant, 1992; Torrey, 1995). Hogan (2000), who was recently appointed by President Bush to chair a national commission on mental health, cautions that viewing deinstitutionalization as the sole culprit for criminalization of the mentally ill is an oversimplification and mistakenly implies that somehow reinstitutionalization would be the appropriate remedy.

Furthermore, private psychiatric hospitals and care providers are often selective in who they treat and can have a tendency to turn away the indigent mentally ill, with psychiatrists facing the prospects of losing their jobs and being sued for malpractice due to inadequate treatment resulting from managed-care penalties for excessive referrals (Miller, 1997). According to Stone (1997), a causal relationship exists between insurance restrictions and the manifestation of serious, persistent mental illness; better insurance coverage for the mentally ill would result in fewer mentally ill persons in jail. Unfortunately, legislation supporting parity coverage, whereby mental illnesses would be given the same preference on par with physical illnesses, was recently defeated in Congress (Sperling, 2002).

In addition to deinstitutionalization and the lack of community-based treatment services, Goldkamp and Irons-Guynn (2000) reported that an increasing homeless population,[6] the proclivity of the mentally ill to suffer from problems with substance abuse (co-occurring disorders)—coupled with heightened law enforcement initiatives as part of the war on drugs—and the increased criminal justice scrutiny given to quality-of-life violations and ordinance infractions has served to propel the criminal justice system into the social service system of last resort. Some officers who resort to the criminal justice system as a method of intervention for persons with mental illness refer to such actions as mercy bookings to provide shelter, safety, food, and treatment for those who may very well not obtain it elsewhere (Sargeant, 1992). Thus, seemingly, the only opportunity for treatment for impoverished persons with mental illness often comes with an arrest, yet the vehicle of arrest typically drives a person with mental illness into a criminal justice system that is largely inept at offering appropriate treatment (Butterfield, 1998; Kerle, 1998).

Many law enforcement officers throughout the country receive little training on how to effectively deal with the mentally ill in crisis, and, although there are some innovative models in place for handling this population, this is increasingly becoming a high liability area for law enforcement agencies (Hill & Logan, 2001). Assuming a person with mental illness is successfully brought for processing into jail, the person enters a world in which training for detention officers across the nation is woefully inadequate. Kerle (1998) found in a survey of 1,330 jails that 36% of jails provided officers no training on how to handle the mentally ill, with 84% of the jails offering anywhere from fewer than 3 hours of this type of training to no training at all. Walsh and Bricourt (1997) found that in excess of 20% of jails provide no formal access to mental health treatment, and Kerle (1998) reported that out of more than 3,000 jails nationwide, only 35 reflect models worthy of replication for the design of mental health treatment programs in jail. Such inadequacies recently led to a $5.4 million award for damages to a mentally ill defendant by a federal jury for reckless indifference, and this is said to constitute the largest damage award for lack of mental health treatment in jail (Kondo, 2000).

As noted by del Carmen (1998), in the law, duty follows knowledge (*City of Canton v. Harris*, 1989). In essence, better methods are known than the so-called treatment that most persons with mental illness are receiving within the criminal justice system, but we continue to abdicate our responsibility by forcing individuals into an ill-prepared system and do not consider the consequences of our intervention. The majority of persons jailed with mental illness are taken into custody for noncriminal conduct or for minor criminal offenses, but, regardless, jails are not likely to have a positive impact on per-

sons with mental illness and actually tend to exacerbate the symptoms of mental illness (Stone, 1997).

THERAPEUTIC JURISPRUDENCE

The traditional criminal justice system tends to look backward, finding fault and assessing blame, carrying out a punishment on someone for perpetrating a criminal act without much, if any, consideration of the consequences of the imposition of the penalty on the perpetrator or society. Therapeutic jurisprudence has been defined as the analysis of how "substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences" (Wexler & Winick, 1991, p. 981). Traditionally, lawyers are tuned in to their clients' desires when engaged in the adversarial process (Miller, 1997), and they tend to disregard what results from their decisions for both clients and society, as traditionally the long-range consequences of a legal decision are not considered (Finkleman & Grisso, 1994). In other words, it has been argued (Winick, 1997) that the criminal defense model is not conducive to assessing the treatment needs of persons with mental illness and is in actuality antitherapeutic:

> Therapeutic jurisprudence seeks to apply social science to examine law's impact on the mental and physical health of the people it affects. It recognizes that, whether we realize it or not, law functions as a therapeutic agent, bringing about therapeutic or nontherapeutic consequences. (Winick, 1997, p. 187)

Decisions within the therapeutic jurisprudence framework are made with consideration of future ramifications for individuals, relationships, and society long after a person's contact with the criminal justice system has ceased.

THE EMERGENCE OF MENTAL HEALTH COURTS

Judge Dennis Challeen (1986) has argued that common sense should be employed to resolve a number of issues confronting the criminal justice system.[7] In fact, the foundation for establishment of what is considered the nation's first mental health court in Broward County Florida, which began operation in 1997, was laid by mere citizens—members of a grand jury (Slate, 2000).[8] All too often, it takes tragedies to provide the impetus for meaningful change in the treatment and handling of the mentally ill within the criminal justice system, as has also been the case with various police departments that have implemented crisis intervention training for their offi-

cers to more appropriately deal with encounters with the mentally ill without unnecessary escalation (Slate, 2000).

Broward County's mental health court was founded squarely on the principle of therapeutic jurisprudence and has been used as an example for a number of different jurisdictions to consider in the implementation of their own mental health courts (Slate, 2000). The first drug court originated in Miami, Florida in 1989 (Hasselbrack, 2001), and, although a separate, distinct movement from that of mental health courts, drug courts are in line with the concept of therapeutic jurisprudence and balancing the criminal process with therapeutic drug treatment concerns (Watson, Luchins, Hanrahan, Heyrman, & Lurigio, 2000). Goldkamp and Irons-Guynn (2000) considered drug courts and mental health courts, as well as community courts, domestic violence courts, and re-entry courts to fall within the general purview of "problem-solving" initiatives. Due to similar philosophical underpinnings and the magnitude of co-occurring disorders, it is not surprising that several mental health court tracks have sprung up within drug treatment courts (Watson et al., 2000).

What Constitutes a Mental Health Court

Although Congress initially attached no money to America's Law Enforcement and Mental Health Project Act for funding mental health courts (Public Law, 2000) on being signed by President Clinton, Congress ultimately authorized $4 million to be dispensed by the attorney general to support the grant program. Currently, Congress has also appropriated $5 million to the Substance Abuse and Mental Health Services Agency (SAMHSA) to assist in initiatives aimed at diverting persons with mental illness from the criminal justice system (M. Thompson, personal communication, March 18, 2002). Officials from SAMHSA met with Department of Justice (DOJ) representatives in Chicago in March of 2002 to explore how their allocation of monies might serve to complement each other at an event coordinated by the Council of State Governments.

As has been noted by several observers, there is no single, common mental health court model (Goldkamp & Irons-Guynn, 2000; Steadman, Davidson, & Brown, 2001; Watson et al., 2000, 2001). With this in mind, the Council on State Governments convened a number of panelists from across the country to meet with representatives from the DOJ and the SAMHSA, as well as other interviewers representing the criminal justice and mental health systems, to provide guidance in structuring grant parameters for mental health court funding prior to the issuance of a request for grant proposals (which was posted on the Bureau of Justice Assistance Web site). Several of us who testi-

fied before Congress in September of 2000, preceding passage of the bill authorizing funding for mental health courts, were among the panelists appearing before the interviewers; Steadman and Goldkamp (via telephone) cited above were also interviewed. Other mental health advocates and another consumer of mental health services participated as well. Law enforcement representatives, prosecutors, defense attorneys, a court administrator, mental health court judges, a victim's advocate, mental health directors, and community-based mental health and correctional directors from all over the country also appeared before the interviewers over a 3-day period.

Some of the recommendations centered on commonalities that Goldkamp and Irons-Guynn (2000) had identified in their study of four of the earliest mental health courts in Broward County (Fort Lauderdale), Florida; King County (Seattle), Washington; Anchorage, Alaska; and San Bernardino, California. These Goldkamp and Irons-Guynn commonalities between the four courts include the following:

- A special docket composed primarily of nonviolent mentally ill misdemeanants (exception: Broward County will accept battery cases if the victim voluntarily consents, and San Bernardino County will actually hear felony cases).
- Acceptance of mentally ill defendants with extensive criminal backgrounds in an effort to stop the recycling through the system with proper treatment interventions.
- The judge as a central, integral part of the process, with varying styles among the four different courts, giving voice to persons with mental illness who appear before him/her in accordance with the principle of therapeutic jurisprudence.
- New working relationships established between the criminal and mental health systems, wherein roles and responsibilities for various entities can be specified in the form of memorandums of understanding delineating agreements between agencies.
- Participation from all of the key players from the initial planning processes for the mental health court to periodic meetings and evaluation after the court is operating; generally, among the key players can be, of course, the presiding judge and his or her immediate staff, clinical caseworkers and administrators linked to public and/or private mental health care providers in the community, representatives from both the prosecution and the defense, law enforcement personnel to include jail administrators, sometimes probation officials, mental health advocates, and consumers of mental health services.
- Much of the courtroom process is aimed, with the assistance of clinical caseworkers, at trying to make an initial, sometimes cursory, assessment of an individual for a history and/or signs and symptoms of mental illness and then getting a person with mental illness typically out of jail and voluntarily into treatment as expeditiously as possible.
- A linkage to a varying range of treatment and support services contingent on availability in the community, with the whole process being underpinned by multiagency and system support.

In research conducted by Griffin et al. (in press), they focused on the four courts covered in the previous study, as well as mental health courts in Santa Barbara, California; Clark County (Vancouver), Washington; Seattle, Washington; and Marion County (Indianapolis), Indiana. They found three types of postbooking statuses emerged after examination of these eight courts. Some of the courts tended not to accept a plea and to withhold adjudication, whereby charges would be dismissed on successful completion of requirements set by the court. Other courts operated after the matter was adjudicated (postplea) but would defer imposition of sentence; in other courts, an individual would be convicted and then placed on probation sometimes via a deferred or suspended sentence.

As noted by Griffin et al. (in press), many of the courts in the study relied on dismissed charges once the mental health court regimen had been successfully completed and, with the exception of the one court that routinely accepts felony cases (San Bernardino), the courts very infrequently resort to jail confinement as a sanction for noncompliance with court dictates, which is contrary to the trend seen in drug courts. The linkage of individuals to treatment in the community, as opposed to jail, is considered to be of paramount importance in hopefully preventing the revolving door back into the criminal justice system of persons with mental illness. In one jurisdiction, on successful completion of program requirements, guilty pleas can be withdrawn, and in another jurisdiction, once charges are dismissed, a request for expungement of the arrest from the record can be made (Griffin et al., in press).

Griffin et al. (in press) uncovered three different methods for supervision of mental health court clients in the community in their study. According to Griffin et al., supervision is maintained by representatives from area community treatment providers, probation officers or mental health court staff, or teams composed of both mental health and probation personnel. State law may need to be consulted to determine if changes are needed to allow probation or supervised release for persons with mental illness who have not been convicted of a crime or for crimes that would not normally allow such statuses and/or would require a mandatory period of confinement (Watson et al., 2000).

These probation and/or mental health personnel can also be utilized in status hearings to assist the court in monitoring the progress of those under supervision by the court (Lurigio & Swartz, 2000; Petrila, Poythress, McGaha, & Boothroyd, 2001). Employees under the mental health court's control can also function as boundary spanners or resource brokers to ensure that persons with mental illness who appear before the court can be linked to essential services such as treatment, benefits, housing, and vocational/employment opportunities (McCampbell, 2001; Steadman et al., 2001).

Areas of Concern With Mental Health Courts

A basic tenet of mental health courts is that participation in them on the part of persons with mental illness should be voluntary; however, some critics view the process as coercive (Goldkamp & Irons-Guynn, 2000; McCampbell, 2001). If a person is mentally ill, it is reasoned, how can it be determined that he/she is competent to make a decision to voluntarily submit to treatment? Although Petrila et al. (2001) acknowledged that voluntariness versus coercion is a point of contention, in a preliminary evaluation of the mental health court in Broward County, approximately 5% of those eligible for processing within the court's framework elected not to participate. It was noted that the court had various diagnostic tools at its disposal, including competency evaluations, to assist in ensuring that persons with mental illness appearing before the court made their decisions voluntarily. It has also been observed that opting for treatment under the auspices of the mental health court may infringe on one's liberty by putting persons under the control of the criminal justice system for a considerably longer period of time than if they had been processed through traditional means; however, mental health court personnel maintain such infringements are aimed at thwarting the cycle of release and rearrest, which leads to the recycling in and out of the criminal justice system that is customary for this population (Petrila et al., 2001). Overemphasis on coercive aspects of mental health courts may lead to underestimation of the increased benefits that can be realized by new alliances and cooperative partnerships between the mental health and criminal justice systems (Griffin et al., in press). An example of such partnerships can be seen in the use of assertive community treatment (ACT) to provide coordinated supervision and treatment options to persons with mental illness who come in contact with the criminal justice system via a team approach (psychiatrists, clinicians, nurses, social workers, substance abuse specialists, and vocational and rehabilitation counselors and peer counselors who provide needed services and help monitor the client in the community and will even follow the client to jail when possible) (Allness & Knoedler, 1999; Edgar, 2001; Kondo, 2000; Lurigio & Swartz, 2000).

Some opponents of mental health courts argue that this process of singling out persons with mental illness who have come in contact with the criminal justice system and placing them on a special docket before a special judge and drawing them under more scrutiny than usual is stigmatizing (McCampbell, 2001). However, it is not clear how many of these critics have actually sat in a mental health courtroom and watched the dignity and respect with which persons with mental illness are treated, as persons with mental illness are given what Petrila et al. (2001) referred to as voice. Nor is it evident how many of these critics have observed status hearings whereby success sto-

ries emerge as persons with mental illness and family members stand before the court and express thanks for changing and saving their lives. Personally, being thrown in jail and assaulted by inmates and detention officers for something I was not responsible for is more dehumanizing and more of a blow to the psyche than being expeditiously brought before a mental health court judge who knows what he or she is doing and can link one to appropriate treatment.

According to George Bernard Shaw, as quoted by Kittrie (1978), "If you are to punish a man, you must injure him. If you are to reform a man, you must improve him, and men are not improved by injuries" (pp. 1-2). Putting persons with mental illness in jail for conduct for which they are not responsible, with little to no treatment and typically no follow-up on reentry to society, is an almost certain way to ensure failure. It appears more often than not that we are doing more harm than good with persons with mental illness who come in contact with the criminal justice system, making symptoms worse and exacerbating recidivism for this population that proves costly for jails and taxpayers. The opportunity to avoid a criminal record and obtain needed treatment through mental health court processing can aid in warding off future law violations and is less stigmatizing, more promising, and more humane than the vast majority of procedures currently in place. Individual law enforcement agencies may maintain internal confidential records coded for future reference to better ensure safety, designating previous calls made to a person with mental illness; however, I believe that in the spirit of avoiding stigma and the punishment of individuals who are not responsible for their actions, it is imperative that where possible, particularly with persons with mental illness who are misdemeanant offenders, arrests should be expunged as individuals are stabilized and prepared for future accountability. Stigmatizing and punishing an individual for a biochemical imbalance is analogous to blaming and retaliating against a person for having diabetes. Education of a largely ignorant public, starting within the criminal justice system, is needed.

Linked to the issue of stigma are concerns about ensuring the confidentiality of medical records containing the mental health histories of individuals appearing before the mental health court as assessments are made (Goldkamp & Irons-Guynn, 2000). Procedures can certainly be put in place to allow for clients, providing they are competent, to sign waivers releasing confidential information to the court. Judges can also restrict inquiries to the mental health of the person before the court and not consider the case that has brought him/her before the criminal court until the individual is stabilized.

Family members can sometimes be a good source of information as well. Also, the utilization by the court of mental health professionals on staff can serve to better facilitate the dissemination and sharing of medical treatment

histories from health care providers to those directly engaged in the treatment process. Notifying area mental health care providers via computer of persons being booked into jail can provide another cross-check for keeping persons with mental illness on the radar screen before they fall through the cracks and flounder within the criminal justice system.

Questions have been raised about whether the implementation of mental health courts merely results in a shifting of scarce resources to a priority group of persons with mental illness who come in contact with the criminal justice system (Steadman et al., 2001; Watson et al., 2001). According to Goldkamp and Irons-Guynn (2000), if mental health treatment services are scarce, more efficient identification of persons in need of treatment via the court may put ever increasing demands on a system unable to adequately respond, perhaps resulting in some individuals not prioritized for treatment intervention going without. However, that line of reasoning is somewhat analogous to blaming incarcerated inmates for receiving free medical care, whereas law-abiding citizens enjoy no such luxury. Instead of condemning the recipients of treatment, shouldn't we be holding lawmakers and policy makers accountable and asking them why everyone within our society does not have needed treatment made available to them?

CONCLUSION

In many respects, the underfunded mental health system has abdicated its responsibility (Goldkamp & Irons-Guynn, 2000; Haney, 1997; McCampbell, 2001; Slate, 2000), and the burden for treatment of persons with mental illness has shifted to a criminal justice system that has been ill-prepared for such endeavors. The two systems working together collaboratively offer promise for successful resolutions. The court is a prime place to look for leadership in this area. When a judge calls a meeting, people show up. As noted by Petrila et al. (2001), rare is a mental health treatment provider who would deny access to a client referred by the court. This power of the court to access services and successfully navigate and ensure the linkage of individuals to treatment cannot be discounted (Kondo, 2000; Slate, 2000). Such mental health court initiatives operating to divert individuals from the criminal justice system and into the community, encouraging and supporting treatment, if successful, should lead to the prevention of the mentally ill from entering the criminal justice system in the first place and arguably could serve eventually to put mental health courts out of business (Goldkamp & Irons-Guynn, 2000).

In addition to the previously mentioned mental health courts in operation, other mental health courts can be found in Jefferson County (Birmingham),

Alabama (Bureau of Justice Assistance, 2000); Sarasota County, Florida (Barton, 2001); Davidson County (Nashville); Tennessee (Tennessee Department of Mental Health and Developmental Disabilities, 2001); Butler County (Cincinnati), Ohio (Harrison, 2001); Riverside County, California (accepts nonviolent felons as well) (Kataoka, 2002); and Santa Clara County, California (a mental health court for juveniles) (Arredondo et al., 2001). Currently, it is estimated that there are approximately 29 mental health courts across the nation (Griffin et al., in press).

The passage of the bill providing federal funding for mental health courts marked congressional support for this concept, yet this support was based on an extremely short history, an ambiguous model, and unevaluated efficiency (Steadman et al., 2001). Even so, with passage of the mental health courts' bill, the number of mental health courts across the country is certain to increase. Furthermore, of some of the initial investigations that have been conducted, of the 240 people diverted by Davidson County's (Nashville) Mental Health Court, as of January 11, 2001, only 6% had recidivated (The Associated Press, 2001); 83% reductions in the number of days spent in jail and 81% reductions in the number of days hospitalized were reported by the Anchorage, Alaska Mental Health Court for participants the year before coming in contact with the court and during their year of court involvement; in Marion County (Indianapolis), Indiana, only 15% of participants were found not to successfully complete the program over the past 3 years (Watson et al., 2001); and general satisfaction with meeting program goals was found by Petrila et al. (2001) among all parties interviewed in their preliminary evaluation of the nation's first mental health court in Broward County, Florida.

As mental health courts continue to develop and exist, more opportunities for research will present themselves. For example, Griffin et al. (in press), among other things, believed that comparison of outcomes of persons with mental illness situated in those mental health courts that require findings of guilt as compared to those diverted without adjudication might prove of interest; likewise, they urged future comparisons of the success of those monitored by mental health personnel versus probation officers.

Based on my personal experience, beyond having the collaborative team concept in place to support the mental health court process, it is imperative that persons with mental illness involved in nonviolent offenses who come into contact with the criminal justice system be identified and routed away from jail and into a conducive treatment environment at the absolute earliest point possible. Jail is a volatile place regardless, but persons with mental illness are particularly vulnerable to victimization. Education and training are essential for criminal justice practitioners to assist them in recognizing the signs and symptoms of mental illness and being able to deescalate encounters

with persons with mental illness. This training should include not only law enforcement and jail personnel (for example, booking officers are situated in a prime location to assist in the identification of individuals exhibiting signs and symptoms of mental illness), but it should also include lawyers and judges.[9]

Consumers of mental health services (and family members of persons with mental illness for that matter) who can be identified in the community through local affiliates of the National Alliance for the Mentally Ill, for example, can play an integral role in this training. Such participation provides an opportunity for criminal justice personnel to see a person with mental illness who is not in crisis and who is actually making a contribution to society and to them. As noted by McCampbell (2001), although less than 1% of individuals with mental illness engage in violent behavior, stereotypes leave the general public believing otherwise. According to Torrey (2000), 80% of persons with manic-depression and 60% of persons with schizophrenia can be treated successfully with today's psychotropic medications, and newer medicines are developed every day. Involving consumers in positive interactions with criminal justice practitioners, whereby insight can be offered by both sides for behaviors, can be beneficial for all concerned.

Early identification of the signs and symptoms of mental illness is not enough, however; persons with mental illness need to be linked to appropriate treatment as soon as possible. Custody without care can serve to further exacerbate the condition of a person with mental illness and can lead to permanent damage, diminishing the chances for full recovery. Too often, while conducting crisis intervention training sessions with law enforcement personnel, I have heard officers lament about how it is well and good to recognize the signs and symptoms of mental illness and to deescalate a situation to get a person with mental illness safely into treatment only to have that same person back on the street after 72 hours, causing the police problems again because he or she had been released by the treatment facility. Follow-up is essential. The court is a logical entity to get the key players to the table from the mental health and criminal justice systems to begin and continue dialogue and to aim for accountability.

There is a crucial balance between individual civil liberties and public safety (Miller, 1997):

> The state has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill. (p. 1173)

As noted by one observer, "In our zeal to protect basic, human freedoms . . . we have created a legal climate in which mentally ill patients, and sometimes the people around them, are dying with their rights on" (Treffert, 1973, p. 1041). Likewise, Hardin (1993), in an article titled "Uncivil Liberties," stated, "Far from respecting civil liberties, legal obstacles to treating the mentally ill limit or destroy the liberty of the person." As emphasized by Miller (1997),

> The central thesis of the procedural justice approach . . . is that participants in formal decision-making processes are often more concerned with the perceived fairness of the processes than with the results. The more active a part they are permitted to play in the decision making, the more satisfied participants are with the outcome. (p. 1174)

Although some judges may consider it contrary to their legal training to intervene in this murky, convoluted area, other judges with knowledge of the mental health system and/or surrounded by those with such expertise and armed with the techniques of therapeutic jurisprudence are willing to embark and navigate the course as problem solvers in the courtroom.

In an ideal world, there would be no need for mental health courts. Unfortunately, this is not an ideal world. If it were, our nation's jails would not contain so many persons with mental illness; I would never have been taken off my medication in 1994; I would not have been thrown in jail and assaulted in the first place and sent back to jail by an uninformed judicial authority for some more "treatment." On the other hand, without those experiences, I probably could not have disproved my former trainer at the department of corrections (with his pail of water metaphor) or my own notions about how laws are made, nor is it likely that I would have written this article. The journey from the jailhouse to Capitol Hill and then to this article has been quite enlightening. In the spirit of therapeutic jurisprudence, I hope that we can be cognizant of the mistakes of the past in the handling of persons with mental illness who have encountered the criminal justice system, without assessing blame and pointing fingers, while we strive in the future to implement commonsense solutions such as mental health courts.

Although John Hinckley Jr., who attempted to assassinate President Reagan, and Mark David Chapman, who assassinated John Lennon, were reportedly influenced by J. D. Salinger's book *The Catcher in the Rye* (Davis, 2000), there may be lessons that can be gleaned for the good of society and the criminal justice system from Salinger's seminal work. The character Holden Caulfield in *The Catcher in the Rye* envisioned himself standing in a field of rye on the edge of a cliff with the mission of catching all those in danger of falling and saving them from going over the edge of the cliff (Salinger, 1991).

I believe that in a civilized society, we are morally responsible for catching those persons with mental illness that we can and saving them from going over the edge of the cliff into the abyss of the correctional system; judges seem to be in a logical position to serve as such catchers.

NOTES

1. Representatives from both the Memphis Police Department and the St. Petersburg Police Department point to incidents in which mentally ill persons were tragically shot by the police as providing an impetus to implement crisis intervention training; likewise, as will be discussed later in Note 8, tragedy precipitated the establishment of the nation's first mental health court (Slate, 2000).

2. Others testifying before the congressional subcommittee were the Honorable Mike DeWine, (R) U.S. Senator, Ohio; the Honorable Ted D. Strickland, (D) U.S. Congressman, Ohio; Dr. Bernard S. Arons, director, Center for Mental Health Services, Department of Health and Human Services; Chief Bernard Melekian, president, Los Angeles County Police Chiefs Association, and Pasadena Police Department, Pasadena, California; Kim Webdale, New York, New York; Michael F. Hogan, Ph.D., director, Ohio Department of Mental Health; Steven Sharfstein, M.D., medical director, Sheppard Pratt Health Systems, Baltimore, Maryland; Donald F. Eslinger, sheriff, Seminole County, president, Stanford, Florida; the Honorable Michael Schrunk, district attorney, Multonomah County, Portland, Oregon; the Honorable James D. Cayce, judge, King County Courthouse, Seattle, Washington; Reginald A. Wilkinson, Ed.D., director, Department of Rehabilitation and Correction, and vice president, Association of State Correctional Administrators, Columbus, Ohio; the Honorable Robert J. Thompson, State Senator and Chair, Law and Justice Committee, Harrisburg, Pennsylvania (Witness List, 2000).

3. Kim Webdale (2000) related the story of the horrific killing of her sister, Kendra, by Andrew Goldstein, to the subcommittee. Kim told of how Goldstein, a mentally ill man who had been repeatedly in and out of treatment, with up to 13 violent incidents in his past, threw her sister in the path of a subway train in New York City. She spoke of how Goldstein would be released from treatment providers with little to no medication or provisions for follow-up. The more Kim and her family delved into what had led to Kendra's tragic death, the more Kim reported they found her sister to have been the "unsuspecting victim of a sick man and an equally sick system."

4. Our commission lasted from October 22, 1999, until May 15, 2001. We traversed the state of Florida holding public hearings and published our recommendations that have seemingly, largely gone unnoticed, particularly in terms of any legislative mandates in the area of persons with mental illness who encounter the criminal justice system (Florida Commission on Mental Health and Substance Abuse, 2001).

5. According to Amador and Johnson (2000), approximately half of all persons with schizophrenia and manic-depression suffer from a medical condition referred to as anosognosia, which leads to lack of awareness or insight that one is ill.

6. Kondo (2000) reported that it is estimated that somewhere between 40% to 50% of the homeless population has a serious mental illness.

7. Kondo (2000, p. 439) indicated that Utah's Division of Mental Health considers the establishment of a mental health court to be a "commonsense approach" for handling the increasing numbers of persons with mental illness crowding Utah's prisons and jails.

8. As related by Chief Public Defender Howard Finklestein to Slate (2000), an individual who had suffered a traumatic head injury, on hearing voices in a grocery store, ran outside and

into a little old lady, knocking her and her bag of groceries to the ground. Witnesses observed him trying to put her groceries back into the bag and believed he was trying to rob her, according to Finklestein. The lady ultimately died from injuries sustained in the fall, and the fellow with the head injury was indicted for manslaughter. Finklestein essentially told the grand jury that if they were going to indict his client that they should indict the mental health and criminal justice systems for failing his client time and again and putting him in the position for this to happen. The grand jury launched an investigation that resulted in a 153-page report lambasting both the mental health and criminal justice systems. According to Finklestein, the grand jury's recommendations provided the impetus for establishment of Broward County's mental health court. Wonder how many other jurisdictions in America could withstand such scrutiny? It should also be noted that Hasselbrack (2001) reported that the family of Finklestin's client received a $17 million award as the result of a civil suit against Florida's Department of Children and Families.

9. Howard Finklestein, chief public defender in Broward County Florida, indicated that, fortunately, one of the first cases that ultimately made it to the nation's first mental health court involved a gentleman who had just been released from the hospital. On release, the fellow stood on the steps of the hospital waiting for a stretch limousine to come pick him up and drive him to New York to be married to Joan Rivers. The limousine never materialized, and hospital attendants called the police. The subject was arrested, and, at the initial appearance, the judge did not appreciate the comportment of the man who had been waiting for Joan Rivers. Before the case eventually made it before the mental health court, the presiding judge charged the man with contempt of court and ordered him to spend 179 days in jail (Slate, 2000). This is quite a contrast to the less rigid atmosphere that can be found in most mental health courts. For example, Judge Scott Anders of Vancouver, Washington's mental health court allows consumers appearing before his court to address him by his first name (S. Anders, personal communication, November 29, 2001). Obviously, there is a need for the education of most judges, and lawyers for that matter, regarding the signs and symptoms of mental illness and appropriate measures for processing persons with mental illness who encounter the criminal justice system. Vickers (2001) has been instrumental in getting mental illness awareness training mandated by the Florida Bar as part of continuing legal education credits.

REFERENCES

Allness, D. J., & Knoedler, W. H. (1999). *The PACT model of community-based treatment for persons with severe and persistent mental illnesses: A manual for PACT start-up*. Arlington, VA: National Alliance for the Mentally Ill.

Amador, X., & Johnson, A. L. (2000). *I am not sick, I don't need help: Helping the seriously mentally ill accept treatment, a practical guide for families and therapists*. Peconic, NY: Vida Press.

Arredondo, D. E., Kumli, K., Soto, L., Colin, E., Ornellas, J,. Davilla, Jr., et al. (2001). Juvenile mental health court: Rationale and protocols. *Juvenile and Family Court Journal*, *52*(4), 1-19.

The Associated Press. (2001, December 26). Court's focus is on mental health. *Chattanooga Times*.

Barton, J. (2001, December 26). *New court will help mentally ill*. Retrieved April 20, 2002, from the Sarasota Herald-Tribune's Web site, www.heraldtribune.com/2news.cfm?ID=58717

Bureau of Justice Assistance. (2000, September 7). *Jefferson County receives Justice Department grant to pursue innovative solutions to local problems*. Retrieved April 20, 2002, from

the U.S. Department of Justice, Office of Justice Programs's Web site, www.ojp.usdoj.gov/pressreleases/2000/sept7-19.htm

Butterfield, F. (1998, March 5). Prisons replace hospitals for the nation's mentally ill. *The New York Times*, pp. 1A, 18A.

Challeen, D. A. (1986). *Making it right: A common sense approach to criminal justice*. Aberdeen, SD: Melius and Peterson.

City of Canton v. Harris, 489 U.S. 378 (1989).

Davis, P. (2000, April 17). *Don't let Hinckley roam free*. Retrieved May 26, 2002 from Time magazine's Web site, www.time/magazine/printout/0,8816,42859,00html

del Carmen, R. V. (1998). *Criminal procedure: Law and practice* (4th ed.). Belmont, CA: Wadsworth.

Ditton, P. M. (1999). *Mental health and treatment of inmates and probationers: Special report*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Dowie, M. (1982). Pinto madness. In J. H. Skolnick & E. Currie (Eds.), *Crisis in American institutions* (5th ed., pp. 21-37). Boston: Little, Brown.

Edgar, E. (2001, fall). Assertive community treatment provides jail diversion. *NAMI Advocate*, 28.

Finkelman, D., & Grisso, T. (1994). Therapeutic jurisprudence: From idea to application. *New England Journal on Criminal and Civil Confinement*, *20*, 243-257.

Florida Commission on Mental Health and Substance Abuse. (2001, January). *Final report* (Unpublished).

Goldkamp, J. S., & Irons-Guynn, C. (2000). *Emerging judicial strategies for the mentally ill in the criminal caseload: Mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance.

Griffin, P. A., Steadman, H. J., & Petrila, J. (in press). The use of criminal charges and sanctions in mental health courts. *Psychiatric Services*.

Haney, C. (1997). Psychology and the limits to prison pain: Confronting the coming crisis in Eighth Amendment law. *Psychology, Public Policy and Law*, *3*, 499-588.

Hardin, H. (1993, July 22). *Uncivil liberties*. Retrieved April 21, 2002, from the Vancouver Sun's Web site, www.psychlaws.org/GeneralResources/Article1.htm

Harrison, B. K. (2001, October 15). *Butler County treatment alternative court program: Mental health diversion*. Cincinnati, OH: Butler County Mental Health Board.

Hasselbrack, A. M. (2001). Opting in to mental health courts. *Corrections Compendium*, *26*(10), 4-25.

Hearing on the impact of mentally ill offenders on the criminal justice system: Hearing before the Subcommittee on Crime of the Committee on the Judiciary, U.S. House of Representatives, 106th Cong., 2nd Sess. (2000, September 21).

Hill, R., & Logan, J. (2001, June). Civil liability and mental illness: A proactive model to mitigate claims. *The Police Chief*, pp. 29-32.

Hogan, M. F. (2000, September, 21). *Testimony before the Subcommittee on Crime of the Committee on the Judiciary, U.S. House of Representatives*. Retrieved May 18, 2002, from www.house.gov/judiciary/hoga0921.htm

Jerrell, J. M., & Komisaruk, R. (1991). Public policy issues in the delivery of mental health services in a jail setting. In J. A. Thompson & G. L. Mays, (Eds.), *American jails: Public policy issues* (pp. 100-115). Chicago: Nelson-Hall.

Kalinich, D., Embert, P., & Senese, J. (1991). Mental health services for jail inmates: Imprecise standards, traditional philosophies, and the need for change. In J. A. Thompson & G. L. Mays, (Eds.), *American jails: Public policy issues* (pp. 79-99). Chicago: Nelson-Hall.

Kataoka, M. (2002, February 4). *Mental health courts impress, inland: Evaluators say trying to salvage the lives of even violent felons is money well spent*. Retrieved April 20, 2002, from The Press Enterprise's Web site, http://pe.com/localnews/stories/10025187_PE_NEWS_nmental04.html

Kerle, K. E. (1998). *American jails: Looking to the future*. Boston: Butterworth-Heinemann.

Kittrie, N. N. (1978). *The right to be different*. Baltimore: Johns Hopkins University Press.

Kondo, L. L. (2000). Therapeutic jurisprudence: Issues, analysis and applications: Advocacy of the establishment of mental health specialty courts in the provision of therapeutic justice for mentally ill offenders. *Seattle University Law Review*, *24*, 373-464.

Leifman, S. (2001, August 16). Mentally ill and in jail. *The Washington Post*, p. A25.

Lerner-Wren, G. (2000). Broward's mental health court: An innovative approach to the mentally disabled in the criminal justice system. *Community Mental Health Report*, *1*(1), 5-6, 16.

Lurigio, A. J., & Swartz, J. A. (2000). *Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness*. Washington, DC: National Institute of Justice.

McCampbell, S. W. (2001). Mental health courts: What sheriffs need to know. *Sheriff*, *53*(2), 40-43.

Miller, R. D. (1997). Symposium on coercion: An interdisciplinary examination of coercion, exploitation, and the law: III. Coerced confinement and treatment: The continuum of coercion: Constitutional and clinical considerations in the treatment of mentally disordered persons. *Denver University Law Review*, *74*, 1169-1214.

Petrila, J., Poythress, N. G., McGaha, A., & Boothroyd, R. A. (2001). Preliminary observations from an evaluation of the Broward County mental health court. *Court Review*, *37*, 14-22.

Public Law 106-515, *America's Law Enforcement and Mental Health Project Act*. (2000).

Salinger, J. D. (1991). *The catcher in the rye*. Boston: Little, Brown.

Sargeant, G. (1992, December). Back to bedlam: Mentally ill often jailed without charges. *Trial*, pp. 96-98.

Sharfstein, S. S. (2000, September 21). *Testimony before the Subcommittee on Crime of the Committee on the Judiciary, U.S. House of Representatives*. Retrieved April 21, 2002, from http://www.house.gov/judiciary/shar0921.htm

Sharfstein, S. S. (2001). The case for caring coercion. *Catalyst*, *3*(4), 1-2.

Slate, R. N. (2000). Courts for mentally ill offenders: Necessity or abdication of responsibility. In G. L. Mays & P. R. Gregware (Eds.), *Courts and justice* (2nd ed., pp. 432-450). Prospect Heights, IL: Waveland.

Solomon, P., & Draine, J. (1995a). Issues in serving the forensic client. *Social Work*, *40*(1), 25-33.

Solomon, P., & Draine, J. (1995b). Jail recidivism in a forensic case management program. *Health and Social Work*, *20*(3), 167-173.

Sperling, A. (2002, winter). House members vote down parity amendment. *NAMI Advocate*, *1*, 16.

Steadman, H. J., Davidson, S., & Brown, C. (2001). Mental health courts: Their promise and unanswered questions. *Psychiatric Services*, *52*(4), 457-458.

Stone, T. H. (1997). Therapeutic implications of incarceration for persons with severe mental disorders: Searching for rational health policy. *American Journal of Criminal Law*, *24*, 283-358.

Tennessee Department of Mental Health and Developmental Disabilities. (2001). Mental health courts gaining momentum. *Update*, *7*(3), 2.

Torrey, E. F. (1995). Jails and prisons—America's new mental hospitals. *American Journal of Public Health*, *85*(12), 1611-1613.

Torrey, E. F. (2000, June 19). *Keeping the mentally ill out of our jails and in treatment*. Panel presentation at the National Sheriffs' Association Conference, Kansas City, MO.

Treffert, D. A. (1973). Dying with their rights on [Letter]. *American Journal of Psychiatry*, *130*, 1041.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.

Vickers, A. D. (2001). Attorney education about mental illnesses. *Catalyst*, *3*(4), 2-4.

Walker, S. (1989). *Sense and nonsense about crime: A policy guide* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Walsh, J., & Bricourt, J. (1997, July-August). Services for persons with mental illness in jail: Implications for family involvement. *Families in Society: The Journal of Contemporary Human Services*, pp. 420-428.

Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the complex issue of mentally ill offenders. *Psychiatric Services*, *52*(4), 477-481.

Watson, A., Luchins, D., Hanrahan, P., Heyrman, M. J., & Lurigio, A. (2000). Mental health court: Promises and limitations. *Journal of the American Academy of Psychiatry and the Law*, *28*, 476-482.

Webdale, K. (2000, September, 21). *Testimony before the Subcommittee on Crime of the Committee on the Judiciary, U.S. House of Representatives*. Retrieved April 21, 2002, from www.house.gov/judiciary/webd0921.htm

Wexler, D. B., & Winick, B. J. (1991). Therapeutic jurisprudence as a new approach to mental health law policy analysis and research. *University of Miami Law Review*, *45*, 979-1004.

Winfree, L. T., & Wooldredge, J. D. (1991). Exploring suicides and deaths by natural causes in America's large jails: A panel study of institutional change, 1978 and 1983. In J. A. Thompson & G. L. Mays (Eds.), *American jails: Public policy issues* (pp. 63-78). Chicago: Nelson-Hall.

Winick, B. J. (1997). The jurisprudence of therapeutic jurisprudence. *Psychology, Public Policy and Law*, *3*, 184-206.

Witness List. (2000). *Hearing on the impact of mentally ill offenders on the criminal justice system: Hearing before the Subcommittee on Crime of the Committee on the Judiciary*. U.S. House of Representatives, 106th Cong., 2nd Sess. Retrieved April 21, 2002, from www.house.gov/judiciary/cr