Winter 2007

Court Review: Volume 43, Issue 4 – Mental Illness and the Courts: Some Reflections on Judges as Innovators

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Mental Illness and the Courts:

Some Reflections on Judges as Innovators

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Issues raised by the influx of defendants with serious mental illnesses are some of the most important that criminal judges confront. Because of the volume of defendants with mental illnesses, the impact goes beyond that of the individual case and extends to jails, police and sheriff departments, the treatment system, and ultimately to the role of the judge. This article suggests some of the ways in which communities have attempted to respond to these issues, and highlights the fact that judges have become significant leaders as well as innovators in such efforts. Not every judge will decide to adopt one or more of these roles, but regardless, it is likely that the issues that mental illness creates for the criminal justice system will exist far into the future.

PART 1. MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM

On January 18, 2006, the Conference of Chief Justices adopted a resolution endorsing the use of problem-solving courts to address the impact of mental illness upon the criminal justice system.[1] This resolution formally acknowledged the emergence of therapeutic courts as part of the jurisprudential mainstream. As important, it highlighted the changing role of the judiciary in response to the many issues caused by the prevalence and volume of serious mental illnesses among defendants in courts across the country.[2] In fact, as this article suggests, state judges have been responsible for some of the most innovative solutions to these issues, a trend likely to continue for the foreseeable future. Some judges have embraced this new role, others have not, but—regardless of perspective—it is difficult for any criminal judge today to simply ignore the issue of mental illness.

There were approximately 14 million arrests in the United States in 2005.[3] The most conservative estimate is that approximately 900,000 of these arrestees were acutely mentally ill at the time of the arrest.[4] When substance abuse and other mental illness diagnoses are considered, the prevalence of mental disorder among arrestees is over 70%.[5] In addition, it is estimated that between 16% and 24% of people who are in jails and prisons have a major diagnosable mental illness such as depression, schizophrenia, or other psychotic or bipolar disorders.[6] Again, if all mental disorders—including substance-abuse disorders—are included, the prevalence of mental disorder in incarcerated populations is over 70%.

Until three decades ago, the majority of people with severe mental illnesses were confined for at least part of the time in state psychiatric hospitals. However, since then there has been a major diminution of the role of state hospitals, while the number of people with mental illnesses in jails and prisons has increased significantly. For example, in 2000, people with severe mental illnesses were more than five times likely to be confined to a jail than to a state psychiatric hospital (the rate of hospitalization in state psychiatric hospitals was 22 people per 100,000, but the rate of confinement in jail was 113 people with severe mental illnesses per 100,000.[7]) This is not to suggest that the answer to the problem of mental disorder in the criminal justice system is to recreate the state psychiatric hospital system. Rather, as we suggest below, the lack of effective community treatment in many jurisdictions is a more pressing issue than the absence of state hospital beds. In addition, changes in sentencing policy, particularly regarding substance-abuse offenses, has contributed to the influx of people with mental disorders. However, regardless of *why* it has hap-

Footnotes

1. Conference of Chief Justices, Policy Statements and Resolutions, Resolution 11, *In Support of the Judicial Criminal Justice/Mental Health Leadership Initiative,* January 18, 2006, available at http://ccj.ncsc.dni.us/CriminalAdultResolutions/resol11JudicialCriminalJusticeMentalHealthInitiative.html.
2. Therapeutic courts are a comparatively recent development; the first drug court emerged in 1989 in Dade County, Florida, and the first mental-health courts of this era began in 1997 in Broward County, Florida and Marion County, Indiana. Today there are more than 1,000 such courts in the United States and their "fit" within the traditional justice system has been the subject of frequent discussion, including in this journal. For an example, *see* Daniel J. Becker & Maura D. Corrigan, *Moving Problem-Solving Courts Into the Mainstream: A Report Card from the CCJ-COSCA Problem-Solving Courts Committee*, COURT REVIEW, Spring 2002, at 1. *See also* Aubrey Fox and Greg Berman, *Going to Scale: A Conversation About the Future of Drug Courts*, COURT REVIEW, Fall 2002, at 4. Therapeutic courts have been developed in a number of other countries as well. John Petrila, *An Introduction to Special Jurisdiction Courts.* 26 INT'L J. LAW AND PSYCH. 3 (2003).
3. Table 29, U.S. Dept. of Justice, Fed. Bureau of Investigation, *Crime in the United States* (2005), available at http://www.fbi.gov/ucr/05cius/data/table_29.html.
4. NAT'L GAINS CTR., THE PREVALENCE OF CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE USE DISORDERS IN JAILS (rev. ed. 2004), available at http://gainscenter.samhsa.gov/pdfs/disorders/gainsjailprev.pdf.
5. *Id.*
6. RICHARD LAMB AND LINDA E. WEINBERGER, *THE SHIFT OF PSYCHIATRIC INPATIENT CARE FROM HOSPITALS TO JAILS AND PRISONS*, 33 J. AMER. ACAD. PSYCH. & LAW 529 (2005). For the underlying data behind Lamb and Weinberger's estimates, *see* NAT'L COMM'N ON CORRECTIONAL HEALTH CARE, 2 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS ix-x, 57-80 (2002), available at http://www.ncchc.org/pubs/pubs_stbr.html.
7. *Id.*

pened, it is clear that there are many more individuals with major mental illnesses in the criminal justice system today than was the case 20 or 30 years ago.

The increase poses serious problems for the individual and for the justice system. People with mental illnesses are jailed on average two to three times longer than individuals without a mental illness arrested for a similar crime. A stay in jail may exacerbate the person's illness, and an arrest record may further complicate the person's efforts to live successfully in the community. In addition, jails incur significant costs associated with the oversight of individuals with mental illnesses (particularly regarding the threat of suicide) and for medication and other health-care services.

Mental-illness issues also present complications for a judge. Many criminal courts have overburdened dockets, which allow little time for an individual case. Yet dispositional questions involving a defendant with an acute mental illness are often not readily resolved. Ordering a competency examination may be easy; deciding whether and how to gain access to treatment that the individual needs may be considerably more difficult.[8] In addition, judges often encounter the same defendant with mental illness repeatedly; the individual is arrested usually for a comparatively minor offense, is released often for time served but with no access to treatment, and is then rearrested for the same type of offense. This cycle with "repeat defendants" creates frustration for judges unable to gain access to treatment that might have some impact on the defendant's behavior.

As the impact of mental illness on the criminal justice system has grown, judges increasingly have become leaders in seeking innovative solutions. This has often been by default; few judges take the bench with a primary goal of designing solutions to systemic issues that often appear to flow from failures in the mental-health and human-services systems. Yet in many communities, judges may be the only officials with the necessary formal and symbolic authority to create change.

This article describes a number of innovations that have been developed by individual judges and others within the criminal justice system in response to mental-illness issues. We first briefly describe the realities of today's mental-health system, which provides the context in which many criminal courts now sit. We then briefly discuss a number of discrete initiatives (pre-arrest diversion programs; post-arrest diversion programs, including therapeutic courts; post-disposition oversight, including specialty probation for defendants with mental illness) that various communities have tried. We conclude with some comments on the role of the judge in identifying and resolving these issues. We do not suggest that these initiatives are a good fit for every community. In fact, it is quite clear that local circumstances are the first thing that must be considered in determining which solutions to attempt. Nor will every judge wish to adopt a proactive role in seeking solutions. But addressing the needs of defendants with serious mental illnesses will be a problem that confronts virtually every criminal court judge, and so it may be useful, particularly for judges new to these issues, to have information regarding the strategies communities have used in response.

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Contextual issues. Mental illness has always been an issue in the criminal justice system, primarily because of its potential impact on mental state. Competency to stand trial assessments were (and continue to be) a staple of criminal proceedings, and the insanity defense and related pleas—such as guilty but mentally ill—have continuing relevance in a modest number of cases. In addition, courts have long made mental-health treatment a condition of disposition in resolving some criminal cases.

However, these traditional tools have little relevance to the vast majority of the people arrested each year who are acutely ill at the time of arrest. This is for at least two reasons. First, many defendants with serious mental illness are arrested on relatively minor charges, and therefore formal competency adjudications and pleas of insanity may have little appeal as a practical matter, though legally they might be preferred. Second, even if these mechanisms were employed in every one of the 900,000 cases in which the defendant is acutely ill at the time of arrest, it would only further exacerbate the problem of overburdened court dockets, because these issues do not lend themselves to quick disposition. As a result, many of the innovations discussed below are designed either to reduce the number of acutely ill defendants who enter the criminal justice system or to shorten the time spent there.

There have also been major changes in the last few decades in the treatment of people with serious mental illnesses.[9] Three are relevant here. First, the location and duration of much treatment has changed. State psychiatric hospitals used to provide most long-term care for serious mental illnesses. Most psychiatric hospital care today is provided in community outpatient settings because of a number of factors, including horrific conditions that developed in many state hospitals, as well as changing philosophies of—and advancements in—treatment. Community outpatient care is designed largely to control and reduce symptoms. Inpatient care is generally

8. It may be difficult even to gain access to treatment services for competency restoration. In Florida, judges held the Secretary of the state agency responsible for providing such services in contempt because of long waiting lists for beds in the hospitals charged with providing competency restoration. Abby Goodnough, *Officials Clash Over Mentally Ill in Florida Jails*, N.Y. TIMES, Nov. 15, 2006.

9. It should be noted that the influx of people with drug-abuse disorders that eventually resulted in the development of drug courts was caused in large part by changes in criminal laws, which brought more defendants into the criminal justice system for offenses related to substance abuse and resulted in lengthier sentences as well. *See* Petrila, *supra* note 2.

Formal diversion programs for persons with mental illness are growing in popularity and number.

short-term, and occurs most often in psychiatric units of community hospitals. There is little long-term, inpatient care for psychiatric illnesses available in the United States today.

Second, and relatedly, most people with serious mental illnesses spend the vast majority of their time in the community. At this juncture, it is beyond dispute that most people with serious mental illnesses can be treated successfully in the community and live productive lives, even if they suffer relapses during treatment.[10] However, the network of treatment services, social supports, and housing necessary to provide such treatment is rarely available in sufficient supply and in many communities is woefully lacking. As a result, many people with serious mental illnesses receive little or inadequate treatment. As a result, the symptoms of serious mental illness may be exacerbated. Mental illness does *not* necessarily lead to arrest, but conduct that may lead to arrest, such as loitering, public urination, or petty theft, may become more likely in the absence of treatment and social stability for at least some individuals with serious mental illnesses.

Third, the primary locus of responsibility for dealing with these failed treatment systems has shifted in many places from state government to local communities. The federal government funds many mental-health services through the Medicare and Medicaid programs but plays virtually no role in designing treatment systems. State governments traditionally assumed a leadership role for designing mental health services through the state mental health agency. However, many states have reduced funding for mental-health as a percentage of human services funding, and the authority of many state mental-health commissioners has been reduced as states grapple with rising costs in their Medicaid programs.

While there may not be a direct correlation between these changes and the impact of mental illnesses on local courts, they are contextual factors that have shifted the venue for innovative responses to local communities. Over time, a number of strategies have emerged in various communities that appear to hold some promise. We discuss the most common strategies below.

PART 2. STRATEGIES

As indicated above, the volume of persons with mental illness coming into contact with the justice system is so immense that the majority of communities have developed their own informal and formal strategies to combat associated issues. We focus here on formalized strategies that occur at different points along the criminal justice continuum, including 1) pre-arrest diversion programs; 2) post-arrest diversion programs, including mental-health courts; and 3) specialty probation. Below we provide brief descriptions and operational definitions of these three subtypes. For more detailed information, we refer interested readers to the National GAINS Center and its Technical Assistance and Policy Analysis Center for Jail Diversion[11] and the Council of State Governments' Criminal Justice Mental Health website.[12] These on-line resources offer many free publications, including guides on how to implement different diversion programs as well as an overview of the mental health service system for criminal justice professionals.[13]

Formal diversion programs for persons with mental illness are growing in popularity and number. While it is accurate to state that these diversion programs have resulted from local initiatives, the federal government also has demonstrated support. Specifically, the President's New Freedom Commission on Mental Health[14] recommended "widely adopting adult criminal justice and juvenile justice diversion….strategies to avoid the unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illness." Further, over the past five years, federal government agencies, such as the Bureau of Justice Assistance and the Substance Abuse and Mental Health Administration, have contributed millions of dollars in grant funds toward the creation of local diversion programs.[15]

Pre-arrest diversion. As the name implies, pre-arrest—or pre-booking—diversion programs focus on diverting persons to treatment as an alternative to arrest. Such programs depend on law enforcement given that police and sheriff's deputies make the vast majority of decisions whether or not to arrest an individual engaged in criminal behavior. It is becoming increasingly popular because this type of diversion when suc-

10. Relapse is common for the most serious mental illnesses, for example, schizophrenia. As one group of commentators recently noted, "the course of early-phase schizophrenia is characterized by initial improvement in symptoms followed by repeated relapse and a low rate of sustained recovery." However, the same authors note that early intervention with effective medications can result in good control of symptoms and that even those who may not respond to treatment of an initial episode of treatment may attain recovery over time, given adequate treatment. Delbert G. Robinson et al., *Pharmacological Treatments for First-Episode Schizophrenia*, 31 SCHIZOPHRENIA BULL. 705 (2005). Not all mental illnesses are as devastating as schizophrenia, but because they often manifest themselves episodically, it is difficult to assume that an individual with a serious mental illness will necessarily be wholly compliant with court orders, particularly in the absence of adequate treatment and supervision.

11. *See* http://gainscenter.samhsa.gov/html/default.asp.

12. *See* http://www.consensusproject.org/.

13. JACKIE MASSARO, OVERVIEW OF THE MENTAL HEALTH SYSTEM FOR CRIMINAL JUSTICE PROFESSIONALS (2005), available at http://209.132.230.103/pdfs/jail_diversion/MassaroII.pdf.

14. PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HELATH CARE IN AMERICA 43-44 (2003) (hereinafter ACHIEVING THE PROMISE], available at http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html.

15. *See, e.g., America's Law Enforcement and Mental Health Project*, 42 U.S.C. §§ 3711, 3796ii-3796ii-7, 3793, Pub. L. 106-515 (2000). It is also worth noting that these grants have often been comparatively small, and while they have been important in seeding local projects, the funds allocated by the federal government for diversion are rarely adequate to enable the programs to sustain themselves.

Three core factors have been identified as essential to the success of a pre-arrest diversion program.

cessful can have an impact on court dockets and the use of jail beds.

There are three basic types of pre-arrest diversion: 1) police-based specialized police response, 2) police-based specialized mental-health response, and 3) mental-health-based specialized mental-health response.[16] In the first model, police officers are specially trained in crisis intervention and act as liaisons to the mental-health system. In the second model, mental-health professionals collaborate with police to provide on-site or telephone consultation on responding to individual cases. In the third model, which is the most common, mental-health professionals provide on-site help to the police in situations involving persons with mental illness.[17]

One of the most successful and most duplicated models for pre-arrest diversion is the Crisis Intervention Team (CIT) model, originally developed in Memphis, Tennessee. Today, many major and smaller U.S. cities have adopted CIT programs of their own. The CIT program in Memphis has been described in the following manner: A cadre of selected patrol officers (10 to 20 percent of those assigned to patrol) receive extra training (40 hours initially) and then serve as generalists/specialists; they perform the full range of regular patrol duties, but respond immediately (from anywhere in the city) whenever crisis situations occur involving people with mental illness. In those situations, these officers assume on-scene command as soon as they arrive. They are trained to handle the crisis situations as well as to facilitate the delivery of treatment and other services. In particular, they become knowledgeable about voluntary and involuntary commitment, plus they become well known to professionals in the mental-health community, facilitating the delivery of treatment and other services to the people in crisis.[18]

Three core factors have been identified as essential to the success of a pre-arrest diversion program. The first is training. The Memphis CIT model prides itself on its 40-hour (plus) intensive training for officers selected for the program. The curriculum includes information on mental illness, crisis skills, and a heavy concentration on interactive activities, such as role play. Refresher trainings are utilized as well. The second core element is the creation of partnerships between community mental-health providers and law-enforcement officials. Pre-arrest diversion programs require that police have access to treatment services reliably, predictably, and at all hours. If an officer finds it more difficult to gain access to assessment and treatment than to arrest the individual, diversion programs will founder. Therefore, in developing this option, communities often use a single point of entry to services, assure that no one referred for services will be refused at least an assessment, and provide streamlined intakes for police officers.[19] The third core element is re-conceptualizing the traditional police-officer role for the specialized-diversion officers. That is, under the CIT model, officers volunteer or are specially selected rather than randomly assigned, and the agency promotes collegiality and a sense of shared responsibility among the officers. It is also important that relevant statutes and policies encourage and support rather than create impediments to diversion. For example, crisis facilities must be enabled legally to accept and detain persons who may or may not have criminal charges pending.

Early research suggests that pre-arrest diversion programs can be successful in creating access to treatment without creating additional community risk. For example, in comparison to persons not diverted, persons diverted were more likely to be in counseling and to be taking prescribed medications. Re-arrest rates were not higher than those for non-diverted populations, despite the fact that individuals diverted before arrest were typically in the community for longer periods of time (and therefore potentially at risk for behavior leading to another arrest) than non-diverted individuals.[20] Currently, a major evaluation is underway of 32 pre and post-booking diversion programs, which may provide more definitive answers to whether pre-diversion programs are successful, for whom, and why.

Post-arrest diversion. After a person is arrested, formal diversion can occur at any point during the criminal process. We first discuss post-arrest, or post-booking diversion programs generally, and address mental-health courts (MHCs) separately.

16. For discussions of the various methods for organizing pre-arrest diversion, *see* Martha Williams-Dean et al., *Emerging Partnerships between Mental Health and Law Enforcement,* 50 PSYCH. SERVICES 99 (1999); Henry Steadman et al., *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies,* 51 PSYCH. SERVICES 645 (2000).
17. MELISSA REULAND, A GUIDE TO IMPLEMENTING POLICE-BASED DIVERSION PROGRAMS FOR PEOPLE WITH MENTAL ILLNESS (2004), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/PERF.pdf.
18. This description is taken from an article at the website of the Center for Problem-Oriented Policing: Gary Cordner, *People with Mental Illness* 4 (2006), available at http://popcenter.org/problems/mental_illness. The article provides a good description not only of the CIT model but also of a number of other approaches adopted by police departments across the United States in addressing issues involving people with mental illnesses. The growing popularity of CIT as a strategy is reflected in attendance at the 2nd National CIT Conference held in fall 2006 in Orlando. It was attended by more than 800 individuals from 40 states, Canada, and Australia. Many of the attendees were police officers, and there were a number of judges in attendance and presenting as well.
19. Henry Steadman et al., *A Specialized Crisis Response as a Core Element of Police-Based Diversion Programs,* 52 PSYCH. SERVICES 219 (2001).
20. See Michelle Naples & Henry Steadman, *Can Persons with Co-Occurring Disorders and Violent Charges Be Successfully Diverted?*, 2 INT'L J. FORENSIC MENTAL HEALTH 137 (2003); THE NATIONAL GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYSTEM, WHAT CAN WE SAY ABOUT THE EFFECTIVENESS OF JAIL DIVERSION PROGRAMS FOR PERSONS WITH CO-OCCURRING DISABILITIES? (2004), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/WhatCanWeSay.pdf.

Post-booking diversion. Post-booking diversion programs, like pre-arrest diversion programs, seek to engage eligible persons in community treatment with the hope that treatment will reduce the risk of behavior leading to future arrests. An obvious difference between the two approaches is that pre-arrest diversion attempts to keep the person from entering the criminal justice system at all, while post-arrest programs are not used until the person has already been arrested.

Post-booking diversion programs may seek to divert the individual to treatment at any point during the criminal process, and therefore, depending on the program, referrals may come from a variety of parties to the criminal justice system, including jail officials, law enforcement, magistrates, judges, and attorneys. One commentator suggests that there are two particularly important points at which defendants may be diverted post-arrest. The first is at the person's first court appearance, which in many jurisdictions will occur within a day or two after arrest. At this point, an arraigning judge might order the person released to community treatment as an alternative to continuing custody. A second point at which diversion might occur is when the prosecutor decides whether to proceed with charges. If the prosecutor is aware that the person has been accepted into a diversion program, he or she may be more willing to hold charges in abeyance pending successful completion of the program. Six critical elements of these diversion strategies have been identified: 1) involvement of all key parties (e.g., judges, prosecutors, defense attorneys, mental-health providers, etc.), 2) strong judicial leadership, 3) quick access to services to assess the defendant's mental health, 4) availability of mental-health-treatment resources, 5) assistance to the defendant in complying with imposed treatment conditions, and 6) patience among professionals from differing and sometimes conflicting systems. Of importance, both options—pretrial release and deferred prosecution—can occur in a matter of days after arrest.[21]

Post-diversion arrest also can take place much later. For example, a person may come before another judge who suspects the person may have a mental illness and be eligible for diversion. Similarly, a person's attorney, after some interaction, may conclude that the best option for his or her client is the diversion program. Diversion may even occur after sentencing, such that the sentence of jail or prison time is put on hold pending successful completion of treatment. Each of these options is available even if there is no formal effort at diversion; however, many communities have begun to attempt to formalize the processes by which defendants may be diverted into treatment as the criminal process proceeds.

New York City's Nathaniel Project . . . began in 2000 and appears to be very effective in gaining access to treatment while reducing re-arrest . . . .

A successful example of a post-booking diversion program attempting to address the needs of individuals charged with felonies is New York City's Nathaniel Project. The Nathaniel Project is "exclusively for people with psychiatric disabilities who have been indicted on a felony offense and are facing a lengthy sentence in New York State prison…. the program will consider any defendant regardless of offense, including violent offenses."[22] The Nathaniel Project began in 2000 and appears to be very effective in gaining access to treatment while reducing re-arrest: new arrests among their clients have dramatically decreased, 100% of their clients are engaged in treatment, and after one year, 79% had permanent housing. While many communities will choose not to focus diversion efforts on those charged with felonies, the Nathaniel Project provides evidence that diversion to treatment in lieu of incarceration can be effective in some circumstances even for a difficult population of offenders with mental illness.

Mental-health courts. Mental-health courts are one of the fastest growing vehicles for addressing the needs of mentally ill defendants. The first two mental-health courts appeared in 1997 in Marion County, Indiana and Broward County, Florida. However, today, there are estimated to be more than 150 U.S. mental-health courts with the number continuing to grow rapidly. A survey completed in January 2005 determined that MHCs were in operation in 34 states with many of the states operating multiple MHCs in different counties and jurisdictions.[23] Like other diversion programs, these therapeutic courts attempt to provide defendants with access to treatment and oversight with the goal of reducing the likelihood of future cycling through the criminal justice system.

Although MHCs vary in their procedures, operations, and eligibility requirements, there are several defining characteristics. First, MHCs are criminal courts, usually with one judge carrying a dedicated docket.[24] Second, MHCs typically have mental-health and criminal justice eligibility criteria in that they will only allow in persons with certain diagnoses and/or certain criminal charges. Earlier, or first-generation, mental-health courts usually limited their docket to misdemeanants,

21. For a general discussion of this type of diversion, *see* JOHN CLARK, NON-SPECIALTY FIRST APPEARANCE COURT MODELS FOR DIVERTING PERSONS WITH MENTAL ILLNESS: ALTERNATIVES TO MENTAL HEALTH COURTS (2004), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/pre_trial_nocover.pdf.
22. For a description of the Nathaniel Project, *see* THE NATIONAL GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYSTEM, THE NATHANIEL PROJECT: AN ALTERNATIVE TO INCARCERATION PROGRAM FOR PEOPLE WITH SERIOUS MENTAL ILLNESS WHO HAVE COMMITTED FELONY OFFENSES (rev. ed. 2005), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/nathaniel_project.pdf.
23. Allison D. Redlich et al., *Patterns of Pracice in Mental Health Courts: A National Survey*, 30 LAW & HUMAN BEHAV. 347 (2006).
24. It is worth noting that most mental-health courts have been created from existing resources; few jurisdictions have obtained additional judicial or attorney resources for these courts. In addition, caseloads in most jurisdictions are comparatively small (a mental-health court with a docket of more than 100 cases would be a relatively large mental-health court), and so the judge who presides over the court typically does so in addition to his or her usual responsibilities.

but a number of more recent courts use a mixed (misdemeanor-felony) caseload or only felony cases.[25] Third, MHCs not only require the defendant to receive treatment but also arrange for supervision and oversight of treatment compliance. Oversight takes several forms; for example, the judge will hold periodic status hearings on most cases, and ongoing supervision is provided by the probation officers, case managers, and/or MHC personnel. Fourth, the courts use a mix of incentives and sanctions in an effort to gain compliance. Incentives might include praise in the courtroom from the judge or gift cards marking progress with treatment, while punishment can range from reprimands from the judge to incarceration. Fifth, the courts generally adopt the philosophy of "therapeutic jurisprudence," which is an approach to law that places the therapeutic or non-therapeutic impact of legal rules and processes at the core of judging and practice.[26] Finally, participation in all mental-health courts is voluntary, and it is generally estimated that approximately 5% of defendants offered participation in a mental-health court decline.[27]

While MHCs continue to proliferate, they are not without controversy. Some of the controversies concern the use of jail as a sanction, whether the courts are truly voluntary, and whether MHCs are appropriate venues for persons charged with low-level crimes. Another issue is whether or not the courts "work." That is, do mental-health courts cause people to engage in treatment and ultimately reduce or eliminate future criminal justice involvement? Preliminary research suggests that the courts can be effective, especially when demographic, criminal, and diagnostic factors are considered, but the studies done to date have been of single courts, and so it is difficult to generalize from their findings.[28]

To encourage standardization of MHC operations and requirements, the Council of State Governments (CSG) has proposed 10 "essential elements" of mental-health-court design and implementation.[29] Although we list them here, readers are referred to the original document for more specific information on each element. The elements that must be tended to in the CSG's judgment are 1) Planning and Administration, 2) Identification of the Target Population, 3) Timely Participant Identification and Linkage to Services, 4) Terms of Participation, 5) Informed Choice, 6) Treatment Supports and Services, 7) Confidentiality, 8) Identi-fication of the Mental Health Court Team, 9) Monitoring Adherence to Court Requirements, and 10) Sustainability. In addition, CSG has identified five MHCs as "learning sites." The learning sites have been designated to provide support, including observation opportunities, to other courts looking to set up or expand upon an existing mental health court." The five courts were chosen primarily because of their fidelity to the Essential Elements. Judges and others who are considering establishing a MHC in their community might first obtain the *Essential Elements of a Mental Health Court* guide, and perhaps contact one or more of the MHCs identified as learning sites.[30]

[T]he Council of State Governments has proposed 10 "essential elements" of mental health court design and implementation.

Specialty probation. A more recent development for addressing the needs of defendants with mental illness is specialty probation. Because probationers with mental-health issues often have distinct issues that might affect their ability to comply with the usual conditions of probation, they may require more intensive supervision. While specialty probation is not a diversion program, a growing emphasis on it as a tool makes it worth mentioning here.

As discussed by Skeem, Emke-Francis, and Eno Louden,[31] specialty probation differs from traditional probation in several ways. In comparison to traditional probation officers, specialty probation officers 1) have exclusive caseloads of persons with mental illness, 2) have reduced caseloads (e.g., 30 open cases), and 3) receive mental-health training. Additionally, specialty probation officers tend to forge close working relationships with other professionals in the community relevant to the probationers' well-being. For example, specialty probation officers report having close relationships with treatment providers and

25. Allison Redlich et al., *The Second Generation of Mental Health Courts*, 11 PSYCH., PUB. POL'Y & LAW 527 (2005).
26. David Wexler and Bruce Winick, two law professors, are primarily responsible for the emergence of "therapeutic jurisprudence" as an approach to law. They have written extensively regarding the topic, as well as the manner in which therapeutic jurisprudence might be applied to various legal issues. One of their books is devoted specifically to therapeutic jurisprudence and the role of a judge. BRUCE WINICK & DAVID WEXLER, JUDGING IN A THERAPEUTIC KEY: THERAPEUTIC JURISPRUDENCE AND THE COURTS (2003).
27. Allison Redlich, *Voluntary, But Knowing and Intelligent? Comprehension in Mental Health Courts,* 11 PSYCH., PUB. POL'Y & LAW 605 (2005).
28. For results from two single court studies, *see* Annette Christy et al., *Evaluating the Efficiency and Community Safety Goals of the Broward County Mental Health Court*, 23 BEHAV. SCI. & LAW 227 (2005); Merith Cosden, Jeffrey Ellens, Jeffrey Schnell & Yasmeen Yamini-Diouf, *Efficacy of a Mental Health Treatment Court with Assertive Community Treatment*, 23 BEHAV. SCI. & LAW 199 (2005), available at http://czresearch.com/dropbox/Cosden_BehavSciLaw_2005v23p199.pdf.
29. COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT (2008), available at http://consensusproject.org/mhcp/essential.elements.pdf.
30. *Id.* Additional resources may be viewed at http://consensusproject.org. The five learning sites are the Akron (Ohio) Municipal Mental Health Court, the Bonneville (Idaho) County Mental Health Court, the Bronx (New York) County Mental Health Court, the Dougherty (Georgia) Superior Court, and the Washoe County (New York) Mental Health Court. *See* http://consensusproject.org/mhcp/.
31. Jennifer Skeem et al., *Probation, Mental Health, and Mandated Treatment,* 33 CRIM. JUSTICE & BEHAV. 158 (2006).

[A] judge who wishes to play an active role in addressing mental illness issues may find that leadership is not forthcoming from the treatment community.

case managers. Finally, specialty officers report utilizing problem-solving strategies as their first strategy to deal with probationers' noncompliance (e.g., generating alternative strategies, and modifying treatment plans jointly with the probationer) rather than initially seeking punishment for violation of probation conditions. Currently, a comprehensive research study is underway comparing outcomes (e.g., re-arrests, treatment utilization) of probationers under traditional and specialty models.

PART 3. JUDICIAL ROLES

All judges with a criminal docket must address issues created by the presence of growing numbers of defendants with serious mental illnesses. However, individual judges will have different views about the appropriateness of assuming an active role in addressing these issues.

A recent article in this journal by Roger Hanson asserted, "…there are few judges who would claim that judging today is just like it was 30 years ago, or like they think it was 30 years ago."[32] Hanson observed that the emergence of problem-solving courts and problem-solving judges was having a significant impact on the discussion regarding judicial role. He characterized the discussion in the following manner:

"Frequently the discussion is framed in terms of whether the judiciary should be expected to behave in one of two polar-opposite ways. Should they be primarily almost aloof finders of fact, impartial and nearly devoid of intimate contact with and knowledge of litigants and their circumstances? Or should they be one of many possible partners to a diagnostic, therapeutically oriented response process to ameliorate underlying and messy problems of litigants?"[33]

Therefore, the manner in which a particular judge defines his or her role is a threshold question that will significantly influence whether the judge then plays the additional roles described briefly below. It should be noted that there is considerable evidence that many judges are interested in assuming a more active role in assuring access to community services for defendants with mental illnesses or substance-abuse problems and for those who have been victims of domestic violence.[34]

The judge as community convener and leader. Problem-solving or therapeutic courts by definition create a different relationship between the court and the surrounding community. Community treatment providers may lack experience in dealing with the needs of individuals who come into treatment through the criminal justice system, may be reluctant to assume responsibility for such clients because of liability concerns, and may be wary of working too closely with the criminal courts.[35] In addition, the lack of adequate housing is a systemic issue that affects the ability of nearly all people with serious mental illnesses to live successfully in the community and will become an issue for judges who seek to achieve successful treatment outcomes for defendants, particularly in therapeutic courts.[36]

For these reasons and for the reasons noted in Part 1 of this article, a judge who wishes to play an active role in addressing mental-illness issues may find that leadership is not forthcoming from the treatment community. As a result, a judge may find that assuming a leadership role is critical in bringing together community stakeholders. There has been considerable commentary in the last decade regarding why and how courts might reach out to communities, so the topic is not new.[37] The need for such a leadership role also is assumed as a sine qua non for

32. Roger Hanson, *The Changing Role of a Judge and Its Implications*, COURT REVIEW, Winter 2002, at 10.
33. *Id.*
34. *See, e.g.,* Aubrey Fox, *And the Survey Says . . . : State Court Judges and Problem-Solving Courts*, *in* CTR. FOR COURT INNOVATION, A PROBLEM-SOLVING REVOLUTION, MAKING CHANGE HAPPEN IN STATE COURTS (2004); Fox's chapter is available at http://www.courtinnovation.org/_uploads/documents/andthesurveysays.pdf. Fox reports the majority of judges responding to a survey of approximately 500 judges believed that the courts should be active in attempting to create access to services; he also reported widespread interest in problem-solving courts among the respondents. In a number of judicial systems, creating access to treatment for some types of defendants has become an article of faith; for example, the Massachusetts Supreme Judicial Court has asserted "Court involvement creates a crisis in a person's life, and courts are uniquely situated to take advantage of the crisis by directing the person toward treatment. A timely response to the individual's crisis is most likely to lead to success in treatment." Supreme Judicial Court Standards on Substance Abuse, Standard 5, Commentary. This and the other standards set by the Massachusetts Supreme Judicial Court can be found at http://www.mass.gov/courts/formsandguidelines/substancev.html
35. DEREK DENCKLA & GREG BERMAN, RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS (2001), available at http://www.courtinnovation.org/_uploads/documents/rethinkingtherevolvingdoor.pdf.
36. Finding housing for people with mental illnesses is a long-standing problem in part because of stigma associated with mental illness and in part for economic reasons. In the last two decades, there has been significant experimentation with different models of housing, particularly regarding the linkage between housing and treatment. See, e.g., Sam Tsemberis, Ph.D. & Ronda F. Eisenberg, M.A., *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities,* 51 PSYCH. SERVICES 487 (2000); Pamela Clark Robbins et al., *The Use of Housing as Leverage to Increase Adherence to Psychiatric Treatment in the Community*, 33 ADMIN. & POL'Y MENTAL HELATH & MENTAL HEALTH SERVICES RES. 226 (2006).
37. For example, David Rottman et al. have suggested that six benefits accrue from judicial outreach to communities: 1) an opportunity to influence public opinion and increase accessibility and fairness, 2) the opportunity to permit judges to respond to public criticism thereby strengthening judicial independence, 3) the opportunity to create better case dispositions, 4) the opportunity to create new programs required by defendants and victims in court proceedings, 5) an opportunity to strengthen communities by combining the force of judicial sanctions with the power of

[T]hese are parties that are typically not used to working together, and the building of enough trust to have non-defensive conversations ordinarily takes time.

judges overseeing therapeutic courts.[38] However, a judge may wish to convene community leaders *before* a therapeutic court or other specific initiatives are developed. A judge may be the one community official with sufficient prestige and authority to create a venue for discussion that other community leaders feel obligated to attend. Indeed, the Conference of Chief Justices, in the resolution noted at the beginning of this article, stated, "while leadership can come from different facets of the criminal justice and mental health systems, judges are particularly well positioned to lead reform efforts because of their unique ability to convene stakeholders."[39]

In considering strategies for addressing mental-illness issues, a judge might consider convening a number of parties, including the state's attorney, the public defender, the major local treatment providers, the local hospital that operates the major emergency services (since many people with mental illnesses may be hospitalized in the emergency room during an acute phase of illness), the sheriff and other local law-enforcement representatives, and social-welfare administrators. Each of these parties (and this list may not be exhaustive) will have some responsibility for—and feel the impact of—the issues associated with serious mental illness. Each will be necessary to creating any solutions to these issues.

If such a meeting occurs, little can be done in a single session. In most communities, these are parties that are typically not used to working together, and the building of enough trust to have non-defensive conversations occur ordinarily takes time. But over time, at least three things may happen. First, some measure of trust will develop. Second, once it does, problem identification may occur at both the individual-case level and at a systemic level. In many communities, a number of individuals will be known to all parts of the system; discussion of those individuals may assist in identifying gaps in services at a more general level.[40] Finally, such meetings, over time, will enable community leaders to discuss a variety of strategies, rather than a single strategy. Not every strategy fits every community, and efforts by one part of the criminal justice or treatment systems to impose a solution on all parts of those systems may have little chance of success. However, a group of community leaders that has developed trust may have the opportunity to sift through a variety of strategies, considering them against the backdrop of the group's collective knowledge of local resources, capacities, and political realities.[41]

The judge as program designer. Few communities have adequate treatment capacity for individuals with mental illnesses, and judges may conclude that treatment services for defendants in the criminal justice system are particularly lacking. This may be true, especially for the very high percentage of defendants with co-occurring mental illness and substance-

community networks to create better access to treatment and other resources, and 6) an opportunity to better accommodate concerns regarding diversity. David B. Rottman, Pamela Casey & Hillery Efkeman, *Court and Community Collaboration: Ends and Means* (1998), available at http://www.courtinfo.ca.gov/programs/community/endsmeans.htm. For another of many examples, the work of the California Court and Community Collaboration Project provides a number of documents on community collaboration largely initiated by the courts. *See* http://www.courtinfo.ca.gov/programs/community/

38. In other countries where therapeutic courts have been created, the judge as community leader is also considered essential. For example, a commentary reporting on such courts in Australia, Canada, and the United States observed "Judges in community courts are expected to have a high profile in the local community and to maintain good contacts with the community leaders. This is outside the normal judicial role." JOYCE PLOTNIKOFF & RICHARD WOOLFSON, REVIEW OF THE EFFECTIVENESS OF SPECIALIST COURTS IN OTHER JURISDICTIONS (2005), available at http://www.dca.gov.uk/research/2005/3_2005.pdf.
39. Conference of Chief Justices, *supra* note 1.
40. The identification of needs within a particular system has become quite sophisticated in recent years. One example, called Sequential Intercept Mapping Training, enables community representatives to create a map of how individuals with mental illnesses move across the criminal justice (and treatment) systems. In turn, this permits better planning for the allocation of assessment and treatment resources, as well as the identification of gaps in services. Information about this training may be obtained at http://gainscenter.samhsa.gov/html/tta/trainings.asp.
41. There are many examples of judicial leadership in convening community stakeholders on these issues. One occurred in Miami, Dade County, Florida, where the county was paying 16 million dollars per year to house and treat people with mental illnesses in the jail. Under the leadership of Judge Steve Leifman, a summit of key stakeholders was convened; this in turn led to the creation of Miami-Dade's 11th Judicial Circuit Criminal Mental Health Project under Judge Leifman's leadership. The group, which continues to meet, has been instrumental in efforts to create systemic responses to these issues. For a description, *see* http://www.naco.org/CountyNewsTemplate.cfm?template=/ContentManagement/ContentDisplay.cfm&ContentID=8091. In Broward County, Florida, Judge Mark Speiser created a multiagency Criminal Justice Mental Health Task Force in 1994. The Task Force continues to meet and has spawned a number of initiatives, including two mental-health courts (the first a misdemeanor court, the second a felony court) and specialty probation. In Ohio, Supreme Court Justice Evelyn Stratton has been a forceful advocate for the creation of mental-health courts, and, at least in part as a result, Ohio has more mental-health courts than any state in the United States. More recently, the Florida Supreme Court, under Judge Leifman's leadership, published a comprehensive report suggesting reforms in both the mental-health and criminal justice systems to provide better care for people with mental illnesses at risk of entering the criminal justice system. The report can be found at http://mhlp.fmhi.usf.edu/web/mhlp/documents/Supreme-Court-Report-2007.pdf.

abuse diagnoses. Treatment is often lacking for people with co-occurring disorders in the general population, and so the lack of adequate treatment capacity will be an issue confronting therapeutically oriented judges as well.[42]

Given these difficulties, judges may find themselves a part of an effort to create or design treatment and other services for defendants. Certainly there is precedent for this; judges presiding over drug courts are often intimately involved in overseeing treatment, and drug courts may operate services directly as well as contract with other treatment providers.[43] While a discussion of appropriate treatment services for defendants with mental illnesses is beyond the scope of this article, a judge in this position might consider the following:

First, creation of the capacity to assess serious mental-health issues rapidly and effectively is important, clinically and programmatically. From a clinical perspective, early assessment increases the chances for effective treatment to be provided. From a programmatic perspective, early assessment is important in determining whether an individual is suited for a particular intervention, for example, whether the individual meets criteria governing admission to a mental-health court. Therefore, the availability of good assessment services is critical, whether a community focuses on pre-arrest diversion, therapeutic courts, or post-sentencing alternatives such as specialty probation.[44]

Second, the development of treatment services does not occur in a scientific vacuum. In recent years, there has been a move toward the use of "evidence-based practices" for treating mental illnesses. Such practices are based on research and have been described as "specific interventions and treatment models that have been shown to improve client functioning and the course of severe mental illness."[45] According to the President's New Freedom Commission on Mental Health, a number of treatments can be characterized as evidence-based practices, including specific medications for specific conditions, cognitive and interpersonal therapies for depression, preventive interventions for children at risk for serious emotional disturbances, multisystemic therapy, parent-child interaction therapy, medication algorithms, family psycho-education, assertive community treatment, and collaborative treatment in primary care.[46] It should be noted that these treatments have not been proved effective in treating every type of mental illness, and therefore should not be adopted without first considering the clinical profile of individuals that are the focus of an intervention. However, they can provide a common frame of reference for discussions between representatives of the criminal justice and mental-health treatment systems.

Frequently the discussion is framed in terms of whether the judiciary should be expected to behave in one of two polar-opposite ways.

Third, the use of "boundary spanners" seems essential to cross-system collaboration. Henry Steadman describes boundary spanners as positions that link two or more systems whose goals and expectations are at least partially conflicting.[47] Specifically, an individual in a boundary-spanning position manages the day-to-day interactions between the criminal justice and mental-health systems. Whether the person works for the criminal justice system or the mental-health system is less important than whether the person has authority to make decisions regarding interactions between the systems.[48]

The judge as advocate. Judges may not act as lobbyists for ethical and legal reasons. However, judges increasingly play a role as advocates for services to people with mental illnesses. This role as advocate is a natural out-growth for a judge who becomes a community leader on these issues or who presides over a therapeutic court such as a mental-health court.

42. The President's New Freedom Commission on Mental Health found that individuals with co-occurring mental-illness and substance-abuse disorders are "treated for only one of the two disorders—if they are treated at all." According to the Commission, only 19% of individuals with serious co-occurring disorders received treatment for both disorders, while 29% received treatment for neither. The Commission observed that such individuals often use the most expensive forms of care, including hospital emergency rooms and inpatient facilities, and that the lack of treatment increased their risk for suicide attempts, violent behavior, legal problems, serious medical problems, and homelessness. *See* ACHIEVING THE PROMISE, *supra* note 14.
43. For a good overall discussion of drug courts, including recidivism and treatment issues, *see* U.S. GOV'T ACCOUNTABILITY OFFICE, ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES (2005), available at http://www.gao.gov/new.items/d05219.pdf.
44. Rapid assessment has long been a benchmark of drug-court programs, and it is also considered critical in the treatment of mental illnesses more generally. *See, e.g.*, NAT'L ASS'N OF DRUG CT. PROFESSIONALS, DEFINING DRUG COURTS: THE KEY COMPONENTS (1997 ed., reprinted 2004), available at http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf. *See also* ACHIEVING THE PROMISE, *supra* note 14.
45. COUNCIL OF STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 251 (2002), available at http://consensusproject.org/downloads/Entire_report.pdf. Policy Statement No. 35 of the consensus project report urges the use of evidence-based practices in mental-health treatment. *Id.* at 250-56.
46. ACHIEVING THE PROMISE, *supra* note 14, Goal 5. The development of evidence-based practices is in an embryonic stage, and there is not complete consensus on which treatments should be classified as evidence-based practices. In addition, most jurisdictions rely on a treatment system in which some or all such practices are absent. This does not mean that treatment in such jurisdictions is necessarily suspect in all cases; however, in developing services to fill gaps in treatment, it seems useful to focus on evidence-based practices as an anchor for discussion.
47. Henry J. Steadman, *Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems*, 16 LAW & HUMAN BEHAV. 75 (1992).
48. Steadman notes that there is no best way to create a boundary-spanner position and that deciding where to place a boundary-spanner position "depends upon local politics, history, economics, and personalities." *Id.* at 84 n.23.

An example of such advocacy, as part of a broader coalition of stakeholders, is provided by the Florida Partners in Crisis. This coalition was begun in central Florida in 1999 under the leadership of Judge Belvin Perry in response to mental-health and substance-use issues affecting the mental-health system. Members include judges, law-enforcement officials, behavioral-health providers, correctional officials, and family members. Partners in Crisis has a number of goals, including increasing public awareness of mental-health and substance-use service needs throughout Florida.[49]

The emergence of organizations like Partners in Crisis is an important development politically. For years, mental-health providers, in particular, were suspicious of the legal system and the courts for a variety of reasons including malpractice concerns, and treatment providers also associated client involvement in the legal process with long, uncompensated hours spent waiting to testify. However, given declining financial support for mental-health services in many states, and given the reality that law-enforcement officials typically have more clout politically than mental-health providers, a coalition such as Partners in Crisis has the potential to focus legislative and executive branch attention on service needs in a way that treatment providers, acting alone, often cannot.

The judge as a member of the treatment team. Finally, therapeutic courts, in particular, require the judge to play a role that may conflict with the more traditional role of the judge. One commentator in this journal has written, "Specialized courts…are manifestations of a change in the role of the judge from 'dispassionate, disinterested magistrate' to that of a 'sensitive, emphatic counselor."[50] Justice Kaye, Chief of the New York Court of Appeals, has observed that therapeutic courts require a change in the role of lawyers as well, writing that in therapeutic courts, "the lawyers also have new roles. The prosecution and defense are not sparring champions, they are members of a team with a common goal: Getting the defendant off drugs. When this goal is attained, everyone wins. Defendants win dismissal of their charges…the public wins safer streets and reduced recidivism."[51]

Others have criticized these roles on a number of grounds including a claim that they may lead to the derogation of important legal rights enjoyed by the defendant. As noted earlier, this conflict over judicial role is not new. Boldt, for example, has argued that the creation of a "therapeutic relationship" between judge and defendant may compromise the role of defense counsel, among other things.[52]

Indeed, these arguments over the appropriate role of judges and lawyers have been at the heart of many of the debates regarding such roles in the context of civil commitment.[53] As with other role issues discussed in this article, judges will make individual decisions regarding the roles they wish to play, but the potential role conflict is worth noting.

Judges are providing critical leadership in communities across the United States in responding to the crisis of mental illness in the criminal justice system. In doing so, judges have adopted new and sometimes unfamiliar roles. While not all judges are comfortable with these new roles, it seems clear that in many instances, reform is simply impossible without judicial leadership.

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49. For a description of Partners in Crisis and its membership and activities, *see* http://www.flpic.org.
50. David Rottman, *Does Effective Therapeutic Jurisprudence Require Specialized Courts (And Do Specialized Courts Imply Specialist Judges)?*, COURT REVIEW, Spring 2000, at 22. Rottman provides an excellent summary of the arguments for and against specialization. He concludes that "the long-term future of the new specialized courts depends upon their successful incorporation into larger trial court systems…the investment of so many resources in special courts must ultimately be justified in terms of their role as agents of change beyond a few courtrooms." *Id.* at 26.
51. Judith Kaye, *Lawyering for a New Age,* 67 FORDHAM L. REV. 1 (1998).
52. Richard C. Boldt, *Rehabilitative Punishment and the Drug Court Treatment Movement,* 76 WASHINGTON UNIV. L.Q. 1206 (1998).
53. The most used legal textbook on mental-disability law notes "numerous studies have documented that attorneys rarely spend more than a few minutes preparing for the [civil commitment] hearing, seldom call witnesses, and usually fail to engage in vigorous cross-examination of the experts." RALPH REISNER, CHRISTOPHER SLOBOGIN & ARTI RAI, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 800 (4th ed. 2003).