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Perceived coercion and procedural justice in the Broward mental health court

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1. Introduction

1.1. The rise of mental health courts

Approximately 700,000 people with major mental disorder enter United States jails each year (U.S. Department of Justice, 1999), many of whom are arrested repeatedly for minor felonies and misdemeanors. It is increasingly assumed that their mental disorder and attendant difficulties accessing clinical services and social support programs contribute to this pattern of repeated contact with the criminal justice system. This in turn frustrates the efficiency concerns of the criminal justice system because of the extensive resources consumed by repeatedly booking, jailing, and attempting to treat these individuals in the jail setting. It also frustrates therapeutic objectives because these individuals may become increasingly distant and disengaged from their families and from community-based mental health services.

The most recent innovation to address this problem has come in the form of specialty courts called mental health courts. Based somewhat on the drug court model, mental health courts vary in terms of point of intervention (e.g., pre- versus postadjudication), eligibility requirements (most are limited people with mental illness charged with nonviolent misdemeanors), the use of sanctions, and in other particulars (see Goldkamp & Irons-Guynn, 2000). However, all appear to have as a primary goal interrupting the cycle of repeat offending and incarceration through the expeditious processing of defendants with mental illness, providing access to treatment and social supports, and assuring public safety (Lerner-Wren, 2000).

To date no mental health court has been evaluated systematically to determine its efficacy and outcomes. We are currently involved in a 2-year evaluation of the Broward County

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mental health court in Ft. Lauderdale, Florida, which became operational in June 1997 and was the first mental health court in the country. Our evaluation is multifaceted (see Petrila, Poythress, McGaha, & Boothroyd, 2001) and will eventually yield information on treatment involvement, community adjustment, criminal recidivism, quality of life and other outcomes. Many of the study outcomes relate to efficiency and efficacy issues and the findings will not be available until the follow-up interviews and analyses are completed. However, the court also has an explicit philosophy that directs its mission and specific aspirations regarding the impact of the mental health court process on defendants and the role of the court vis-a-vis that of the client in taking ultimate responsibility for treatment involvement and therapeutic gain. In this regard, defendants' subjective experiences in terms of perceived coercion, procedural justice, and the emotional impact of mental health court involvement become important concerns in their own right as well as factors that may ultimately mediate other outcomes. In this paper, we describe findings regarding these issues.

1.2. The Broward County Florida mental health court

The Broward County mental health court (hereafter, MHC) was established by administrative order of the chief judge of the 17th Florida Judicial Circuit on June 6, 1997.[1] The court's jurisdiction is limited in general to nonviolent misdemeanants. Individuals charged with assault may come before the court with the victim's consent. The court employs no formal diagnostic screens to determine whether to accept jurisdiction; rather, a history of mental illness or mental health treatment, or apparent symptoms when the person comes before the court, may result in a decision by the court to take jurisdiction. According to a report on the court's operation, diagnoses of these individuals at the time of their appearance before the MHC included schizophrenia (18%); depression (10%); dual diagnoses of mental illness and substance or alcohol abuse (29%); bipolar disorders (13%); mental retardation (2%); and unknown (20%) (Second Year Progress Report, 1999).

Referral of a defendant to the court may come at any time or from any point in the criminal justice system, though magistrates conducting initial hearings make most referrals. The MHC generally conducts a jurisdictional hearing within 24 hours (and often sooner) from referral. Treatment staff from local mental health agencies are commonly present at the court, and the lawyers for the state and the defendant play very limited roles. If the court accepts jurisdiction, in most cases it will attempt to arrange treatment for the individual, and in many cases will conduct periodic status hearings to determine how the person is faring.

1.3. Therapeutic jurisprudence: legal philosophy guiding the Broward mental health court

Law professor David Wexler coined the term "therapeutic jurisprudence" to describe the view that the therapeutic consequences of legal action may be affected by variations

[1] Circuit Court of the Seventeenth Judicial Circuit, Broward County, Florida, *In Re: Creation of a Mental Health Court Subdivision Within the County Criminal Division*, Administrative Order No. VI-97-I-1A.

or interpretations in substantive rules, legal procedures, and in the roles of lawyers and judges (Wexler, 1990; Wexler & Winick, 1991). The Broward MHC "wholly adopts and applies the principles of Therapeutic Jurisprudence" (Lerner-Wren, 2000, p. 19) and has abandoned much of the "formal lawyering" and other stylistic aspects of a traditional adversarial forum in favor of methods designed to "advance the Court's role as an active therapeutic agent in the recovery process" (Lerner-Wren, 2000, p. 19; see also: Goldkamp & Irons-Guynn, 2000). Within this framework, the court hopes to reduce the stigma of mental illness, enhance defendants' autonomy, and promote "the assumption of personal responsibility and personal empowerment of the Court participant" (Lerner-Wren, 2000, p. 19). Both the actions and the aspirations of the MHC imply that reducing defendants' sense of coercion and enhancing their perceptions of procedural justice are important intermediate goals.

1.4. Coercion in court-ordered mental health services

The definition of "coercion" in mental health has received much attention and debate (Wertheimer, 1993). The crux of the debate, often in the context of civil commitment, is whether psychiatric and psychological treatment must be voluntary in order to work (see e.g., Group for the Advancement of Psychiatry, 1994; Stone, 1975). Early studies focused on patients' official legal status (involuntarily committed or not) as an objective indicator of coercion, although more recently consumers' subjective experience of the process of entering treatment has emerged as a critical outcome variable (Monahan et al., 1999). This assumes that "Coercion exists on a continuum . . . Mental health commitment and other court-ordered treatment is thus just the extreme end of the spectrum of pressures or restrictions that make up coercion" (Diamond, 1996, p. 55). The research summarized in Table 1 suggests that there may be a positive relationship between the degree to which psychiatric treatment is (objectively) legally compelled and the extent to which consumers experienced coercion in the treatment that they receive. However, most investigators note the considerable variation in perceived coercion within groups and caution against inferring too strongly any individual patient's level of perceived coercion from official legal status.

In the Broward County MHC, a defendant who agrees to the court's jurisdiction is usually referred to community mental health services. The law considers such treatment *voluntary* because the defendant has the legal right to opt out of MHC in favor of a regular misdemeanor court disposition. In light of this formal voluntary status and the MHC's goal that its clients become autonomous participants in their mental health care, our hypothesis for this study was that defendants would report relatively low levels of perceived coercion in MHC, comparable perhaps to the levels reported by patients receiving voluntary outpatient services in other studies (Table 1). However, some studies of civil commitment note that some patients report being unaware of the voluntary or involuntary nature of their hospitalizations even immediately after their hearings were concluded. We also considered, therefore, that some defendants might not be fully aware of the "voluntary" nature of their involvement in the MHC (and subsequent court-facilitated treatment). Thus, our second hypothesis was that defendants who reported being unaware of a clear legal choice about remaining in the

Table 1
Perceived coercion in various mental health populations

	Study site	*N*	Perceived coercion[a] mean (S.D.)
Involuntary psychiatric inpatients			
Hiday, Swartz, Swanson, and Wagner (1997)	US	331	2.9[b]
Hoge et al. (1997)	US	66	3.27 (2.16)
Cascardi et al. (1997)[c]	US	60	3.68 (1.76)
McKenna, Simpson, and Laidlaw (1999)	New Zealand	69	3.4 (1.7)
Poulsen (1999)	Denmark	47	3.5 (1.4)
Quasi-voluntary psychiatric inpatients[d]			
Cascardi et al. (1997)[c]	US	60	2.35 (1.79)
Poulsen (1999)	Denmark	48	2.1 (1.5)
Involuntary psychiatric outpatients			
Swartz et al. (1999)	US	123	2.1[b]
Voluntary psychiatric inpatients			
Hoge et al. (1997)	US	91	0.64 (1.07)
McKenna et al. (1999)	New Zealand	69	1.9 (1.8)
Poulsen (1999)	Denmark	48	1.7 (1.5)
Voluntary psychiatric outpatients			
Swartz et al. (1999)	US	129	1.3[b]

[a] All studies use one of two metrically equivalent measures of perceived coercion developed by Gardner et al. (1993). Possible mean scores range from 0 (*low*) to 5 (*high* perceived coercion).

[b] Standard deviation not reported.

[c] Data from Cascardi et al. (1997) were recoded for this analysis.

[d] In Cascardi et al. (1997), patients involuntarily admitted for a psychiatric evaluation to determine whether they met civil commitment criteria were subsequently permitted to sign into the facility on a "voluntary" basis. In Poulsen (1999) these patients had come into the hospital on a voluntary basis but were then detained by staff when they attempted to leave the facility.

jurisdiction of the MHC would report greater perceived coercion than defendants who were explicitly aware of their full range of options.

1.5. Procedural justice implications for mental health court

Procedural justice provides another perspective from which to view MHC and its potential impact on defendants served by the court. Procedural justice focuses on participants' subjective experience of the case disposition *process*. Research in a variety of conflict resolution contexts suggests that perceived fairness of the process is perhaps the most critical determinant of procedural justice. Key factors that affect perceived fairness include (1) voice (having one's own side of the dispute presented to and heard by the decision maker) and (2) being treated with respect and dignity by the authoritative decision maker (Lind & Tyler, 1988; Tyler, 1992).

Tyler (1992) hypothesized that in the context of court-ordered psychiatric treatment enhanced perceptions of procedural justice would be "... likely to facilitate the subsequent therapeutic process" (p. 439). While there has been very little empirical research to explore this hypothesis, at least two studies have concluded that individuals who have been subject to involuntary civil commitment hearings could discern procedural justice attributes in such hearings (Cascardi, Poythress & Hall, 2001; Greer, O'Regan, & Traverso, 1996).

It is clear that the Broward MHC aspires to facilitate positive procedural justice features. We have observed, as did Goldkamp and Irons-Guynn (2000), that

> ... the Broward Court was designed to be informal, often involving interaction and dialogue between the judge and the participant about problems and treatment options.... The ... Court [has] a respectful and helpful manner toward participants ... [and] ... adopts a supportive, instructive, problem-solving and understanding style ... designed to ... contribute to the improved mental health of its participants.... The patience and tolerance for the problems of comprehension and communication that defendants may have create an impression that speedy disposition of a large number of cases is not necessarily high priority. (pp. 23–24)

In contrast, our observations of the comparison court (a court of similar jurisdiction in a county chosen for its similarities to Broward County) suggest that such features are largely absent. Hearings are conducted by remote video, the judge and attorneys do most of the talking, and the implicit (if not explicit) agenda appears to be quick resolution of the charges, often through a plea agreement that is offered by the judge and agreed to by counsel, and defendants usually are not encouraged to speak except in response to plea offerings.

Against a null hypothesis of no differences in perceived procedural justice (PPJ) between these two courts, our alternative hypothesis was that mean scores on measures of PPJ would be higher for MHC defendants. Further, we predicted that both perceived coercion and procedural justice factors would predict clients' ratings of satisfaction with the outcome of their court hearings.

1.6. Emotional impact of court hearings

The expectation that MHC clients might have more positive emotional reactions to their hearings is derived from the considerations above regarding coercion and procedural justice. In MHC defendants become engaged in a dialogue with a highly respected authority who speaks to them in a respectful manner, offers a potentially better future through a court-monitored regime of mental health services (that often includes exploring for clients' benefits and entitlements), and places their criminal charge in abeyance with the (often explicit) prospect of no formal adjudication or, at least, no formal legal sanction. In contrast, defendants are relatively passive participants in the traditional misdemeanor court, which appears to have a clear agenda of rapid case disposition. Thus, against a null hypothesis of no differences, our alternative hypothesis was that more positive emotional reactions to the court hearing would be reported by defendants in the

MHC. Further, we hypothesized that the participants' emotional reactions to their hearings would be explained by perceived coercion, outcome satisfaction, and procedural justice factors; our hypothesis was that participants reporting less perceived coercion, greater satisfaction, and greater perceived fairness would report more positive emotional reactions to their court hearings.

2. Method

2.1. Participants

The MHC sample ($n = 121$) consisted of English-speaking defendants of either gender, between the ages of 18 and 64, whose cases were accepted by the MHC between December 1, 1999 and April 30, 2001. MHC jurisdiction depends on judicial findings that the individual (a) is charged with a nonviolent misdemeanor, ordinance violation, or criminal traffic offense;[2] (b) currently has, or previously has had, mental health problems;[3] (c) is able and willing to make a voluntary choice to have the case disposed in the MHC; and (d) would not pose significant public safety concerns. Individuals not meeting all of these criteria are returned to a regular misdemeanor court for disposition of their cases.

Our comparison group included 101 defendants from another county in Florida that does not have an MHC but who met the criteria (a) and (b) above for MHC jurisdiction in Broward County. Each currently had, or reported a history of, mental health problems.[4] To minimize the chance that clinical and demographic variables would be confounded with site differences in this study, our design called for the MHC and comparison samples to be matched on certain demographic variables (age, gender, race) and on current mental status. Thus, the recruitment in the comparison county lagged recruitment in the Broward

[2] Individuals charged with misdemeanor battery offenses may be accepted into MHC if the victim in the case agrees to this route of disposition. The Broward MHC does not accept persons charged with domestic violence or driving while intoxicated charges.

[3] Mental health screening is conducted in court or just prior to court by mental health professionals who work with the court or graduate students in clinical psychology from Nova Southeastern University working under supervision (Rabasca, 2000). However, the court may accept jurisdiction in the absence of formal diagnostic findings.

[4] In the comparison county, defendants with mental health issues were not automatically identified by the fact of their referral to/acceptance by an MHC. Thus, in this county our research assistants conducted brief mental health screening interviews in the jail with individuals who otherwise (e.g., appropriate type of offense; age and English-speaking criteria) met inclusion criteria. The screening questions asked: (1) Have you ever been treated for a mental health problem? (2) Have you ever been to a mental health center or psychiatric hospital for problems with your nerves, or have you ever had a case manager? (3) Have you ever had thoughts of hurting yourself or have you tried to hurt yourself? (4) Do you take now, or have you ever taken, medication for nerves (psychiatric medication)?

MHC in order to permit selection of comparison clients whose demographic and clinical features matched those of the Broward sample.

2.2. Measures

Basic demographic information was obtained from each participant by self-report. Other measures described here are part of a more extensive protocol used in our comprehensive evaluation of the MHC.

2.2.1. Perceived coercion

The MacArthur Perceived Coercion Scale (MPCS) is a 5-item measure derived from the MacArthur Admission Experience Interview (AEI: Gardner et al., 1993, p. 310). It was designed to assess perceived coercion associated with the process of hospital admission. The MPCS queries about (1) factors (e.g., "Mostly what I wanted. . . . Mostly what other people wanted") that *influence* the outcome (going into the hospital), (2) perceived *control* ("How much control did you have . . .?") over the outcome, (3) perceived *choice* in the outcome, (4) perceived *freedom* to accept or reject the outcome, and (5) perceived initiative ("Whose idea was it . . .? [Mostly mine . . . Mostly someone else's]") to go into the hospital. Participants select from an array of categorical responses for each item and these responses are quantified using a scoring scheme provided by Gardner et al. (1993, Table 6, p. 319). Total MPCS scores range from 0 (*low*) to 5 (*high* perceived coercion) and are reliable over brief intervals (r=.72, 12- to 24-hour retest), although stability is lower for individuals with severe psychotic symptoms (Cascardi, Poythress, & Ritterband, 1997). Because the MPCS was originally worded to assess perceptions of coercion in involuntary hospitalization, modifications in the items' wording was necessary for this study so that items referenced participation in MHC as the relevant outcome.[5] Because defendants in the comparison court did not have a choice about venue for disposing their cases, this measure was administered only to participants from the MHC.

2.2.2. Perceived procedural justice

A 5-item PPJ measure, similar to that used by Cascardi et al. (2001), was used to solicit participants' perceptions of the procedural justice features of their court hearings. Participants rated from 1 (*not at all*) to 7 (*definitely*) the degree to which (1) they had an opportunity to tell the judge information about their personal and legal situation (voice), (2) the judge seemed genuinely interested in them as a person, (3) the judge treated them with respect, (4) the judge treated them fairly, and (5) they were satisfied with how the judge treated them and dealt with their case. One additional Likert item, scored from 1 (*not at all*) to 7 (*definitely*), solicited participants' rating on the question "Are you satisfied with the decisions made about your

[5] A copy of the modified MPCS is available from the authors.

case today?'' (see Table 3). This item served as an index of defendants' satisfaction with the outcomes of their hearings.

2.3. Impact of hearing

A 6-item impact of hearing (IOH) measure solicited participants' ratings about how they felt as a result of being in court. On a scale ranging from 1 to 7, participants indicated whether they felt (1) worse or better, (2) upset versus calm, (3) less respected versus more respected, (4) confused versus informed, (5) less hopeful versus more hopeful, and (6) good or bad (globally) in comparison to how they felt prior to court (see Table 4).

2.3.1. Mental status

The anchored version of the Brief Psychiatric Rating Scale (BPRS-A: Woerner, Mannuzza, & Kane, 1988) was used to assess current mental status. The BPRS-A involves a brief interview (about 15 minutes) that inquires about recent (''the past week or two'') symptoms (e.g., anxiety, hostility, suspiciousness, etc.). Ratings of symptom severity for each of 18 items are made on the basis of observations and interview responses and these ratings are summed to yield a global index of current psychopathology. The BPRS has been used extensively in psychiatric research and in most studies reliability for the total pathology score exceeds 0.80, while median reliability for individual symptom ratings is about 0.75 (Gabbard et al., 1987).

2.4. Procedures

At each site, prospective participants were approached by trained research assistants who attended the court hearings and identified individuals who appeared to meet study criteria. Where possible an attempt was made to approach these individuals on the day of their hearing, but in no case any longer than 1 week after their hearing date. Written informed consent was obtained from each participant using procedures approved by the University of South Florida Institutional Review Board. In addition to the research assistant making a judgment regarding the participant's competence to consent to research, a brief (5 items) multiple-choice ''test'' of consent disclosure comprehension was administered to each prospective participant and only those who answered correctly three or more items were allowed to enroll in the study. As noted above (footnote 6), with defendants at the comparison site for whom no information was available regarding current or prior psychiatric problems, the research assistants also conducted a brief screening interview to determine that the defendant had current or prior mental health problems comparable to those that would likely provide an sufficient basis for acceptance into MHC.

The research protocol was administered on a one-to-one basis at a place convenient for the defendant. In some instances, the protocol was administered in an empty jury room adjacent to the court, in other instances at a place in the community (e.g., defendant's home, fast food restaurant). Some defendants not yet released from custody completed the protocol in the jail. Within the larger research protocol, the order of administration of the research

measures described here was demographics/social history interview, MPCS (MHC participants only), PPJ, IOH, and BPRS-A. Each participant received twenty dollars upon completion of the protocol.

3. Results

3.1. Sample description

Table 2 presents demographic and clinical features of the MHC and comparison site samples. These data indicate that our efforts to obtain matched samples have been highly successful. The mean ages of the two groups are comparable and the samples contain approximately the same proportions of defendants by primary racial groups, $\chi^2(1) = 1.93$, n.s. The MHC sample contains a slightly higher percentage of male participants than the comparison sample, although this difference is not statistically significant, $\chi^2(1) = 2.03$, n.s. In terms of marital status (not a matching variable), equal percentages of participants from both groups report being married currently; a somewhat higher percentage of comparison sample participants, 62.4% vs. 43%, $\chi^2(1) = 8.30$, $P < .005$, reports ever being married.

Table 2
Demographic and clinical characteristics of the mental health court and comparison samples

	Broward mental health court sample ($n = 121$)	Comparison sample ($n = 101$)
Demographics		
Age (*M*, S.D.)	38.04 (10.64)	37.98 (9.62)
Gender (*N*, %)		
Male	83 (68.6%)	60 (59.4%)
Race (*N*, %)		
African American	29 (24%)	27 (26.7%)
Caucasian	80 (66.1%)	57 (56.4%)
Marital status (*N*, %)		
Currently married	7 (5.8%)	6 (5.9%)
Ever married[a]	52 (43%)	63 (62.4%)
Never married	68 (56.2%)	38 (37.6%)
Current mental status (M, S.D.)		
Brief Psychiatric Rating Scale		
Total Score	34.42 (9.90)	34.21 (7.88)
Psychoticism subscale	4.89 (2.61)	4.23 (2.24)
Depression subscale	8.91 (4.42)	10.96 (4.12)
Hostility subscale	5.51 (2.43)	4.72 (2.04)
Emotional Withdrawal subscale	4.41 (2.37)	4.59 (2.37)

[a] Includes "currently married" category.

The groups are also highly similar in terms of global psychopathology as means scores between the groups for the BPRS-A Total do not differ significantly. There are statistically significant differences between the groups for three BPRS-A subscales, however. Mean scores for the Broward MHC sample are higher for psychotic features, $t(218) = 2.00$, $P < .05$, and hostility, $t(219) = 2.59$, $P < .01$, but lower on the depression subscale, $t(218) = -3.53$, $P = .001$.

3.2. Perceived coercion

Full MPCS data were available for 93 of the 121 MHC participants.[6] The mean MPCS score for the sample was 0.69 (S.D. = 1.30). MPCS scores can range from 0 to 5, and lower scores reflect greater perceived autonomy, control, choice, and freedom. Thus, the overall sample mean suggests that defendants in MHC perceive relatively little coercion in the decision to have their case disposed in MHC, which is usually tantamount to agreeing to continue or to enter community-based mental health treatment and to have that treatment monitored by the court.

We considered that one factor that might influence participants' perceptions of coercion was their explicit awareness of a choice about MHC participation. Therefore, this sample of 93 participants was split according to their response to the protocol question: "Either during your court hearing or before the hearing, did anyone explain to you that you could choose to have your case kept in the mental health court or that you could have your case transferred back to a regular misdemeanor court?" Thirty-two participants reported that they were UNAWARE of this option, while 61 participants reported that they were AWARE of the option.[7] A comparison of mean MPCS scores for these subgroups revealed that the mean score for the AWARE group ($M = 0.20$, S.D. = 0.71) was statistically different from that of the UNAWARE group ($M = 1.67$, S.D. = 1.64), $t(37.17) = 4.85$, $P < .001$.[8]

One potential alternative explanation for this difference was that the UNAWARE groups may have been more severely ill than the AWARE group and therefore less able to comprehend or appreciate that a choice about remaining in MHC was available to them. To explore this explanation the scores of these two groups on the BPRS were compared; there were no statistically significant differences between these groups on the BPRS-A Total score or on any of the BPRS-A subscales (psychoticism, depression, hostility, emotional withdrawal).

[6] For 17 participants, research assistants inappropriately failed to administer the MPCS. Six remaining participants were dropped from analyses due to one or more items of missing data.

[7] Our observations reveal that on many (but not all) days the judge explains this option, either to the group of defendants as a whole or in the course of discussing a particular individual's case (which discussion can be heard by the other defendants). The option may also be communicated to defendants privately (e.g., by the mental health screening staff or by the public defenders). Thus, we do not know in every case what any particular defendant was told about this option and our analysis is based on what defendants reported that they were (or were not) told.

[8] Degrees of freedom adjusted due to unequal variances in the two groups.

3.3. Perceived procedural justice

The 5 items that solicited participants' ratings on PPJ dimensions (Items 1–5) and the item for rating satisfaction with hearing outcome (Item #6) are presented in Table 3, along with the mean scores and standard deviations for each group. Multivariate analysis of variance (MANOVA) revealed that there were statistically significant differences between the groups on these items, Wilks $\lambda = 0.371$, $F(6,213) = 60.20$, $P < .001$. Univariate analyses revealed that, for each item, the MHC was rated higher than was the conventional misdemeanor court, Fs(1, 220) range 115 to 333.69, all Ps $< .001$.

As Table 3 reveals, participants in the conventional misdemeanor court rated only one procedural justice dimension—being treated respectfully by the judge—at least as high as "somewhat" present ($M = 4.28$). The opportunity for "voice" (Item #1) and the sense that the judge was interested in the defendant as an individual (Item #2) were perceived as largely absent in regular misdemeanor court proceedings, with mean ratings (1.80, 1.95) near the bottom of the rating dimension. In contrast, all procedural justice features were rated higher than "somewhat" present by the MHC participants and toward the "definitely" present end of the scale; the highest ratings were assigned to items that represent the perception of fair ($M = 6.55$) and respectful ($M = 6.57$) treatment by the MHC judge.

3.4. Predictors of satisfaction with hearing outcomes

We had hypothesized that outcome satisfaction (Table 3, Item #6) would be explained by a combination of perceived coercion and procedural justice variables. A preliminary examina-

Table 3
Perceived procedural justice in mental health court versus conventional misdemeanor court

Procedural justice item	Mental health court mean (S.D.)	Comparison court mean (S.D.)
1. At court today, did you have enough opportunity to tell the judge what you think he/she needed to hear about your personal and legal situation? ("voice")	5.39 (2.15)	1.80 (1.82)
2. At court today, did the judge seem genuinely interested in you as a person?	6.12 (1.59)	1.95 (1.80)
3. At court today, did the judge treat you respectfully?	6.57 (0.99)	4.28 (2.08)
4. At court today, did the judge treat you fairly?	6.55 (1.08)	3.78 (2.34)
5. Are you satisfied with how the judge treated you and dealt with your case today?	6.45 (1.38)	3.12 (2.47)
Outcome satisfaction		
6. Are you satisfied with the decisions made about your case today?	6.28 (1.37)	3.39 (2.48)

Each item rated on a 7-point scale with anchors at 1 (*not at all*), 4 (*somewhat*), and 7 (*definitely*).
Group means on all items are statistically different at $P < .001$.

tion of correlations among these variables for the mental health group, however, revealed that MPCS was not statistically associated with outcome satisfaction (r=.01, n.s.). Therefore, we used procedural justice Items 1 through 4 as predictors in a multiple regression analysis to determine the best predictors of outcome satisfaction in the combined samples.[9] The regression program in SPSS 10.0 for Windows was used to conduct the analysis, and the Backward removal method was used to select variables. In this method, each predictor was forced into the regression equation last in order to determine the unique variance explained by that predictor. In successive iterations, variables that did not contribute independent variance were deleted, effectively redistributing shared variance to the remaining predictors. The analysis ends when none of the remaining predictor variables can be deleted because each explains independent variance in the dependent variable. Results from this analysis revealed that outcome satisfaction was best explained by three procedural justice variables, voice (Item #1), person (Item #2) and fairness (Item #4). Together these variables explained 63% of the variance in outcome satisfaction, R=.790, $F(3,216) = 119.85$, $P < .001$.

3.5. Impact of hearing

The 6 items that solicited participants' ratings of the emotional impact that the court hearing had on them are presented in Table 4, along with the mean scores and standard deviations for each group. Multivariate analysis of variance (MANOVA) revealed that there were statistically significant differences between the groups on these items, Wilks $\lambda = 0.621$, $F(6,211) = 21.51$, $P < .001$. Univariate analyses revealed that, for each item, MHC participants rated their hearings as having a more positive emotional impact than did participants in the conventional misdemeanor court, Fs(1,217) range 57.99 to 88.36, all Ps < .001.

As Table 4 reveals, for participants in the conventional misdemeanor court mean scores on all items were at, or less than one scale point below, anchored Point #4 (''no different'') on the response scale; these ratings indicate that these defendants emerged from their hearing feeling no different, or perhaps slightly worse, than they had felt prior to their hearings. In contrast, MHC clients reported uniformly positive emotional effects from their hearings. All items' mean ratings were more than 1.5 scale points above #4 (''no different''), with the most positive emotional impacts being feeling more hopeful ($M = 5.99$), more calm ($M = 6.06$) and better (6.07) than they felt prior to their hearings.

3.6. Predictors of impact of hearing

We had hypothesized that IOH would be explained by a combination of perceived coercion, outcome satisfaction, and procedural justice variables. To test this hypothesis a total IOH score was computed by adding the ratings for IOH Items 1–6. A preliminary

[9] PPJ item #5 was excluded from this analysis because its wording includes ''satisfaction'' and it appears to be somewhat redundant with the outcome variable (item #6). + The correlation between these two items was 0.82 and statistically significant ($P < .01$).

Table 4
Emotional impact of court hearings as perceived by defendants in mental health court versus conventional misdemeanor court

Impact of hearing item	Mental health court mean (S.D.)	Comparison court mean (S.D.)
After being in court today, do you feel . . .		
1. better or worse than you did before court?	6.07 (1.55)	3.69 (2.18)
2. more upset or more calm than you did before court?	6.06 (1.51)	3.98 (2.07)
3. more respected or more disrespected than you did before court?	5.54 (1.60)	3.63 (2.10)
4. more informed or more confused than you did before court?	5.78 (1.56)	3.63 (2.04)
5. more hopeful or less hopeful than you did before court?	5.99 (1.42)	3.90 (2.21)
6. Overall, how do you feel about being in court today? (bad versus good)	5.56 (1.77)	3.36 (1.86)

Each item rated on a 7-point scale with anchors at 1 representing more of the undesirable impact (e.g., *much worse*, *much more upset*, *much more confused*, etc.), 4 representing feeling *no different* (as a result of the court hearing), and 7 representing more of the desirable impact (e.g., *much better*, *much more respected*, *much more hopeful*, etc.) Group means on all items are statistically different at $P < .001$.

examination of correlations among these variables for the mental health group revealed that MPCS was not statistically associated with IOH (r=.042, n.s.). Therefore, as before we used procedural justice Items 1 through 4 and the outcome satisfaction item (Item #6, Table 3) in a multiple regression analysis to determine the best predictors of IOH in the combined samples. As before, backward removal was the method used to identify items that explained unique variance in IOH. The results indicate that both procedural justice and outcome satisfaction are useful in explaining the emotional impact on participants of court hearings. Both the opportunity for voice (PPJ Item #1) and respectful treatment by the judge (PPJ Item #3), combined with outcome satisfaction to explain 61% of the variance in total IOH scores, $R = 0.83$, $F(3,214) = 153.20$, $P < .001$.

4. Discussion

The results of this study are consistent with several hypotheses concerning the Broward MHC and the subjective experience of individuals whose cases are before the court. First, MHC defendants do not experience their involvement with the court as being coercive. Their mean score on a self-report perceived coercion measure (0.69) was low in an absolute sense and, as a comparison with data in Table 1 reveals, lower than almost any score on a comparable measure of perceived coercion previously reported in the literature.[10] As a route

[10] Readers are reminded that the comparison with Table 1 data is somewhat inapposite. Our coercion measure elicited perceptions about the legal process itself (rather than about treatment encounters that may have resulted from the court referral), while in the Table 1 studies the measures elicited responses about perceived coercion in going into a psychiatric hospital or mental health center.

into psychiatric treatment, MHC appears to be experienced as considerably less coercive than other legal routes that have been studied. The low level of perceived coercion reported in this context is particularly interesting in light of findings reported by Lidz et al. (1998) that higher perceived coercion was associated in particular with negative pressures such as threats and formal legal coercion; virtually all of the MHC participants in this study had been arrested and jailed within the 72-hour period preceding their appearance in the court.

Although perceived coercion appeared generally low across the MHC sample, the results also suggest that making explicit to defendants that they have a choice whether to remain in MHC may further reduce perceived coercion. As noted above (see footnote 7) defendants may be advised that they have this choice by any of several courtroom participants. We have observed the judge on many occasions to address all of the defendants present about this issue at the outset of court, although on other occasions such a general statement is not made. Clinical staff conducting screening interviews or public defenders talking privately with their clients may also broach this issue with the defendants. When the judge decides to accept a client into the court, we have observed that there is sometimes an explicit statement made that the defendant has assented to a MHC disposition, although the determination that a choice has been made sometimes appears to be more implicit. Our results suggest that perceived coercion in MHC may be minimized if it is made explicit to clients that they have a choice in this regard.

At the same time, the fact that a number of defendants reported that they were unaware that they had a choice regarding their participation in the court raises important issues. A central tenet of therapeutic jurisprudence is that in at least some circumstances the role of counsel must become markedly less adversarial; David Wexler for example has argued that the law can become therapeutic only if the ''culture of critique'' that he believes characterizes the law's usual approach to issues can be replaced (Wexler, 1999). It has also been argued that in a specialty court, for example, a drug court, that lawyers must adopt a nonadversarial role for such courts to work (Kaye, 1998). Others, however, have argued that the adoption of a nonadversarial role in a specialty court such as a drug court is unwarranted because defendant rights and potential punishment are at issue (Boldt, 1998).

Regardless of one's views on the role of counsel, all would presumably agree that defendants should be permitted to enter a special court's jurisdiction only with knowledge that a choice was available; the importance of choice is perhaps even more critical when a court's philosophy is premised on the voluntary agreement to pursue treatment. This suggests that as MHCs develop, particular attention should be paid to assuring that individuals are informed when deciding to enter the court's jurisdiction, not only because of a philosophic commitment to voluntary treatment but because agreement to participate in the court may often mean the waiver of speedy trial and other rights available in a criminal context.

The MHC has made a number of procedural adaptations in its effort to have the courtroom experience be one that potentially reduces stigma and contributes as an ''active therapeutic agent in the recovery process'' (Lerner-Wren, 2000, p. 19). Our findings suggest that these adaptations have resulted in the kinds of procedural justice enhancements that theory suggests might ultimately be beneficial to therapeutic outcomes. On all procedural justice dimensions, including those that relate to critical factors such as voice, respectful treatment by authority,

and fairness, MHC received significantly higher ratings than did conventional misdemeanor court. As has been found in procedural justice studies in other legal contexts, voice and respectful treatment by authority emerged as significant determinants of outcome satisfaction in this study. However, contrary to expectations perceived coercion was not related to outcome satisfaction in the MHC sample (although this may be a consequence of the low variability in scores on our measure of perceived coercion).

Several interesting questions remain to be answered through future research. As noted above, within the framework of this ongoing study of the Broward MHC we will investigate the role, if any, that perceived coercion and PPJ play in longer term, more objective outcomes such as treatment participation and compliance, community adjustment, and recidivism. While reducing coerciveness and enhancing satisfaction with dispute resolution procedures are desirable objectives in their own right, the procedures that have evolved in the Broward court that (apparently) contribute to these outcomes come at some cost—for example, hearings may be prolonged somewhat by the judge's efforts to engage the defendant in mental health disposition planning. Those who place a greater premium on efficiency concerns may expect to see evidence of benefits that go beyond the subjective experiences of the MHC defendants.

It would also be interesting to compare the experiences of defendants across different MHCs on these subjective outcomes. The Broward court is but one of several models for an MHC (Goldkamp & Irons-Guynn, 2000; Watson, Luchins, & Hanrahan, 2001) and differences among them (e.g., degree of adherence to traditional roles and evidentiary procedures; interpersonal styles of the judges; pre- versus postadjudication implementation of mental health interventions and monitoring) may affect both the levels of perceived coercion and procedural justice and the degree to which these subjective factors affect longer range outcomes. Because of these unexplored considerations, the findings of the present study are primarily descriptive of the MHC experience in Florida and cannot be presumed to generalize to MHCs in other jurisdictions.

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