THEORIZING MENTAL HEALTH COURTS

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ABSTRACT

To date, no scholarly article has analyzed the theoretical basis of mental health courts, which currently exist in forty-three states. This Article examines the two utilitarian justifications proposed by mental health court advocates—therapeutic jurisprudence and therapeutic rehabilitation—and finds both insufficient. Therapeutic jurisprudence is inadequate to justify mental health courts because of its inability, by definition, to resolve significant normative conflict. In essence, mental health courts express values fundamentally at odds with those underlying the traditional criminal justice system. Furthermore, the sufficiency of rehabilitation, as this concept appears to be defined by mental health court advocates, depends on the validity of an assumed link between mental illness and crime. In particular, mental health courts view participants' criminal behavior as symptomatic of their mental illnesses and insist that untreated mental illness serves as a major driver of recidivism. Drawing upon social science research and an independent analysis of mental health courts' eligibility criteria, this Article demonstrates that these relationships may not hold for a substantial proportion of individuals served by mental health courts. The Article concludes by identifying alternative theories that may justify this novel diversion intervention.

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INTRODUCTION

Fueled by federal funding,[1] approximately 250 mental health courts now exist in forty-three states.[2] While no single definition of "mental

1. *See* Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. No. 108-414, 118 Stat. 2327 (2004) (codified as 42 U.S.C. § 3797aa) (authorizing funding, training, and technical assistance for collaborative efforts between criminal justice and mental health agencies, including mental health courts); America's Law Enforcement and Mental Health Project Act of 2000, Pub. L. No. 106-515, 114 Stat. 2399 (2000) (codified as amended in scattered sections of 42 U.S.C.) (granting funding for the development or expansion of mental health courts).

2. Henry J. Steadman et al., *Effect of Mental Health Courts on Arrests and Jail Days*, 68 ARCHIVES GEN. PSYCHIATRY 167 (2011), *available at* http://archpsyc.ama-assn.org/cgi/content/abstract/archgenpsychiatry.2010.134v1; NAT'L ALLIANCE ON MENTAL ILLNESS, GRADING THE

health court" enjoys universal agreement,[3] the term generally describes a specialized court for certain defendants with mental illnesses who choose to eschew traditional court processing in favor of a problem-solving approach involving court-ordered and court-supervised treatment.[4] Currently, mental health courts vary in the charges and mental illness diagnoses they accept, their consideration of individuals with a history of violence, plea requirements, treatments offered, intensity and length of supervision, potential sanctions, and the impact of program completion on participants' criminal cases.[5] Mental health courts may follow a pre- or post-adjudication model.[6] While early mental health courts typically limited eligibility to individuals charged with misdemeanors, mental health courts have increasingly opened their doors to accused felons and violent felons.[7] Mirroring the expressed purpose of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, which authorizes

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STATES: A REPORT ON AMERICA'S HEALTH CARE SYSTEM FOR ADULTS WITH SERIOUS MENTAL ILLNESS 42 (2009), *available at* http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/contentmanagement/contentdisplay.cfm&ContentID=75019.

3. COUNCIL OF STATE GOV'TS, A GUIDE TO MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION 1 (2005), *available at* http://www.ojp.usdoj.gov/BJA/pdf/Guide-MHC-Design.pdf [hereinafter GUIDE TO MENTAL HEALTH COURT DESIGN].

4. *See* LAUREN ALMQUIST & ELIZABETH DODD, MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 5 (2009), *available at* http://consensusproject.org/jc_publications/mental-health-courts-a-guide-to-research-informed-policy-and-practice/Mental_Health_Court_Research_Guide.pdf; COUNCIL OF STATE GOV'TS JUSTICE CTR., MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS 4 (2008), *available at* http://consensusproject.org/jc_publications/mental-health-courts-a-primer-for-policymakers-and-practitioners/mhc-primer.pdf [hereinafter MENTAL HEALTH COURTS: A PRIMER]. For a list of elements common to early and "second generation" mental health courts, see Henry J. Steadman et al., *Mental Health Courts: Their Promise and Unanswered Questions*, 52 PSYCHIATRIC SERVICES 457 (2001) and Allison D. Redlich et al., *The Second Generation of Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 527 (2005), respectively. This Article does not address the other functions that may be served by mental health courts, such as competence restoration.

5. GUIDE TO MENTAL HEALTH COURT DESIGN, *supra* note 3, at 28–35, 38–43 (a fairly comprehensive account of the operations of thirty-seven federally funded mental health courts). The Bureau of Justice Assistance's Justice and Mental Health Collaboration Program has issued a number of publications concerning mental health courts that can be found online at http://www.consensusproject.org/issue_areas/courts. An online database of individual mental health court profiles is maintained by the Council of State Governments' Justice Center, at http://consensusproject.org/programs_start. For a list of additional policy guides and web resources on mental health courts, see MENTAL HEALTH COURTS: A PRIMER, *supra* note 4, at 20–22.

6. *See* GUIDE TO MENTAL HEALTH COURT DESIGN, *supra* note 3, at 38–40; Redlich et al., *Second Generation*, *supra* note 4, at 534–35.

7. *See* ALMQUIST & DODD, *supra* note 4, at 7–9 (reporting the findings of several studies—including a 2006 survey of eighty-seven mental health courts that found that 40 percent accepted only misdemeanants, 10 percent only accepted felons, and 50 percent accepted misdemeanants and felons—and concluding that mental health courts are increasingly likely to accept individuals charged with violent crimes).

federal funding for mental health courts,[8] the primary goal of most mental health courts is to reduce recidivism, typically defined in terms of new arrests or convictions.[9]

It is unclear whether mental health courts actually reduce recidivism and, to the extent they do, what accounts for that success.[10] Mental health court staff and participants have provided strong anecdotal support for the ability of these courts to decrease criminal behavior and increase treatment compliance,[11] and it appears that participants' experience with the courts has largely been positive. Most research to date has been descriptive rather than evaluative, however, and the quality of the research has varied significantly.[12] Most studies are marred by methodological shortcomings,[13]

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8. *See* Mentally Ill Offender Treatment and Crime Reduction Act of 2004, S. 1194, *available at* http://www.gpo.gov/fdsys/pkg/BILLS-108s1194enr/pdf/BILLS-108s1194enr.pdf ("The purpose of this Act is to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems.").

9. *See, e.g.*, David Cooke, *Diversion from Prosecution: A Scottish Experience*, *in* WHAT WORKS: REDUCING REOFFENDING 173, 185 (James McGuire ed., 1995) (arguing that reconviction rates, the typical outcome measure used in treatment programs for offenders with mental illnesses, are the most sensible measure of success because "[r]econviction is the one objective criterion that can be applied irrespective of the presenting psychological problem, or the therapeutic approach adopted in tackling this problem," "can be used to determine whether the public interest is being well served" by programs, and "may assist in the identification of appropriate and non-appropriate referrals"); Sarah L. Miller & Abigayl M. Perelman, *Mental Health Courts: An Overview and Redefinition of Tasks and Goals*, 33 LAW & PSYCHOL. REV. 113, 122 (2009) (characterizing available research as suggesting that the primary objective of mental health courts is to influence criminal justice outcomes, such as number of arrests and recidivism rates).

10. *See* ALMQUIST & DODD, *supra* note 4, at 21 (observing that very little empirical evidence exists on the impact of mental health courts and that "[w]hat is not yet known is *why* some individuals do well in mental health courts and others do not, or *why* certain programs seem to be more effective than others.") (emphasis in original); Steven K. Erickson et al., *Variations in Mental Health Courts: Challenges, Opportunities, and a Call for Caution*, 42 COMMUNITY MENTAL HEALTH J. 335, 337 (2006) (remarking that "the paucity of research regarding [mental health courts'] effectiveness is noteworthy."). For a recent evaluation of the cost-effectiveness of mental health courts, see Richard Frank & Thomas G. McGuire, *Mental Health Treatment and Criminal Justice Outcomes* 29–30, 36 (Nat'l Bureau of Econ. Research, Working Paper No. 15858, 2010), *available at* http://ssrn.com /abstract=1583799 (concluding that some, but not all, evaluations of mental health courts show a reduction in criminal activity but that little evidence connects the mental treatment component of the courts to decreases in recidivism).

11. *See* ALMQUIST & DODD, *supra* note 4, at 21; Susan Stefan & Bruce J. Winick, *A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 507, 507 (2005) ("The efficacy of the mental health court model has not as yet been demonstrated empirically, although some anecdotal reports have suggested that it is a promising development.").

12. *See* ALMQUIST & DODD, *supra* note 4, at 21–22; CTR. FOR BEHAVIORAL HEALTH SERVS. CRIMINAL JUSTICE RESEARCH, INTERVENTION FACT SHEET: MENTAL HEALTH COURTS (2009), *available at* http://www.cbhs-cjr.rutgers.edu/pdfs/MentalHealthCourts.pdf ("Although there are numerous descriptive accounts and anecdotal assessments of the positive impact of [mental health courts], little reliable *research* has been done to assess the impact of [mental health courts] on the behavioral health, criminal justice, or employment futures of those who have participated in [mental health courts].") (emphasis in original); Arthur J. Lurigio & Jessica Snowden, *Putting Therapeutic*

such as including inadequate outcome measures and short follow-up periods, which limit their worth.[14] The few rigorous studies that have been published have reached generally positive but inconsistent conclusions,[15] ranging from finding no effect on re-arrest rate to a decrease in recidivism by mental health court participants of fifteen percent at eighteen months.[16] Some forensic psychologists have suggested that, to the extent mental health courts *do* reduce recidivism, this result may stem from courts' attendance to needs that are *unrelated* to offenders' mental illnesses.[17]

While it is certainly important, as an empirical matter, to determine the extent to which mental health courts reduce recidivism, the concern of this Article is largely theoretical. Its guiding thesis is that a coherent theoretical justification should support the decision to create a separate system of

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Jurisprudence into Practice: The Growth, Operations, and Effectiveness of Mental Health Court, 30 JUST. SYS. J. 196, 197 (2009).

13. *See* ALMQUIST & DODD, *supra* note 4, at 21–22 (listing methodological shortcomings of most studies); CTR. FOR BEHAVIORAL HEALTH SERVS. CRIMINAL JUSTICE RESEARCH, *supra* note 12; Lurigio & Snowden, *supra* note 12, at 197, 214; Nancy Wolff & Wendy Pogorzelski, *Measuring the Effectiveness of Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 539, 540 (2005) (explaining that the descriptive evaluations of mental health courts have all the limitations of early drug court evaluations, which include poor research designs and methods).

14. ALMQUIST & DODD, *supra* note 4, at 21–22 (noting that most studies did not follow participants beyond twelve months); CTR. FOR BEHAVIORAL HEALTH SERVS. CRIMINAL JUSTICE RESEARCH, *supra* note 12 (explaining that no randomized controlled trial of mental health courts has been conducted, and the evidence that exists is based on small numbers of clients, non-equivalent comparison groups, and short follow-up periods); Lurigio & Snowden, *supra* note 12, at 197.

15. *See* ALMQUIST & DODD, *supra* note 4, at 21, 23–25; Lurigio & Snowden, *supra* note 12, at 197; Jennifer L. Skeem, Sarah Manchak & Jillian K. Peterson, *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110, 113, 115 (2010) (Tables 1, 2).

16. *See* Skeem, Manchak & Peterson, *supra* note 15, at 113, 115 (Tables 1, 2); *cf.* ALMQUIST & DODD, *supra* note 4, at 21–25 (reviewing peer-reviewed studies whose methodological rigor meets minimal standards and concluding that preliminary evidence suggests that mental health court participation is associated with lower recidivism rates). A recent, particularly well-designed study funded by the John D. and Catherine T. MacArthur Foundation found that mental health court participation resulted in a lower annualized re-arrest rate, fewer post-eighteen-month arrests, and fewer post-eighteen-month incarceration days than treatment as usual. *See* Steadman et al., *Effect of Mental Health Courts on Arrests and Jail Days*, *supra* note 2 (utilizing an experimental design that included treatment and comparison samples from multiple locales). The study found that both clinical and criminal justice factors—but particularly criminogenic factors—were associated with better public safety outcomes among mental health court participants. *Id.* at 167, 171. These factors included lower pre-eighteen-month arrests and incarceration days, treatment at baseline, refraining from using illegal substances, and a diagnosis of bipolar disorder (as opposed to schizophrenia or depression). *Id.* at 171.

17. *See* Skeem, Manchak & Peterson, *supra* note 15, at 120 ("[T]o the extent that staff intuitively focus on changing an individual's general risk factors for crime, programs may be more effective in reducing criminal behavior than those that bank more exclusively on psychiatric services."); *id.* at 121 (suggesting that programs like mental health courts are more likely to be effective when they apply core correctional practices, mitigate the criminogenic effects of unhealthy social environments (like by providing supported employment), and target factors that "get an offender in trouble" (like antisocial influences)).

justice for a historically stigmatized population.[18] In essence, some theory of sentencing or social welfare should be capable of explaining *why* it is appropriate to segregate offenders with mental illnesses and *why* coercive treatment is more appropriate for these individuals than traditional sentencing. In addition, once a potential justification has been identified, any empirical assumptions necessary to the internal coherence of that theory should survive scrutiny.[19] If existing evidence contradicts necessary presuppositions—or if a coherent theory supporting the existence of the courts cannot be identified at all—then the legitimacy of the mental health court venture is in doubt.[20]

Thus far, commentators have largely limited their inquiries to the practical effects of mental health courts. In particular, some commentators have criticized the emasculated role of defense counsel in mental health courts[21] and the courts' net-widening effects.[22] Others have expressed concerns about the coercive nature of the courts,[23] offenders' competence

18. Persons with mental illnesses have suffered isolation and stigmatization throughout our nation's history. *See, e.g.*, Leonard S. Rubenstein, *Ending Discrimination Against Mental Health Treatment in Publicly Financed Health Care*, 40 ST. LOUIS U. L.J. 315, 349–50 (1995). The findings in the Americans with Disabilities Act stress that, "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2) (2006).

19. *See* Jeffrie G. Murphy, *Introduction*, *in* PUNISHMENT AND REHABILITATION 1, 4 (Jeffrie G. Murphy ed., 1973) (explaining that philosophical theories may presuppose empirical claims for their truth or intelligibility and that philosophers have an obligation to keep informed of relevant scientific work pertaining to their theoretical presuppositions).

20. *See* Nancy Wolff, *Courts as Therapeutic Agents: Thinking Past the Novelty of Mental Health Courts*, 30(3) J. AM. ACAD. PSYCHIATRY & L. 431, 433–34 (2002).

21. *See* Timothy Casey, *When Good Intentions Are Not Enough: Problem-Solving Courts and the Impending Crisis of Legitimacy*, 57 SMU L. Rev. 1459, 1483 (2004); Stacey M. Faraci, *Slip Slidin' Away? Will Our Nation's Mental Health Court Experiment Diminish the Rights of the Mentally Ill?*, 22 QLR 811, 825, 838–40, 844–45 (2004); Tamar M. Meekins, *"Specialized Justice": The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense Paradigm*, 40 SUFFOLK U. L. REV. 1, 1–55 (2006); Erickson et al., *supra* note 10, at 337, 340; Wolff & Pogorzelski, *supra* note 13, at 558–59; *see also* Mae C. Quinn, *Whose Team Am I on Anyway: Musings of a Public Defender about Drug Treatment Court Practice*, 26 N.Y.U. REV. L. & SOC. CHANGE 37, 37 (2001) [hereinafter *Whose Team*] (analyzing and critiquing the role of defense counsel in context of drug treatment courts).

22. *See* Allison D. Redlich et al., *Patterns of Practice in Mental Health Courts: A National Survey*, 30 LAW & HUM. BEHAV. 347, 348 (2006); Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illness*, 11 PSYCHOL. PUB. POL'Y & L. 570, 581–82 (2005); Faraci, *supra* note 21, at 850; Stefan & Winick, *supra* note 11, at 518.

23. *See* Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illness: The Role of Mental Health Courts in System Reform*, 7 UDC/DCSL L. REV. 143, 150–51 (2003); Casey, *supra* note 21, at 1498–99; Faraci, *supra* note 21, at 845–47; Allison D. Redlich, *Voluntary, But Knowing and Intelligent?*, 11 PSYCHOL. PUB. POL'Y & L. 605 (2005); Seltzer, *supra* note 22, at 574–75, 582; Stefan & Winick, *supra* note 11, at 512.

to consent to diversion,[24] and infringement on participants' privacy.[25] Finally, others have pointed to the increased discretionary power and partiality of specialty court judges[26] and the potential of these courts to divert resources from law-abiding individuals with mental illnesses.[27]

This Article marks the first attempt to canvass and scrutinize theoretical justifications for mental health courts.[28] To date, mental health court judges and advocates have identified two utilitarian theories to justify the existence of the courts:[29] therapeutic jurisprudence and a narrow form of rehabilitation.[30] Therapeutic jurisprudence is the most popular justification for mental health courts.[31] This academic discipline, developed in the early 1990s by Professors David B. Wexler and Bruce J. Winick,[32] encourages the use of social science to investigate the ways in which a legal rule or practice affects the psychological and physical well-

24. *See* Erickson et al., *supra* note 10, at 339; Faraci, *supra* note 21, at 846–47; Lurigio & Snowden, *supra* note 12, at 206; K. Stafford & R. Wygant, *The Role of Competency to Stand Trial in Mental Health Courts*, 23 BEHAV. SCI. & L. 245 (2005).

25. *See* Bernstein & Seltzer, *supra* note 23, at 159.

26. *See id.* at 156–57; John A. Bozza, *Benevolent Behavior Modification: Understanding the Nature and Limitations of Problem-Solving Courts*, 17 WIDENER L.J. 97, 113–14 (2007); Casey, *supra* note 21, at 1491–93, 1497–1500; Faraci, *supra* note 21, at 838–43; Wolff & Pogorzelski, *supra* note 13, at 556, 558–59.

27. *See* Erickson et al., *supra* note 10, at 341; Faraci, *supra* note 21, at 848; Lurigio & Snowden, *supra* note 12, at 212; Seltzer, *supra* note 22, at 581.

28. The focus of this Article is on the extent to which a theory of social risk or punishment supports the creation of mental health courts. It does not address the practical reasons why mental health courts might have been created, such as states' failure to provide constitutionally adequate mental health treatment in jails and prisons.

29. Utilitarian theories of punishment hold that an infliction of punishment is justified as a means to increase social welfare by reducing future crime. *See* Jeremy Bentham, *On the Principle of Utility*, *in* PUNISHMENT AND REHABILITATION, *supra* note 19, at 64, 66–68 & n.2. Utilitarian theories or methods include deterrence, rehabilitation, and incapacitation. *See* Michael T. Cahill, *Punishment Pluralism*, *in* RETRIBUTIVISM: ESSAYS ON THEORY AND POLICY (Mark D. White ed., 2011) (briefly defining the three utilitarian theories); Stanley I. Benn, *Punishment*, *in* PUNISHMENT AND REHABILITATION, *supra* note 19, at 18, 22–23 ("By reforming the criminal, by deterring him or others from similar offenses in the future, or by directly preventing further offenses by imprisonment, deportation, or execution, the good that comes out of punishment may outweigh (so the utilitarian argues) the intrinsic evil of suffering deliberately inflicted.").

30. According to Professor Michael T. Cahill, rehabilitation "aims to transform those who were formerly motivated to commit crimes into law-abiding citizens." Cahill, *supra* note 29, at 8. Therapeutic rehabilitation, one of several models of rehabilitation, posits that crime often results from pathologies that can be diagnosed and ameliorated through treatment. *See infra* notes 41–44. While mental health courts consider a criminal act to be a necessary predicate for State intervention, in principle rehabilitative efforts could be applied to individuals suspected of posing social risk *before* they commit a crime. *See* Cahill, *supra* note 29, at 8.

31. *See infra* notes 54–55.

32. *See* THERAPEUTIC JURISPRUDENCE (David B. Wexler ed., 1990); ESSAYS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1991).

being of offenders and other legal actors.[33] Therapeutic jurisprudence proposes that, other things being equal, the law should be restructured to accomplish therapeutic goals.[34] Therapeutic jurisprudents point to the antitherapeutic effects of mandatory incarceration[35] and assume that the coercive provision of mental health treatment will have a positive therapeutic impact on participants by addressing the source of their underlying criminal problem.[36]

In addition, a few mental health court judges have suggested a second possible theory—a form of therapeutic or medical rehabilitation—as animating their courts.[37] Therapeutic rehabilitation, which gained prominence in the mid-twentieth century through the writings of Karl Menninger,[38] Benjamin Karpman,[39] and others,[40] is based on a medical

33. *See* Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL. PUB. POL'Y & L. 193, 196 (1995).

34. Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCHOL. PUB. POL'Y & L. 184, 198 (1997).

35. *See* David B. Wexler, *A Tripartite Framework for Incorporating Therapeutic Jurisprudence in Criminal Law Education, Research, and Practice*, *in* REHABILITATING LAWYERS 11, 15 (David B. Wexler ed. 2008) (characterizing "a rigid, inflexible sentencing scheme, especially one characterized by mandatory incarcerative penalties" as antitherapeutic).

36. *See* RICHARD D. SCHNEIDER ET AL., MENTAL HEALTH COURTS: DECRIMINALIZING THE MENTALLY ILL 49–50 (2007); Bruce J. Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, 30 FORDHAM URB. L.J. 1055, 1064–65 (2003).

37. *See, e.g.*, Jeff Lehr, *First Defendant Accepted at Local Mental Health Court*, JOPLIN GLOBE, Apr. 9, 2010, http://www.joplinglobe.com/local/x435293406/First-defendant-accepted-at-local-mental-health-court (explaining that the goal of the mental health court "is to reduce the likelihood that such defendants will commit another crime by seeing that they get the mental health treatment they need"); Rob Perez, *Fiscal Crisis Threatens Special Courts*, HONOLULU ADVISOR, Feb. 22, 2010, Section News, *available at* 2010 WLNR 3788360 ("The idea behind the courts is that if the underlying problems contributing to the person's troubles aren't addressed, the person is likely to offend again and pass such behavior on to the next generation. . . . The main difference between Mental Health and regular court . . . was that the latter didn't address the causes of [a participant's] behavior problems."); *Will County Launches Mental Health Court*, MORRIS DAILY HERALD, May 1, 2010, http://www.morrisdailyherald.com/articles/2010/04/30/48631081/index.xml (quoting Chief Judge Gerald Kinney as stating: "[The Mental Health Court] allows us to identify and treat individuals whose primary causes of being within the criminal justice system are their mental health issues. We can identify resources that will assist them and keep them from re-offending."); *see also* SCHNEIDER ET AL., *supra* note 36, at 48–50, 60 (conceptualizing therapeutic jurisprudence as a stand-alone theory of crime that encourages identification of the roots of criminality and the creation of a therapeutic response tailored to addressing and eliminating those criminal roots).

38. *See, e.g.*, KARL MENNINGER, THE CRIME OF PUNISHMENT (1968); Karl Menninger, *Medicolegal Proposals of the American Psychiatric Association*, 19 J. CRIM. L., CRIMINOLOGY & POLICE SCI. 367 (1928); Karl Menninger, *Therapy, Not Punishment*, *in* PUNISHMENT AND REHABILITATION, *supra* note 19, at 132.

39. *See, e.g.*, BENJAMIN KARPMAN, THE SEXUAL OFFENDER AND HIS OFFENSES (1954); BENJAMIN KARPMAN, CASE STUDIES IN THE PSYCHOPATHOLOGY OF CRIME (1947); Benjamin Karpman, *Criminal Psychodyamics: A Platform*, *in* PUNISHMENT AND REHABILITATION, *supra* note 19, at 118.

40. *See, e.g.*, BARBARA WOOTTON, CRIME AND THE CRIMINAL Law (1963) (arguing that the

model of crime.[41] According to this theory, criminal behavior is symptomatic of mental illness or personality disorder.[42] In essence, offenders are considered "sick" and in need of a state-coerced "cure" to address their underlying sources of criminality.[43] Therapeutic rehabilitation holds that treatment—not traditional sentencing or incarceration—is necessary to transform criminals, whose acts are the product of pathology, into law-abiding individuals.[44]

Mental health court proponents appear to embrace a brand of therapeutic rehabilitation based on two propositions. First, mental health courts justify segregating and diverting individuals with mental illnesses from the traditional justice system on the basis that their illnesses likely contributed to their criminal behavior. Second, and relatedly, mental health courts operate under the assumption that the amelioration of mental illness symptoms will reduce the likelihood of future criminal behavior. In other words, by treating individuals' mental illnesses, mental health courts will rehabilitate offenders into law-abiding citizens.

This Article examines the theories of therapeutic jurisprudence and therapeutic rehabilitation and ultimately finds both unavailing for a substantial proportion of the offenders diverted into mental health courts. A careful review of the definition of therapeutic jurisprudence reveals that the structure and aim of this discipline preclude its use as a justification for mental health courts. The creators of therapeutic jurisprudence have consistently stressed that health is not a transcendent norm, and, in the face of significant normative conflict, therapeutic jurisprudence does not provide a means to mediate between competing values.[45] Because mental health courts express values that conflict substantially with those endorsed by the traditional criminal justice system, therapeutic jurisprudence is inadequate to justify the existence of mental health courts.

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criminal justice system should serve preventative, not punitive, ends and treat the origins of criminality).

41. For a description of the tenets and evolution of therapeutic rehabilitation, see EDGARDO ROTMAN, BEYOND PUNISHMENT: A NEW VIEW ON THE REHABILITATION OF CRIMINAL OFFENDERS 60–63 (1990). Most of the criticism of rehabilitation in the 1970s was aimed at the therapeutic model of rehabilitation. *Id.* at 5.

42. *See* Murphy, *supra* note 19, at 5; Karpman, *Criminal Psychodynamics: A Platform*, *supra* note 39, at 119 (arguing that "criminality is but a symptom of insanity").

43. *See* ROTMAN, *supra* note 41, at 5.

44. *See* WOOTTON, *supra* note 40, at 77, 79; Karpman, *Criminal Psychodynamics: A Platform*, *supra* note 39, at 128, 131.

45. *See* Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 191, 198; David B. Wexler & Robert F. Schopp, *Therapeutic Jurisprudence: A New Approach to Mental Health Law*, *in* HANDBOOK PSYCHOL. & L. 361, 373 (Dorothy K. Kagehiro & William S. Laufer eds., 1992).

Moreover, the penal theory of therapeutic rehabilitation—at least as envisioned by mental health court advocates—is largely unavailable as a justification for mental health courts because the factual assumptions underlying this theory are belied by scientific evidence. As Professor Stephen J. Morse has argued for decades,[46] social and psychological research demonstrates that the criminal acts of individuals with mental illnesses often do not stem from their disorders but may arise from a number of motivations.[47] Since many mental health courts do not require a demonstrated nexus between an individual's mental illness and his criminal offense,[48] courts' assumption of a causal link appears misplaced. In addition, the weight of recent scientific evidence demonstrates that mental illness is not a direct contributor to recidivism for most offenders with mental illnesses.[49] Instead, such offenders often simply exhibit the same risk factors—such as substance abuse, family problems, and antisocial tendencies—as other offenders.[50] It is these risk factors, not symptomatic mental illness, that directly contribute to criminal activity for a majority of individuals with mental illnesses.

These two assertions—that crimes are often *not* the product of mental illness, and that mental illness is usually *not* a significant contributor to recidivism—might strike some readers as counterintuitive. Indeed, perhaps in part due to the relentless portrayal of individuals with mental illnesses as dangerous and impulsive by the media,[51] many of us believe in a strong, causal relationship between mental illness and violent or criminal behavior.[52] Even some advocates of individuals with mental illnesses

46. *See, e.g.*, Stephen J. Morse, *Crazy Reasons*, 10 J. CONTEMP. LEGAL ISSUES 189, 210, 211, 216 (1999); Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 564–90 (1978).

47. *See infra* notes 217–30 and accompanying text.

48. *See infra* notes 201–13 and accompanying text.

49. *See infra* notes 274–79 and accompanying text.

50. *See infra* notes 291–99 and accompanying text.

51. *See, e.g.*, OTTO F. WAHL, MEDIA MADNESS: PUBLIC IMAGES OF MENTAL ILLNESS (1995); George Gerbner et al., *Health and Medicine on Television*, 305 NEW ENG. J. MED. 901 (1981); John Monahan, *"A Terror to Their Neighbors": Beliefs About Mental Disorder and Violence in Historical and Cultural Perspective*, 20 BULL. AM. ACAD. PSYCHIATRY L. 191, 192 (1992) (describing results of studies of media images of individuals with mental illnesses); Nancy Signorielli, *The Stigma of Mental Illness on Television*, 33 J. BROADCASTING & ELECTRONIC MEDIA 325 (1989).

52. *See, e.g.*, Andrew B. Borinstein, *Public Attitudes Toward Persons with Mental Illness*, 11 HEALTH AFFS. 186 (1993) (reporting results from a 1989 Robert Wood Johnson Foundation Program on Chronic Mental Illness study finding that 15 to 24 percent of respondents were concerned about the potential violence and dangerousness of persons with mental illness); Deborah A. Dorfman, *Through a Therapeutic Jurisprudence Filter: Fear and Pretextuality in Mental Disability Law*, 10 N.Y.L. SCH. J. HUM. RTS. 805, 808 (1993) ("[W]e often presume that all mentally disabled individuals are dangerous by virtue of their mentally ill status, regardless of their actual condition and despite the fact that few of

assume their criminal acts are often symptomatic of their disorders.[53] Decades of social science research, however, demonstrate that this belief may be fueled more by stigma and stereotype than by reality.

This Article is organized in the following manner. Part I defines therapeutic jurisprudence and explores its normative potential. It concludes by listing sources of normative conflict between the values expressed by mental health courts and those of retribution and deterrence, two theories of punishment that predominate in the traditional justice system. Part II investigates the potential of therapeutic rehabilitation to justify the existence of mental health courts. It defines therapeutic rehabilitation and identifies the central empirical assumptions of this theory in the context of mental health courts. The Article next draws on social science research to investigate the relationship between mental illness and crime and suggests that, to the extent mental health courts purport to target individuals whose crimes and recidivistic tendencies stem from their mental illnesses, mental health courts are currently overinclusive. The Article concludes by suggesting other theories of punishment or social welfare that potentially justify the existence of these specialty courts.

I. THERAPEUTIC JURISPRUDENCE

Many mental health court judges, including the judge who founded one of the earliest and most widely emulated courts in Broward County, Florida, in 1997,[54] claim that therapeutic jurisprudence provides

them are actually dangerous."); Bruce G. Link & Ann Stueve, *Evidence Bearing on Mental Illness as a Possible Cause of Violent Behavior*, 17 EPIDEMIOLOGIC REV. 172 (1995) (finding that symptoms of mental illness are strongly connected with fear of potential violence); Monahan, *supra* note 51 (demonstrating that the belief that mental disorder is moderately associated with violence is historically invariant and culturally universal); Michael L. Perlin, *On "Sanism"*, 46 SMU L. REV. 373, 394–97 (1992) (discussing common societal myths held by the public and legal actors regarding mentally disabled individuals, including the myth that they are dangerous and frightening); Jo C. Phelan et al., *Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to Be Feared?*, 41 J. HEALTH & SOC. BEHAV. 188 (2000) (finding a significant increase over time in the number of people describing individuals with mental illnesses as violent).

53. *See infra* note 183.

54. *See* Ginger Lerner-Wren, *Broward's Mental Health Court: An Innovative Approach to the Mentally Disabled in the Criminal Justice System*, FUTURE TRENDS ST. CTS. 3 (2000), *available at* http://contentdm.ncsconline.org/cdm4/item_viewer.php?CISOROOT=/spcts&CISOPTR=184&REC=1 (articulating a central goal as applying "a therapeutic approach to the processing of offenders to better assist them and family in the recovery process and in assuming personal responsibility for their comprehensive health needs"); *id.* (identifying one critical feature of Broward's mental health court as "wholly adopt[ing] and appl[ying] the principles of Therapeutic Jurisprudence—a legal construct that advances the Courts' role as an active therapeutic agent in the recovery process").

theoretical grounding for the courts.[55] Therapeutic jurisprudence contributes to a deeper understanding of the law by recognizing that legal rules, legal procedures, and the approaches taken by legal actors serve as social forces that may produce therapeutic or antitherapeutic consequences.[56] Professor David B. Wexler, a cofounder of therapeutic jurisprudence, has indicated that the definition suggested by Professor Christopher Slobogin best captures the appropriate scope of therapeutic jurisprudence: "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects."[57] Much of the value of therapeutic jurisprudence exists in its service as a "lens" that prompts observers to question the therapeutic effect of legal arrangements and outcomes.[58] Recently, Professor Wexler has stressed that therapeutic jurisprudence "is not and has never pretended to be a full-blown 'theory,'"[59] but instead is "simply a 'field of inquiry'—in essence a research agenda—focusing attention on the often overlooked area of the impact of the law on psychological well-being and the like."[60]

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55. *See, e.g.*, SCHNEIDER ET AL., *supra* note 36, at 39 (identifying therapeutic jurisprudence as having "formed the theoretical underpinning of mental health courts"); *see also id.* at 61 (describing mental health courts as a manifestation of therapeutic jurisprudence in the criminal justice system); Matthew J. D'Emic, *The Promise of Mental Health Courts: Brooklyn Criminal Justice System Experiments with Treatment as an Alternative to Prison*, 22 CRIM. JUST. 24, 25 (2007) (describing the Brooklyn Mental Health Court as "the latest incarnation of 'therapeutic'" courts); Anchorage Coordinated Resources Project, *Anchorage Mental Health Court*, ALASKA COURT SYSTEM, http://www.courts.alaska.gov/mhct.htm (last visited Jan. 8, 2012) (stating that the Anchorage Mental Health Court "is a voluntary 'therapeutic' or 'problem-solving' court . . . that hears cases involving individuals diagnosed with mental disabilities who are charged with misdemeanor offenses and focuses on their treatment and rehabilitation"). Commentators have also stressed the link between therapeutic jurisprudence and mental health courts. *See, e.g.*, Faraci, *supra* note 21, at 816 (stating that mental health courts "employ a philosophy of therapeutic justice instead of punishment, deterrence and retribution."); David Rottman & Pamela Casey, *A New Role for Courts?*, NAT'L INSTIT. JUST. J. 12, 15 (July 1999) (suggesting that "therapeutic jurisprudence arguably provides the underlying legal theory" for problem-solving courts); Shauhin Talesh, *Mental Health Court Judges as Dynamic Risk Manager: A New Conception of the Role of Judges*, 57 DEPAUL L. REV. 93, 125 (2007) (observing that "judges are using mental health courts as a jurisdictional grant of authority to implement therapeutic jurisprudence").

56. *Introduction*, *in* LAW IN A THERAPEUTIC KEY xvii, xvii (David B. Wexler & Bruce J. Winick eds., 1996).

57. David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 PSYCHOL. PUB. POL'Y & L. 220, 223–24 (1995) (quoting Slobogin, *supra* note 33, at 196).

58. David B. Wexler, *Therapeutic Jurisprudence and the Criminal Courts*, 35 WM. & MARY L. REV. 279, 280 (1993).

59. David B. Wexler, *From Theory to Practice and Back Again in Therapeutic Jurisprudence: Now Comes the Hard Part* 1 (Ariz. Legal Stud., Discussion Paper No. 10-12, 2010), *available at* http://ssrn.com/abstract=1580129.

60. *Id.*

One challenging aspect of therapeutic jurisprudence is its creators' steadfast refusal to define "therapeutic" with precision.[61] Encouraging "commentators to roam within the intuitive and common sense contours of the concept" to stimulate scholarly inquiry and debate,[62] Professors Wexler and Winick have offered only the broadest guidance on what subjects may fall within the ambit of the term. Professor Winick, for instance, has suggested that anything that is "at least [in] some sense related to psychological functioning" could be characterized as therapeutic.[63] Professors Winick and Wexler have acknowledged that one consequence of eschewing a stable definition is that opinions will diverge on what should count as therapeutic.[64] Indeed, as Professor Slobogin has recognized, whether a legal rule, procedure, or approach is deemed therapeutic will likely vary according to the identity, ideology, interests, experience, values, and perspective of the evaluator.[65]

Regardless of the definition one chooses to adopt, there is very little empirical evidence on the impact—therapeutic or otherwise—of mental health courts.[66] Even if empirical testing were to demonstrate consistently that mental health courts are more therapeutic for offenders with mental illnesses than the traditional criminal justice system—whether "therapeutic" were defined as decreasing recidivism, improving rates of treatment compliance, enhancing mental functioning, or in any other manner—this finding alone would not suffice to justify the adoption or sustenance of a mental health court. To explain this conclusion, it is necessary to analyze the normative strength of therapeutic jurisprudence.

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61. *See* Mae C. Quinn, *An RSVP to Professor Wexler's Warm Therapeutic Jurisprudence Invitation to the Criminal Defense Bar: Unable to Join You, Already (Somewhat Similarly) Engaged*, 48 B.C. L. REV. 539, 547–50 (2007) [hereinafter *RSVP*] (outlining criticisms of therapeutic jurisprudence, including ambiguities in terminology, and the responses of Professors Wexler and Winick).

62. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, *supra* note 57, at 221.

63. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 194; *see also* Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, *supra* note 57, at 223 (suggesting that "[a] focus on the mental health and psychological aspects of health [is probably] most appropriate, recognizing that even this is (and should remain) very rough around the edges.").

64. *See* Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, *supra* note 57, at 222 ("For example, is *rehabilitation* defined by attitudinal changes or by the absence of criminal activity (itself measured by self-reports or by official records)? Should one care about achieving rehabilitation if it is manifested only by attitudinal change? Why or why not? How is emotional stress to be measured? Should one be concerned with the law's impact on emotional stress in the short-term, in the long-term, or both?"); Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 195.

65. *See* Slobogin, *supra* note 33, at 204, 206–07 (describing how two scholars analyzing the impact of the adversarial process in the civil commitment context reached diametrically opposed conclusions based, apparently, on their different experiences, training, and education).

66. *See supra* notes 10–16.

A. Normative Content of Therapeutic Jurisprudence

Therapeutic jurisprudence is normative in orientation.[67] Professor Wexler has conceded that "[t]he normative side of [therapeutic jurisprudence] is still being worked out,"[68] but the discipline certainly has a "soft normative element"[69] in that it is designed to inspire scholarship that may be useful for legal reform.[70] As explained by Professor Winick:

> Therapeutic jurisprudence's basic insight was that scholars should study [certain] consequences and reshape and redesign law in order to accomplish two goals—too [sic] minimize antitherapeutic effects, and[,] when it is consistent with other legal goals, to increase law's therapeutic potential. Thus, therapeutic jurisprudence is an interdisciplinary approach to legal scholarship that has a law reform agenda.[71]

In essence, therapeutic jurisprudence calls for an exploration of the psychological, physical, and emotional consequences of the law and proposes that research results should factor into policy discussions underlying legal reform efforts.[72]

A key tenet of therapeutic jurisprudence is that a determination of therapeutic or antitherapeutic consequences is predictably suggestive of legal reform only when normative values do not conflict.[73] When the

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67. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 188.

68. Wexler, *From Theory to Practice*, *supra* note 59, at 1 n.4.

69. *Id.*

70. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 185. Some judges and commentators have suggested that therapeutic jurisprudence employs a stable definition of "therapeutic" and has a stronger, consistent normative message in the context of problem-solving courts. *See* SCHNEIDER ET AL., *supra* note 36, at 39–66. This normative vision largely reduces to an endorsement of therapeutic rehabilitation when applied to offenders with mental illnesses. *See id.* at 47 ("[T]herapeutic jurisprudence suggests that, for accused with mental disorders, minor criminal acts in appropriate circumstances may more realistically be the manifestations of an untreated psychiatric illness and crumbling mental healthcare system."); *id.* at 48 (articulating a "first principle" of therapeutic jurisprudence as the idea that "pursuing therapeutic outcomes is an appropriate response to the causes of the 'crime' for some mentally disordered accused"). I address the potential of therapeutic rehabilitation to justify mental health courts in the next Part.

71. Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, *supra* note 36, at 1063.

72. David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. MIAMI L. REV. 979, 1004 (1991); *see also* Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 188 (observing that "[a]ccomplishing positive therapeutic consequences or eliminating or minimizing antitherapeutic consequences . . . emerges as an important objective in any sensible law reform effort.").

73. *See, e.g.*, Wexler & Winick, *Therapeutic Jurisprudence as a New Approach*, *supra* note 72, at 984 ("If the therapeutically appropriate legal arrangements are not normatively objectionable on other grounds, those arrangements may point the way toward law reform."); Winick, *The*

adoption of a therapeutic legal approach would conflict to a significant extent with other legal norms,[74] therapeutic jurisprudence does not provide a way to resolve the conflict.[75] Consistently, Professors Wexler and Winick have emphasized that psychological and physical health are not transcendent norms[76] and that therapeutic jurisprudence "in no way suggests that therapeutic considerations should trump other concerns."[77] Professor Winick has observed that

> although, in general, positive therapeutic consequences should be valued and antitherapeutic consequences should be avoided, there are other consequences that should count, and sometimes count more. There are many instances in which a particular law or legal practice may produce antitherapeutic effects, but nonetheless may be justified by considerations of justice or by the desire to achieve various constitutional, economic, environmental, or other normative goals.[78]

Therapeutic jurisprudence offers no opinion—in general or in specific instances—as to whether therapeutic considerations should be valued more heavily than autonomy, fairness, accuracy, consistency, perceived legitimacy of the criminal justice system, public safety, or a host of other values.[79]

In addition to suggesting legal reform when normative values converge, "[t]herapeutic jurisprudence suggests that, *other things being equal*, the law should be restructured to better accomplish therapeutic

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Jurisprudence of Therapeutic Jurisprudence, *supra* note 34, at 191 ("Although therapeutic jurisprudence suggests that law should be used to promote mental health and psychological functioning, it does not suggest that psychological and physical health is a transcending norm. It suggests that law reform should be informed by this value, but only when otherwise normatively unobjectionable."). *But see* Quinn, *RSVP*, *supra* note 61, at 552–53 (observing that, despite apparent tension between therapeutic and other norms, Professor Wexler has urged criminal defense attorneys to adopt proposed "best practices" to permit greater therapeutic possibilities).

74. At times, Professors Wexler and Winick have suggested that therapeutic values may control when they "strongly" outweigh competing considerations. *See, e.g.*, Bruce J. Winick, *Applying the Law Therapeutically in Domestic Violence Cases*, 69 UMKC L. REV. 33, 79 (2000). It is unclear how, if at all, therapeutic jurisprudence assists in the weighing of competing values.

75. *See, e.g.*, Wexler & Schopp, *supra* note 45, at 373 ("As a research program, therapeutic jurisprudence does not resolve conflicts among competing values."); Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 198 ("Although therapeutic jurisprudence is premised on the notion that, other things being equal, health is a value that law should seek to foster, it makes no attempt to assign relative values to the various other goals of law.").

76. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 191.

77. Wexler, *Therapeutic Jurisprudence and the Criminal Courts*, *supra* note 58, at 280.

78. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 191.

79. *See* Wexler, *Therapeutic Jurisprudence and the Criminal Courts*, *supra* note 58, at 280; David B. Wexler, *Two Decades of Therapeutic Jurisprudence*, 24 TOURO L. REV. 17, 20–21 (2008).

goals."[80] Professor Wexler has acknowledged that identifying when nontherapeutic values stand in equipoise will be difficult and often contestable and that therapeutic jurisprudence is not equipped to resolve this debate.[81] Therapeutic jurisprudence recognizes the value of physiological, physical, and emotional consequences but does not comment on the relative value of other legal goals or effects.[82] Critics have observed that, without articulating rules for determining when other values are equal, therapeutic jurisprudence may promote therapeutic values in ways that appear arbitrary.[83]

When therapeutic considerations exist in tension with other criminal justice norms, scholars and policy makers must appeal to an overarching normative framework to resolve the conflict.[84] The particular ethical or political theory should assign relative weights to the conflicting values.[85] As normative agreement in criminal law and procedure is elusive, so too will be consensus on how therapeutic considerations should be weighed against values of autonomy, fairness, accuracy, consistency, and legitimacy.[86] Recognizing this limitation, scholars have urged proponents

80. Wexler, *Therapeutic Jurisprudence and the Criminal Courts*, *supra* note 58, at 280 (emphasis added); *see also* Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 188 ("Therapeutic jurisprudence suggests that, *other things being equal*, positive therapeutic effects are desirable and should generally be a proper aim of law, and that antitherapeutic effects are undesirable and should be avoided or minimized." (emphasis in original)).

81. Wexler, *Therapeutic Jurisprudence and the Criminal Courts*, *supra* note 58, at 280; *see also* David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 225, 226 (1992).

82. *See* Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 198 ("Although therapeutic jurisprudence is premised on the notion that, other things being equal, health is a value that law should seek to foster, it makes no attempt to assign relative values to the various other goals of law.").

83. *See* John Petrila, *Paternalism and the Unrealized Promise of Essays in Therapeutic Jurisprudence*, 10 N.Y.L. SCH. J. HUM. RTS. 877, 890 (1993) (reviewing ESSAYS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1992)).

84. *See* Wexler & Winick, *Therapeutic Jurisprudence as a New Approach*, *supra* note 72, at 983 (specifying that "[t]he premise that a rule or practice is antitherapeutic . . . does not support the conclusion that the rule should be changed in the absence of a shared, although perhaps unarticulated, normative major premise.").

85. *See* Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 198 ("Resolution of this conflict would require use of an overarching theory of value that would assign weights to the various values in question. . . . To resolve such conflicts of value, one must go outside therapeutic jurisprudence to some ethical or political theory that establishes a hierarchy of values.").

86. *See* Wexler & Winick, *Therapeutic Jurisprudence as a New Approach*, *supra* note 72, at 985 ("It may be difficult to reach agreement on standards for conducting such a comparison of perhaps conflicting therapeutic consequences; this essentially involves the sharing of normative premises about which there may be no consensus."). Ken Kress offers this observation and thoroughly explores its implications in *Therapeutic Jurisprudence and the Resolution of Value Conflicts: What We Can Realistically Expect, in Practice, from Theory*, 17 BEHAV. SCI. & L. 555 (1999).

of "therapeutic" policy proposals to specify their normative assumptions, thus allowing for examination and critique.[87]

It is worth emphasizing that the inability of therapeutic jurisprudence to resolve significant normative conflict does not deprive it of value or consequence. Therapeutic jurisprudence illuminates an important category of legal effects that has been largely neglected.[88] An understanding of the psychological, physical, and emotional effects of legal approaches certainly should inform the normative dispute regarding the ordering of competing values and contribute to the precise weighing of legal alternatives.[89] While therapeutic jurisprudence does not resolve a debate among values, it does sharpen the inputs and enrich the discussion.[90]

B. Normative Conflict Between Mental Health Courts and the Traditional Criminal Justice System

Ultimately, therapeutic jurisprudence is unable to justify the existence of mental health courts because the decision to create and sustain a mental health court is not free of significant normative conflict. Increasingly, scholarship seeking to justify the imposition of punishment blurs the boundaries between retributivism[91] and utilitarianism,[92] and many modern thinkers recognize that a mix of retributive and preventative considerations should guide sentencing in the criminal justice system.[93] While rehabilitating offenders remains an important goal of many sentencing and punishment schemes,[94] retribution and deterrence, along with

87. *See* Kress, *supra* note 86, at 562; Petrila, *supra* note 83, at 889 n.35 (stating, after discussing the failure to articulate competing norms and values with precision, that "the application of therapeutic jurisprudence principles appears somewhat arbitrary and dependent on the subjective preferences of people writing about it."); Slobogin, *supra* note 33, at 210–18 (exploring the difficulty of the internal and external balancing of competing norms called for by therapeutic jurisprudence).

88. *See* David Wexler, *Therapeutic Jurisprudence: An Overview*, 17 T.M. COOLEY L. REV. 125, 125 (2000); Wexler & Winick, *Therapeutic Jurisprudence as a New Approach*, *supra* note 72, at 983.

89. *See* Wexler & Schopp, *supra* note 45, at 373 (stating that therapeutic jurisprudence "seeks information needed to promote certain goals and to inform the normative dispute regarding the legitimacy or priority of competing values"); Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 191 (stating that therapeutic jurisprudence calls for an awareness of therapeutic considerations and "enables a more precise weighing of sometimes competing values.").

90. *See* Kress, *supra* note 86, at 557 (stating that therapeutic jurisprudence may "change one's view of the import, recommendation, or weight of some value"); Winick, *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 34, at 206 ("When therapeutic and other normative values conflict, the conflict sharpens the debate, but does not resolve it."); *id*. at 195 ("Therapeutic jurisprudence cannot resolve this debate but can enrich the decision-making process.").

91. *See infra* notes 97–103 and accompanying text.

92. For a brief discussion of utilitarianism, see *supra* note 29.

93. *See* Cahill, *supra* note 29.

94. Many commentators have recognized that problem-solving courts demonstrate a resurgence

incapacitation, are generally considered the dominant goals of the modern penal system.[95] The goals, values, and communicative message of mental health courts, largely consistent with a theory of rehabilitation, stand in sharp contrast to those espoused by retributive and deterrence theories of punishment.[96] In particular, mental health courts' singular concern with treatment, as opposed to blame, may violate retributivism's cornerstone principles of proportionality and just deserts, convey harmful and stigmatizing messages about offenders, and trivialize underlying criminal acts. Mental health courts may also undermine goals of specific and general deterrence by offering scarce social goods to court participants, thus potentially incentivizing individuals to commit crimes in order to receive these goods.

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of rehabilitation. *See* Daniel M. Filler & Austin E. Smith, *The New Rehabilitation*, 91 IOWA L. REV. 951 (2006); *infra* notes 150–53. In addition, rehabilitation, along with retribution, deterrence, and incapacitation, remains an objective of the federal sentencing guidelines. *See* 18 U.S.C. § 3553(a)(2)(D) (2004) (directing a judge to consider the need for a sentence "to provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner").

95. *See* Darryl K. Brown, *Cost-Benefit Analysis in Criminal Law*, 92 CALIF. L. REV. 323, 329 (2004) ("[T]he intended purpose for incarceration has evolved in the last thirty years from one predominantly of rehabilitation to a mixture of deterrence, incapacitation, and retribution."); Amy Gruber, *A Distributive Theory of Criminal Law*, 52 WM. & MARY L. REV. 1, 16–18 (2010). Exploring the relationship between mental health courts and the penal goal of incapacitation is beyond the scope of this Article.

96. Many of the concerns delineated in this section were voiced during the mid- to late-twentieth century as part of the critique of the rehabilitative theory of punishment, which was then dominant. *See, e.g.*, FRANCIS A. ALLEN, THE DECLINE OF THE REHABILITATIVE IDEAL 32–59 (1981) (presenting three criticisms of rehabilitation: its constitution as a threat to liberal political values, its vulnerability to debasement, and its lack of technique or effectiveness); AMERICAN FRIENDS SERVICE COMMITTEE, STRUGGLE FOR JUSTICE (1971) (arguing that individualized and indeterminate sentencing is inequitable, discriminatory, and paternalistic); Andrew von Hirsch, DOING JUSTICE: THE CHOICE OF PUNISHMENTS 9–34 (1986) (criticizing the viewpoint that rehabilitation should guide the choice of criminal disposition, that the disposition should vary by the offender's likelihood of reoffending, and that officials should possess wide discretion to tailor the disposition to the needs of the individual offender); C.S. Lewis, *The Humanitarian Theory of Punishment*, 3 20TH CENTURY 5 (1948–49), *in* THEORIES OF PUNISHMENT 301, 302 (Stanley E. Grupp ed., 1971) ("[W]hen we cease to consider what the criminal deserves and consider only what will cure him or deter others, we have tacitly removed him from the sphere of justice altogether; instead of a person, a subject of rights, we now have a mere object, a patient, a 'case.'"). For a thorough catalogue of the criticisms levied against rehabilitation, see ROTMAN, *supra* note 41, at 101–33, and Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L.Q. 1205, 1223–45 (1998) (applying these critiques to drug treatment courts).

1. Ignoring Proportionality and Just Deserts

Retributivism, the oldest and most popular justification of punishment,[97] defies easy definition.[98] One strand of retributivism theorizes that deserved punishment, justified by the moral culpability and desert of the offender, is an intrinsic good.[99] Retributivists, in general, believe that punishment is just so long as it is proportionate to the moral culpability of the offender and the wrong he committed.[100] In essence, punishment is an act of reciprocity: the state exacts from the offender the measure exacted by his wrongful act.[101] Immanuel Kant argued that offenders' punishment must match—in kind and degree—the suffering or deprivation endured by their victims,[102] but modern retributivists accept "rough" proportionality between penalties for separate crimes.[103]

Mental health courts embrace a contrary and antagonistic purpose. As discussed below, mental health courts, while not finding eligible offenders

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97. *See* Paul Butler, *Retribution, For Liberals*, 46 UCLA L. REV 1873, 1874 (1999); Leigh Goodmark, *The Punishment of Dixie Shanahan: Is There Justice for Battered Women Who Kill?*, 55 U. KAN. L. REV. 269, 288 (2007).

98. *See* John Cottingham, *Varieties of Retribution*, 29 PHIL. Q. 238 (1979) (delineating nine distinct retributivist theories). For recent scholarship complicating the dominant understanding of retributivism and challenging the strict divide between retributivist and consequentialist theories of punishment, see Mitchell N. Berman, *Two Kinds of Retributivism*, *in* PHILOSOPHICAL FOUNDATIONS OF CRIMINAL LAW 433 (R.A. Duff & Stuart P. Green eds., 2011).

99. G. W. F. HEGEL, ELEMENTS OF THE PHILOSOPHY OF RIGHT 127 (Allen W. Wood ed., H. B. Nisbet trans., Cambridge Univ. Press 1991) (1821) ("[T]he universal feeling of peoples and individuals towards crime is, and always has been, that it *deserves* to be punished, and that *what the criminal has done should also happen to him*.") (emphasis in original); Michael Moore, *The Moral Worth of Retribution*, *in* RESPONSIBILITY, CHARACTER, AND THE EMOTIONS 179, 179 (Ferdinand Schoeman ed., 1987) ("*Retributivism* is the view that punishment is justified by the moral culpability of those who receive it. A retributivist punishes because, and only because, the offender deserves it.").

While traditional retributivism holds that proportionate punishment is an intrinsic good, some retributivists (in particular, those arguing that retributive punishment promotes crime control or provides pleasure or utility) may view retributive punishment as an instrumental good. *See* Cahill, *supra* note 29, at 4–5; *see also* Berman, *supra* note 98 (arguing that retributivism may be viewed as a subtype of instrumentalist justifications for punishment).

100. Butler, *supra* note 97, at 188 ("Retribution measures just punishment by considering whether there is proportionality between crime and punishment.").

101. *See* HEGEL, *supra* note 99, at 127; IGOR PRIMORATZ, JUSTIFYING LEGAL PUNISHMENT 70 (1989) ("Retribution is an act of reciprocity, and thus something that the person on whom it is inflicted has deserved; therefore, it is just, justified, legitimate.").

102. *See* IMMANUEL KANT, METAPHYSICAL ELEMENTS OF JUSTICE 138 (John Ladd trans., Hackett Pub. Co. 2d. ed. 1999) (1797) (discussing the principle of punishment in proportion to the wrong committed and arguing, "If you vilify him, you vilify yourself; if you steal from him, you steal from yourself; if you kill him, you kill yourself.").

103. *See* H. L. A. HART, PUNISHMENT AND RESPONSIBILITY 234 (1968) ("[M]odern retributive theory is concerned with proportionality. . . . [I]t is concerned with the relationships within a system of punishment between penalties for different crimes, and not with the relationship between particular crimes and particular offences.").

"insane" and thus excused under criminal law,[104] attribute their criminal acts to their mental illnesses and society's failure to provide adequate community mental healthcare.[105] This causal ascription creates a belief that eligible offenders are less culpable for their acts than nondisordered offenders and that traditional punishment is thus inappropriate.[106] Instead, court-ordered treatment is considered the morally fitting—and, in the parlance of retribution, the "roughly proportionate"—response of the state to the wrongful acts of offenders with mental illnesses.[107]

Critically, mental health courts' decisions about whom to accept for rehabilitation may not involve a rigorous inquiry into the connection between a potential participant's mental illness and his criminal behavior.[108] As discussed in Part II, many courts appear not to require, for purposes of eligibility, any determination that mental illness contributed to an underlying criminal act.[109] Instead, many eligibility decisions appear to rest upon an assumption that offenders with certain mental illnesses as a

104. Because of the narrow way in which "insanity" is defined in federal and state criminal codes, only a small subset of defendants with mental illnesses raise an insanity defense and are found insane, and thus excused, under criminal law. *See, e.g.*, Ellen Byers, *Mentally Ill Criminal Offenders and the Strict Liability Effect: Is There Hope for a Just Jurisprudence in an Era of Responsibility/ Consequences Talk?*, 57 ARK. L. REV. 447 (2004) (analyzing various constructions of insanity defenses and the problems with punishing mentally ill offenders); Julie E. Grachek, Note, *The Insanity Defense in the Twenty-First Century: How Recent United States Supreme Court Case Law Can Improve the System*, 81 IND. L.J. 1479, 1481 (2006) ("Mental illness itself does not preclude criminal responsibility. In order to successfully plead the insanity defense, a defendant must not only show that he is mentally ill, but must also show that there was a nexus connecting the mental illness and the criminal offense at issue."); *see also* MICHAEL L. PERLIN, THE JURISPRUDENCE OF THE INSANITY DEFENSE 68–69 (1994) (referencing "mad and bad" defendants unable to succeed with a nonresponsibility defense who are subsequently imprisoned); Michael L. Seigel, *Bringing Coherence to Mens Rea Analysis for Securities-Related Offenses*, 2006 WIS. L. REV. 1563, 1569 (2006) (providing an example of an individual "whose mental illness prevents comprehension of reality" as a person who has no level of intention under the criminal law, thus meriting treatment, not punishment).

105. *See infra* notes 178, 179–83, 242–49 and accompanying text.

106. *See* SCHNEIDER ET AL., *supra* note 36, at 3, 45, 62–63, 153–54.

107. *See id*. at 62–63, 153–55. *But see* John A. Bozza, *"The Devil Made Me Do It": Legal Implications of the New Treatment Imperative*, 12 S. CAL. INTERDISC. L.J. 55, 78–81 (2002) [hereinafter *"The Devil Made Me Do It"*] (taking the position that proportionality is not a sentencing consideration under a regime prioritizing treatment). Individuals eligible for participation in mental health courts may already be receiving mental health services. For these individuals, diversion to treatment constitutes an illogical response to a criminal offense. I am grateful to Professor Nancy Wolff for sharing this observation.

108. For the most in-depth analysis of mental health courts' selection and admission processes to date, see Nancy Wolff et al., *Mental Health Courts and Their Selection Processes: Modeling Variation for Consistency*, 35 LAW & HUM. BEHAV. 402 (2011) (describing a variable decisionmaking process that typically consists of three eligibility screening stages). This qualitative study of six mental health courts revealed that some, but not all, courts required a strong connection between a participant's mental illness and his criminal behavior. *See id*. at 408, app.

109. *See infra* notes 199–213 and accompanying text.

group are less blameworthy than other criminals because such individuals do not consciously choose to commit crimes.[110] This assumption derives from outdated and discredited stereotypes about the capacities and motivations of individuals with mental illnesses and violates principles of just deserts and proportionality.[111] This concern may be less acute for mental health courts that require guilty pleas prior to admission.[112]

2. Portraying Offenders as Lacking Autonomy and Moral Agency

Another divergence between mental health courts and the traditional criminal justice system is the message communicated to the public about offenders. Retributive and deterrence theories of punishment treat offenders as moral agents who should be held accountable for their conduct.[113] G. W. F. Hegel, for instance, has argued that, as rational beings, criminals choose to commit acts to which punishments attach, and thus have a right to experience those punishments.[114] Similarly, theories of deterrence rest on the belief that individuals are rational, self-interested beings capable of assessing an action's likely impact and conforming their behavior to the results of this cost-benefit analysis.[115] The traditional

110. *See, e.g.*, Malcomb Daniels, *Mental Health Court Plans Unveiled Today*, BIRMINGHAM NEWS, May 12, 2010, at 1 (quoting Probate Judge Jim Fuhrmeister as stating: "For the people who are going to be treated in mental health court, jail is not the answer. . . . The root of their problem is mental illness."); David J. Hill, *City Court Expands*, TONAWANDA NEWS, Apr. 27, 2010, http://tonawanda-news.com/local/x993514904/City-court-expands (quoting Judge Joseph J. Cassata as stating: "We are finding that more and more people who enter the criminal justice system enter it because of a mental health condition."); *Mental Health Court Gains Support*, TENNESSEAN, June 4, 2007, at B1 ("[Judge] Brandon, likely to preside over the mental health court, said when a person's mental illness leads to crime, the illness needs to be dealt with."); *see also* Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 432 (observing that "[m]ental health courts assume uncritically that criminal behavior is caused by a psychiatric problem"); *infra* notes 179–83.

111. Studies reveal that, like other individuals who commit crimes, offenders with mental illnesses are motivated by a host of goals and impacted by a number of external factors. *See infra* notes 217–33 and accompanying text.

112. Some mental health courts require that participants enter guilty pleas prior to admittance to the court. *See* ALMQUIST & DODD, *supra* note 4, at 13 (listing studies demonstrating that mental health courts that accept felons typically require guilty pleas); Redlich et al., *Second Generation*, *supra* note 4, at 534–35. In these instances, punishment is suspended until and unless the defendant fails to comply with a treatment directive.

113. *See generally* Derek B. Cornish & Ronald V. Clarke, *Introduction*, *in* THE REASONING CRIMINAL 1–16 (Derek B. Cornish & Ronald V. Clarke eds., 1986) (deterrence); Dan Markel, *What Might Retributive Justice Be? An Argument for the Confrontational Conception of Retributivism*, *in* RETRIBUTIVISM: ESSAYS ON THEORY AND POLICY 104 (Mark D. White, ed., 2001) (retributivism).

114. *See* HEGEL, *supra* note 99, at 126.

115. *See* JEREMY BENTHAM, THE THEORY OF LEGISLATION 325 (C. K. Ogden ed., Richard Hildreth trans., 1931) (1802) ("[T]o prevent an offense, it is necessary that the repressive motive should be stronger than the seductive motive. The punishment must be more an object of dread than the offense is an object of desire."). Indeed, law and economics scholars have recognized that

justice system assumes that all individuals—unless adjudged insane or incompetent—understand the difference between right and wrong, or at least are capable of differentiating between those actions that society deems acceptable and unacceptable.[116] In essence, society assumes that an individual's offense reflects his choice to engage in criminal activity. When circumstances reveal that a criminal act was not the product of an offender's choice, he generally will not suffer punishment. The menagerie of excuses and justifications in criminal law—ranging from insanity to duress to accident—reflects this preoccupation with choice.[117] Thus, our traditional criminal justice system conveys a message of respect for the autonomy and choices of offenders.

The predominant message expressed by mental health courts, on the other hand, is that offenders with mental illnesses—who, to be clear, have not been found "insane" under criminal law[118]—so lack autonomy and moral agency that they are inappropriate subjects for the traditional criminal justice system.[119] Mental health courts convey at least three overlapping impressions about offenders with mental illnesses that act synergistically to deepen and reinforce the stigma and isolation associated with mental illness. First, the existence of mental health courts communicates that, unlike other offenders and because of their mental illnesses, offenders with mental illnesses lack autonomy, rationality, self-determination, and the ability to control their behavior. Offenders with mental illnesses, as a class, are therefore not considered to be truly responsible for their actions or proper subjects for typical punishment.[120]

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deterrence theory manifests the economic theory of rational choice. *See, e.g.*, Gary S. Becker, *Crime and Punishment: An Economic Approach*, 76 J. POL. ECON. 169, 172–76 (1968).

116. *See Excerpts from the Reference Manual*, 31 MENTAL & PHYSICAL DISABILITY L. REP. 140, 140 (2007) (noting that, in most jurisdictions, competency is determined by whether defendants know the difference between right from wrong, or understand the wrongfulness of their behavior).

117. *See* Adam Candeub, *An Economic Theory of Criminal Excuse*, 50 B.C. L. REV. 87, 89 (2009) ("'All the several pleas and excuses, which protect the committer of a forbidden act from the punishment which is otherwise annexed thereto, may be reduced to this single consideration, the want or defect of will.'" (quoting 4 WILLIAM BLACKSTONE, BLACKSTONE'S COMMENTARIES ON THE LAWS OF ENGLAND 17 (Wayne Morrison ed., Cavendish 2001) (1765))).

118. *See supra* note 104.

119. For a careful exposition of the role that a similar argument played in the liberal critique of the rehabilitative ideal of the early to mid-twentieth century, see Boldt, *supra* note 96, at 1241–42.

120. *See* Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 434 ("The therapeutic message that goes along with mental health courts is that bad behavior is the fault of the illness, that the illness is in control of the behavior, and that the individual cannot and should not be held responsible for such deviance."); *id.* (observing that "this type of special status for offenders who have mental illness holds the illness responsible for the behavior, not the individual and, as such, opens the opportunity for individuals to use illness to excuse behavior"); *see also* Bozza, *"The Devil Made Me Do It"*, *supra* note 107, at 72 ("Fully embracing a correctional response calculated to address individual deficiencies

Studies have shown that mental illnesses typically do not cause individuals to commit crimes, however,[121] which explains why our justice system only permits mental illness to serve as an excuse for criminal behavior in limited circumstances.

Second, the very existence of mental health courts conveys that mental illness represents a particularly dire source of recidivism that warrants both isolation and an influx of resources to combat.[122] Unlike other problem-solving courts such as drug treatment courts,[123] prostitution courts, and domestic violence courts, mental health courts do not focus on a particular form of crime. Instead, mental health courts extract from the stream of general offenders individuals whose only commonality is that they share a particular characteristic—mental illness.[124] In essence, as Professor Nancy Wolff has observed, the title "mental health courts"—in calling attention to the condition of mental illness rather than a particular category of crime—implies that mental illness *itself* is criminal.[125] Stressing the (assumed and inaccurate) link between mental illness and crime traps these offenders within their illnesses and deepens the stigma and isolation associated with their condition.[126] Thus, mental health courts

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leading to criminal conduct will directly challenge the view of the human species as 'autonomous,' worthy of blame for the bad, and deserving of credit for the good.").

As noted earlier, some mental health courts require defendants to plead guilty prior to admission to the court. *See supra* note 112. In these circumstances, offenders with mental illnesses are held responsible for their acts. However, a guilty plea may be expunged in some jurisdictions pending successful completion of the treatment program. *See* ALMQUIST & DODD, *supra* note 4, at 13.

121. *See, e.g.*, James Bonta, Moira Law & Karl Hanson, *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis*, 123 PSYCHOL. BULL. 123, 135–36 (1998) (finding that most clinical factors, such as diagnosis and treatment history, have little relevance to the assessment of risk for recidivism); Skeem, Manchak & Peterson, *supra* note 15, at 115–17 (summarizing bodies of evidence establishing that "major predictors of violence and recidivism are not unique to offenders with mental illness, but instead shared with general offenders"); *infra* notes 217, 233, 274–80, 291–99.

122. *See* Quinn, *RSVP*, *supra* note 61, at 569 (observing that that the therapeutic jurisprudence model, "with its emphasis on rehabilitation and transforming clients' lives, is laden with assumptions about the criminal defense client population—not the least of which is that they are guilty, likely to offend again, and in need of transformation").

123. Some drug courts do not focus exclusively on drug crimes. I am grateful to Professor Mae Quinn for this insight.

124. Other specialty courts may share this defining characteristic, such as veterans' courts, homelessness courts, and fathering courts.

125. Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 434 ("Furthermore, labeling the court a 'mental health' court, focuses public attention on psychiatric issues, and amplifies the mark associated with the court. It is interesting to note that other specialized courts are named after the related offending behavior—for example, drug courts or domestic abuse courts. The label mental health court implicitly equates mental health with a criminal offense.").

126. *See id.* ("By their existence and behavior, these specialized courts trap persons in their illnesses, distinguish them from 'normal' citizens, and return them to a therapeutic state."); *id.* ("In addition, identifying people by their illnesses is known to mark them in ways that can be shaming.

may offer the worst of both worlds—suggesting that offenders with mental illnesses lack autonomy while also imposing the stigma of criminality.[127]

Third, mental health courts convey that, left to their own devices, offenders with mental illnesses cannot be trusted to make responsible healthcare decisions, even when supplied with treatment options at public expense.[128] This sentiment is reinforced by those commentators and judges who blame these offenders' acts on their unwillingness to recognize their mental illnesses or their failure to take medication.[129] Instead of allowing offenders with mental illnesses to select among treatment options (including the option of foregoing certain types of treatment deemed to carry intolerable side effects or to be too invasive), mental health courts employ the coercive power of the criminal justice system to select and supervise the "best" treatment option, with the specter of incarceration—perhaps for a longer term than would have been imposed had the offender declined to participate in a mental health court[130]—as a potential consequence of noncompliance. Using jail to force compliance with

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Mental health courts create stigma by segregating people by illness and then defining their uniqueness and irresponsibility in terms of the illness."); *see also* William H. Fisher, Eric Silver & Nancy Wolff, *Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research*, 33 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVICES RES. 544, 549 (2006) (stating that the mental health court practice "reinforces the label of 'person with mental illness' as a 'master status'—that status which above all others defines the individual's position within the mental health system, the criminal justice system and society in general.").

127. Indeed, some research suggests that the label "criminally insane" is doubly stigmatizing for this reason. *See* CHRISTOPHER SLOBOGIN, MINDING JUSTICE 59 (2006) (arguing that the insanity defense, by drawing a direct connection between mental illness, crime, and nonresponsibility, generates a "double whammy" of stigma that exceeds the stigma associated with criminality alone). I am grateful to Professor Christopher Slobogin for raising this point.

128. For information on mental health service systems and treatment options available for various mental illnesses, see FRED C. OSHER & IRENE S. LEVINE, NAVIGATING THE MENTAL HEALTH MAZE (Bureau of Justice Assistance 2005), *available at* http://consensusproject.org/mhcp/Navigating-MHC-Maze.pdf.

129. *See, e.g.*, Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, *supra* note 36, at 1067 ("Individuals usually appear before problem solving [sic] courts because of social or psychological problems they have not recognized, or because of their inability to deal with these problems effectively. . . . They may suffer from mental illness that impairs their judgment about the desirability of their continuing to take needed medication. They may be in denial about the existence of these problems, refusing to take responsibility for their wrongdoing, rationalizing their conduct, or minimizing its negative impact on themselves and others."); John P. Coyne, *Courts Try to Address Mental Ills: Emphasis on Treatment Tempers Punishment*, CLEVELAND PLAIN DEALER, Dec. 26, 2006, at A1 (conveying that Judge Mary Jane Boyle, who oversees cases involving defendants with mental illnesses, said most crimes committed by such individuals occur when they stop taking their medications); Mary Orndorff, *New Court to Aid Mental Inmates*, BIRMINGHAM NEWS, Sept. 6, 2000, at 3C (characterizing Foster Cook, the director of an alternative treatment program, as blaming the involvement of individuals with mental illnesses in the criminal justice system on their lack of supervision and failure to take medication).

130. *See* Lurigio & Snowden, *supra* note 12, at 206.

treatment directives conveys a fundamental distrust of the proclivity of individuals with mental illnesses to make rational decisions and a lack of concern about how these individuals experience treatment.

3. Trivializing Underlying Criminal Acts

Mental health courts also differ from the traditional criminal justice system in the way they conceptualize the importance of the crime committed. Our justice system effects the determinations of democratically elected legislative bodies that certain acts are intolerable. The limited purpose of our criminal courts is to determine if a prohibited act was committed and, if so, to impose a permitted punishment that is, under retributive theory, commensurate with the culpability of the offender and the harm exacted by the crime.[131] The formality of the process conveys the seriousness of the charge, and the imposition of punishment expresses society's moral condemnation of the act, both to the offender[132] and to the community at large.[133]

Conversely, in mental health courts, the crimes committed are trivialized. Allowing offenders with mental illnesses to evade traditional punishment sends a message that their conduct was, in some sense, tolerable, and that the harm incurred by their victims does not merit as punitive a response from the state. As David B. Rottman has observed, problem-solving court proceedings typically focus on the circumstances of individuals, "rather than the essence of the wrong they committed."[134]

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131. *See* F. H. BRADLEY, ETHICAL STUDIES 26–27 (1951); PRIMORATZ, *supra* note 101, at 12.

132. *See* ROBERT NOZICK, PHILOSOPHICAL EXPLANATIONS 370–71 (1981) (explaining that the message of retributive punishment is "this is how wrong what you did was" for the purpose of impressing on the offender the wrongness of his act and incentivizing his moral improvement); Joel Feinberg, *The Expressive Function of Punishment*, 49 MONIST 397, 401–04 (1965).

133. *See* Stanley I. Benn, *Punishment*, *in* 7 ENCYCLOPEDIA OF PHILOSOPHY 29, 30 (Paul Edwards ed., 1967) (explaining that "punishment reinforces the community's respect for its legal and moral standards, which criminal acts would tend to undermine if they were not solemnly denounced."). Some retributivists have insisted that the primary audience for the condemnatory message that punishment embodies must be the criminal himself, and not a third party. *See* R.A. DUFF, TRIALS AND PUNISHMENTS 235–36 (1986) ("Though this condemnation is expressed to the criminal himself, punishment may also communicate to the public at large (and especially to potential criminals) as a reminder of the wrongness of the criminal's conduct, and to the victims of crime an authoritative disavowal of such conduct. But if we are to avoid the charge that in pursuing a criminal we are simply using him as a means to some communicative purpose which is directed at others, its essential expressive aim must be that of communicating to the criminal himself as proper condemnation of his crime."); E. Lea Johnston, *Mental Illness, Suffering, and the Distribution of Deserved Punishment* 45–48 (draft on file with author).

134. David B. Rottman, *Does Effective Therapeutic Jurisprudence Require Specialized Courts (and Do Specialized Courts Imply Specialist Judges)?*, 37 CT. REV. 22, 24 (2000).

Mental health courts seek to bolster and encourage offenders as opposed to communicating blame to those offenders or to society.[135] By choosing not to focus on blame or the meting out of punishment, mental health courts express insufficient condemnation of criminal acts.

Furthermore, court-mandated treatment simply does not carry the same seriousness as incarceration.[136] Mental health court participants, unlike those ineligible for participation in mental health courts, can gain valuable commodities (such as treatment, access to social services, and often additional assistance with housing, employment, or transportation)[137] while in most instances remaining free in the community. One could argue that the substitution of treatment for traditional punishment effectively serves to decriminalize those categories of crimes disproportionately committed by individuals with mental illnesses,[138] or at least to limit the full enforcement of these criminal laws to non-ill offenders, thereby violating norms of equal treatment.[139] In essence, exempting a broad category of offenders from the full reach of the criminal law may serve as a limited form of judicial nullification.[140]

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135. Boldt, *supra* note 96, at 1218 ("[W]hile the criminal law component focuses on matters of individual responsibility and blame, the treatment component [of therapeutic problem-solving courts] defines the problem as one of individual pathology and personal recovery."); *See* Faraci, *supra* note 21, at 836 (stating that "the criminal justice system is concerned with responsibility and blame, while the therapeutic justice philosophy is concerned with the pathology and recovery").

136. *Cf.* Christopher Slobogin, *Some Hypotheses About Empirical Desert*, 42 ARIZ. ST. L.J. 1189, 1201–02 (2011) (discussing research indicating that intermediate sanctions designed to achieve rehabilitative goals—such as mandated supervision or weekend sentences—may have lesser but comparable "punitive bite" as incarceration).

137. *See* Julie B. Raines & Glenn T. Laws, *Mental Health Court Survey*, 45 CRIM. L. BULL. 4 (2009) (reporting that mental health court participants receive services to help them function in their community, such as "job placement, job training, housing, mental health treatment programs, supportive services (emergency food, clothing, and personal care items), and after care follow-up"); Talesh, *supra* note 55, at 117 ("[C]ommunity and health agencies linked to courts provide pathways to assist offenders by offering such services as day treatment programs, individual therapy, intensive psychiatric rehabilitation programs, psychosocial clubs, and assertive community treatment teams.").

138. *See* Morris B. Hoffman, *Therapeutic Jurisprudence, Neo-Rehabilitationism, and Judicial Collectivism: The Least Dangerous Branch Becomes Most Dangerous*, 29 FORDHAM URB. L.J. 2063, 2067 (2002) ("[W]hat much of therapeutic jurisprudence is really about, at least in the criminal arena, is a de facto decriminalization of certain minor offenses which the mavens of the movement do not think should be punished, but which our Puritan ethos commands cannot be ignored.").

139. *See* Nancy Wolff, *Courting the Court: Courts as Agents for Treatment and Justice*, *in* COMMUNITY-BASED INTERVENTIONS FOR CRIMINAL OFFENDERS WITH SEVERE MENTAL ILLNESS 143, 168–70 (William H. Fisher ed., 2003) (discussing how mental health courts produce unequal treatment).

140. *See* Morris B. Hoffman, *A Neo-Retributionist Concurs With Professor Nolan*, 40 AM. CRIM. L. REV. 1567, 1570 (2003) ("When judges ignore the law and treat someone's crime as a disease, we call it therapeutic jurisprudence. When juries do the same thing, we call it nullification. As discussed below, the reality is that proponents of therapeutic jurisprudence *want* jurors to nullify in some cases

4. Incentivizing Individuals to Commit Crimes to Obtain Scarce Resources

In addition to flouting retributive concerns, mental health courts also undermine goals of deterrence. Utilitarianism embraces two forms of deterrence: specific and general. Specific deterrence aims to discourage a particular offender from committing the same crime in the future in order to avoid incurring another punishment.[141] For general deterrence, courts publicize the punishment imposed on an individual for a particular crime so that others will refrain from committing that crime and suffering a similar punishment.[142] In imposing a response less severe than would inure under the traditional justice system, mental health courts should expect to yield weaker deterrent effects.[143] Indeed, mental health courts may actually encourage individuals to commit certain crimes in order to obtain treatment and other services.[144] Mental health courts may incentivize several categories of persons to commit crimes: the same individual, after his term of supervised treatment expires (to receive additional treatment and services);[145] other individuals with mental illnesses who are predisposed to commit crimes; and other individuals with mental illnesses who are otherwise law-abiding but desperate to receive treatment. This perverse incentivization stems from the fact that there is currently a shortage of community mental healthcare services.[146] In fact, recognition

(e.g., those involving drugs) because they just don't think certain acts (e.g., drug possession) should be punished.") (emphasis in original).

In contrast, others have argued that mental health courts may penalize individuals with mental illnesses *more harshly* than non-ill offenders. Advocates from the Bazelon Center for Mental Health Law have argued that mental health courts should be limited to individuals who have committed serious felonies, because most misdemeanants should not have been arrested in the first place. *See* Seltzer, *supra* note 22, at 578; Bernstein & Seltzer, *supra* note 23, at 147, 154.

141. *See generally* Kent Greenawalt, *Punishment*, *in* 3 ENCYCLOPEDIA OF CRIME & JUSTICE 1282, 1287 (Joshua Dressler ed., 2d ed. 2002) (explaining the utilitarian theory of individual deterrence).

142. *See generally id.* at 1286 (explaining the utilitarian theory of general deterrence). For a justification of general deterrence from a "weak retributivist" standpoint that considers wrongdoing as making a crucial moral diference as to how an individual justifiably may be treated, see Daniel M. Farrell, *The Justification of General Deterrence*, *in* PUNISHMENT AND REHABILITATION 38, 38–60 (Jeffrie G. Murphy ed., 3d ed. 1995).

143. *See* Bozza, *"The Devil Made Me Do It"*, *supra* note 107, at 81–83.

144. *See* Frank & McGuire, *supra* note 10, at 28 n.22; Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 433. Because no individual is guaranteed placement in a mental health court, however, such a gamble would carry significant risks.

145. *See, e.g.*, Lisa Shoaf, *A Case Study of the Akron Mental Health Court*, 32 CAP. U. L. REV. 975, 976 (2004) (noting that the Akron mental health court targets repeat offenders); *Mental Health Court Set*, CINCINNATI POST, Dec. 26, 2000, at 21A (noting that the Ohio mental health court targets repeat offenders).

146. *See* Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 433.

of this very shortage led to the creation of mental health courts in the first place.[147] In addition, some individuals with mental illnesses ambivalent about treatment might choose to commit crimes in order to access the other services that many mental health courts provide, such as travel vouchers, job or educational assistance, and assistance securing housing and social welfare benefits. Furthermore, it is not inconceivable that the value of this additional assistance is so great that people without a diagnosable mental health condition might even fake symptoms of mental illness to access these services through mental health court participation.[148]

In sum, mental health courts advance values at odds with those of the traditional justice system. In failing to determine the degree to which mental illness or choice motivated the offender's criminal act, mental health courts may impose penalties disproportionate to an offender's just deserts. Mental health courts also project characterizations of offenders with mental illnesses as nonautonomous, irrational, driven by their mental illnesses, and unable to control their behavior—images that are misleading and stigmatizing, as well as contradictory to the central premise of retribution and deterrence. Significantly, mental health courts trivialize predicate crimes. Finally, because they offer scarce social goods, mental health courts may perversely incentivize individuals to commit crimes to gain access to treatment and other valuable services.

Therapeutic jurisprudence professes an inability to mediate between competing norms and values.[149] Because the values advanced and expressed by mental health courts and the traditional justice system conflict to a significant extent, therapeutic jurisprudence by its very terms cannot provide justification for the mental health court model. The next Part investigates the extent to which the penal theory of therapeutic rehabilitation may fill this void.

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147. *See, e.g.*, Stefan & Winick, *supra* note 11, at 511 (identifying the lack of access to adequate community mental health services as part of "the problem that mental health courts are intended to solve"); Jenni Bergal, *Justice that Works*, S. FLA. SUN-SENTINEL, Nov. 24, 2002, at 1A (linking the creation of the Broward Mental Health Court with the insufficient number of community programs to treat individuals with mental illnesses).

148. Faking symptoms of mental illness is unlikely to result in admittance to those mental health courts that require a prior diagnosis of mental illness. *See infra* notes 188–94 and accompanying text. For a discussion of similar issues in the context of drug treatment courts, see Quinn, *Whose Team*, *supra* note 21, at 60–61.

149. *See supra* notes 75–79.

II. THERAPEUTIC REHABILITATION

As an alternative to therapeutic jurisprudence, rehabilitation possibly could justify the existence of mental health courts. Several prominent commentators—most notably Professor Richard C. Boldt,[150] Professor James L. Nolan,[151] Judge John A. Bozza,[152] and Judge Morris B. Hoffman[153]—have argued persuasively that drug treatment courts represent in many ways a return to a rehabilitative theory of punishment.[154] Similarly, mental health courts, in seeking to address the underlying source of offenders' criminality, expressly articulate rehabilitative purposes.[155] In particular, mental health courts appear to embrace a therapeutic or medical model of rehabilitation, where criminal behavior is viewed as symptomatic of offenders' mental illnesses and mental health treatment is believed necessary to reduce future offending.

A. Definition

The social welfare or penal theory of rehabilitation is premised on the malleability of human character[156] and derives from an abiding faith in the

150. *See* Boldt, *supra* note 96, at 1212–18, 1226–34, 1237, 1243–45 (arguing that, while drug treatment courts do not occasion a full return to the rehabilitative ideal, the courts possess multiple rehabilitative elements and should thus be subjected to the critiques levied against rehabilitation in the late 1960s and 1970s).

151. *See* JAMES L. NOLAN, JR., REINVENTING JUSTICE: THE AMERICAN DRUG COURT MOVEMENT 185–208 (2001); James L. Nolan, Jr., *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 40 AM. CRIM. L. REV. 1541, 1554–63 (2003).

152. *See* Bozza, *"The Devil Made Me Do It"*, *supra* note 107, at 62–64.

153. *See* Morris B. Hoffman, Booker, *Pragmatism and the Moral Jury*, 13 GEO. MASON L. REV. 455, 460 (2005) (expressing that the "ghosts" of rehabilitationism have been reincarnated in therapeutic jurisprudence); Morris B. Hoffman, *The Case for Jury Sentencing*, 52 DUKE L.J. 951, 966 n.55 (2003); Hoffman, *Therapeutic Jurisprudence*, *Neo-Rehabilitationism*, *supra* note 138; Morris B. Hoffman, *The Rehabilitative Ideal and the Drug Court Reality*, 14 FED. SENT'G REP. 172, 176–77 (2001); Morris B. Hoffman, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1479 n.166 (2000).

154. *See also* Phillip Bean, *Drug Courts, the Judge and the Rehabilitative Ideal*, *in* DRUG COURTS: IN THEORY AND IN PRACTICE 235, 244–51 (James L. Nolan ed., 2002) (exploring the relationship between drug treatment courts and rehabilitation).

155. *See* SCHNEIDER ET AL., *supra* note 36, at 3 ("[I]n general, mental health courts are all attempting a rehabilitative response to what would otherwise have been criminally sanctioned behavior."); *id.* at 46–50 (expanding upon and defending the idea that therapeutic jurisprudence requires a justice system to be sympathetic to underlying causes of crime); Teresa W. Carns, Michael G. Hotchkin & Elaine M. Andrews, *Therapeutic Justice in Alaska's Courts*, 19 ALASKA L. REV. 1, 4 (2002) (listing these sentencing goals of therapeutic courts: "To correct or heal the offender, who receives most services and benefits. Society is secondary; victim benefits to the extent that offender is rehabilitated.").

156. ALLEN, *supra* note 96, at 11–18 (examining beliefs about the malleability of human character in societies in which the rehabilitative ideal emerged and thrived); William D. McColl, *Theory and Practice in the Baltimore City Drug Treatment Court*, *in* DRUG COURTS, *supra* note 154, at 13.

scientific control of human behavior.[157] Rehabilitation, broadly speaking, uses sociological and psychological criteria to identify individuals who pose social risk and seeks to reform aspects of delinquent character through individualized treatment.[158] Rehabilitation conceptualizes crime as the product of antecedent causes that are capable of identification and control.[159] These antecedent causes, depending on the theorist and offender, may consist of biological components, environmental or social factors, or deficiencies in moral character.[160]

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157. *See* Enrico Ferri, *The Positive School of Criminology*, *in* THEORIES OF PUNISHMENT, *supra* note 96, at 229, 229 ("We must now draw the logical conclusions, in theory and practice, from the teachings of experimental science, for the removal of the gangrenous plague of crime."); Sheldon Glueck, *Principles of a Rational Penal Code*, 41 HARV. L. REV. 453 (1928), *reprinted in* THEORIES OF PUNISHMENT, *supra* note 96, at 279 ("Effective individualization must be based upon as complete an understanding of each offender as modern science will permit. Hence psychiatry, psychology, and social case work—not to mention those disciplines more remotely concerned with the problems of human motivation and behavior—must be drawn into the program for administering criminal justice.").

158. *See* Eric Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1479, 1510 (2004) (defining the elements of "penal welfarism," or the rehabilitative ideal); *see also* ALLEN, *supra* note 96, at 2 (1981) (defining rehabilitation as "the notion that a primary purpose of penal treatment is to effect changes in the characters, attitudes, and behavior of convicted offenders, so as to strengthen the social defense against unwanted behavior, but also to contribute to the welfare and satisfaction of offenders"). Francis A. Allen has crystallized these essential points of rehabilitation:

> The rehabilitative ideal is itself a complex of ideas which, perhaps, defies completely precise statement. The essential points, however, can be articulated. It is assumed, first, that human behavior is the product of antecedent causes. These causes can be identified as part of the physical universe and it is the obligation of the scientist to discover and to describe them with all possible exactitude. Knowledge of the antecedents of human behavior makes possible an approach to the scientific control of human behavior. Finally, and of primary significance for the purposes at hand, it is assumed that measures employed to treat the convicted offender should serve a therapeutic function, that such measures should be designed to effect changes in the behavior of the convicted person in the interest of his own happiness, health, and satisfaction and in the interest of social defense.

Francis A. Allen, *Criminal Justice, Legal Values, and the Rehabilitative Ideal*, *in* PUNISHMENT AND REHABILITATION, *supra* note 19, at 173; *see also* Henry Weihoffen, *Punishment and Treatment: Rehabilitation*, *in* THEORIES OF PUNISHMENT, *supra* note 96, at 255, 255–56 (restating these "essential points").

159. *See* Allen, *supra* note 158, at 173.

160. *See* Ferri, *supra* note 157, at 237 (suggesting that poverty, childhood abandonment, and trampdom are conditions resulting in crime); MENNINGER, THE CRIME OF PUNISHMENT, *supra* note 38, at 262 (citing estimates that 30 percent of offenders are driven by situational difficulties, 30 percent by psychological problems, and another 30 percent by antisocial tendencies); *see also* John Terrence A. Rosenthal, *Therapeutic Jurisprudence and Drug Treatment Courts: Integrating Law and Science*, *in* DRUG COURTS, *supra* note 154, at 150 ("The rehabilitative theory works on the assumption that the criminal has committed a crime due to some underlying pathology like a mental or physical illness, or from learned antisocial behavior."). In the words of Francis Allen, because the rehabilitative ideal does not necessarily specify a theory of crime causation, the definition "does not resolve the perennial controversies between freedom of the will and determinism, although modern expressions of the rehabilitative ideal lean heavily to the latter." ALLEN, *supra* note 96, at 3.

A prominent aim of rehabilitation is to enhance public safety by eliminating or lessening criminal recidivism.[161] This goal is achieved by reforming offenders' behavior and attitudes so that they conform to those identified as socially beneficial.[162] An important anticipated byproduct of rehabilitation is improvement in offenders' health and welfare,[163] so rehabilitation has been associated with humanitarian motivations "and a willingness to expend effort to reclaim [an offender] for his own sake and not merely to keep him from again harming us."[164] Advocates believe that rehabilitation is superior to other justifications of punishment because "no other [theory] gives as much promise of returning the offender to society not with the negative vacuum of punishment-induced fear but with the affirmative and constructive equipment—physical, mental and moral—for law-abidingness."[165]

The therapeutic or medical model of rehabilitation is one strand of rehabilitative theory.[166] Therapeutic rehabilitation is based on a medical model of crime, in which an offender is "sick" and in need of a state-coerced "cure."[167] Proponents of therapeutic rehabilitation believe that criminals suffer from a physical, mental, or social pathology that is susceptible to diagnosis and treatment, largely by psychiatrists.[168] The writings of Karl Menninger[169] and Benjamin Karpman,[170] two eminent

161. ALLEN, *supra* note 96, at 27 ("[Rehabilitationism] seeks, most importantly, to strengthen the social defense against criminal acts by eliminating or lessening criminal recidivism."); *see also* Karl Menninger, *Love Against Hate*, *in* THEORIES OF PUNISHMENT, *supra* note 96, at 245 ("[O]ur object in all this is to protect the community from a repetition of the offense by the most economical method consonant with our other purposes.").

162. ALLEN, *supra* note 96, at 27–28; Weihoffen, *supra* note 158, at 256 ("The main objective is to change the person's attitudes and to help him cope with his circumstances, gain insight into his own motivations, reorient his feelings, and achieve a measure of self-control.").

163. *See* ALLEN, *supra* note 96, at 2, 27–28.

164. Weihoffen, *supra* note 158, at 256.

165. *Id.* at 261.

166. For a description of the tenets and evolution of therapeutic rehabilitation, see ROTMAN, *supra* note 41, at 60–63. The other three strands of rehabilitation include the penitentiary model, which predates the therapeutic theory, and the social learning and rights oriented model, both of which followed the therapeutic model. *Id.* at 4–6. The strands differ in the means used to achieve rehabilitation and in the roles and powers of rehabilitative agents. *Id.* at 4.

167. *See* ROTMAN, *supra* note 41, at 5, 63, 66.

168. *See id.* at 60, 62; Menninger, *Medicolegal Proposals*, *supra* note 38, at 373 ("[T]he time will come, when stealing or murder will be thought of as a symptom, indicating the presence of a disease."); Menninger, *Therapy, Not Punishment*, *supra* note 38, at 135–36; *see also* Kyron Huigens, *Street Crime, Corporate Crime, and Theories of Punishment: A Response to Brown*, 37 WAKE FOREST L. REV. 1, 21–22 (2002) (in context of drug treatment courts).

169. *See, e.g.*, MENNINGER, THE CRIME OF PUNISHMENT, *supra* note 38 (arguing that criminal behavior is the system of disease and that the appropriate response is treatment by medical professionals, not punishment); Menninger, *Medicolegal Proposals*, *supra* note 38, at 373; Menninger, *Therapy, Not Punishment*, *supra* note 38, at 135–38 (outlining a "scientific" response to crime).

psychiatrists and leading proponents of therapeutic rehabilitation, reflect this preoccupation with discovering and treating the psycho-medical origins of crime.

Proponents of rehabilitation believe that the criminal justice system has a duty to diagnose the causal factors underlying an individual's criminality and to generate an appropriate treatment plan.[171] The framing of offenders as patients or victims to be cured, as opposed to responsible moral agents whose predicament is the product of their will,[172] supports a broad paternalism, in which the state is better equipped than an offender to identify his path to reform.[173] The aim of rehabilitation is to reform the offender rather than to punish him in response to a particular criminal act,[174] so typical limits on state action, grounded in relevance, fall away.[175] In essence, to achieve rehabilitation, state-ordered treatment should vary as the treatment needs of individuals charged with similar crimes vary.[176]

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170. *See, e.g.*, KARPMAN, CASE STUDIES, *supra* note 39 (presenting four case studies of criminals to facilitate an understanding of the psychogenic factors underlying criminality); KARPMAN, THE SEXUAL OFFENDER, *supra* note 39 (exploring the etiology and psyhotherapeutic treatment of sexual offenders); Karpman, *Criminal Psychodynamics: A Platform*, *supra* note 39, at 119 (explaining the importance of criminal psychodynamics and concluding that "criminality is but a symptom of insanity"); *id.* at 131 ("Criminal psychodynamics sees criminality as basically a psychiatric, extra-legal problem. . . . It views criminality, however incidental it may seem on the surface, as a basic human expression having a long history and evolution and a pathology all its own. It sees in criminality a disease *sui generis*, a severe disease which, however, can be cured or prevented when and if proper psychotherapeutic measures are taken.").

171. *See* Glueck, *supra* note 157, at 273 (expressing that society has "a duty to use every reasonable instrumentality for the rehabilitation of its anti-social members" and that a criminal "has a right, in justice, to be treated with those instrumentalities that give him the greatest promise of self-improvement and rehabilitation").

172. *See* Zvi D. Gabbay, *Justifying Restorative Justice: A Theoretical Justification for the Use of Restorative Justice Practices*, 2005 J. DISP. RESOL. 349, 390–91 (2005) ("In essence, the rehabilitative ideal views offenders as 'patients' or 'victims,' who commit crimes because of an 'illness' or under the influence of a dysfunctional social environment. . . . The deeper meaning of this approach, however, is that offenders are not to be morally blamed for their wrongdoing. They are not responsible for their criminal act; instead, their sickness is to blame.").

173. *See* MENNINGER, THE CRIME OF PUNISHMENT, *supra* note 38, at 265 ("Some individuals have to be protected against themselves, some have to be protected from other prisoners, some even from the community.").

174. *See* ROTMAN, *supra* note 41, at 2 (explaining that rehabilitation "incorporates a concept of justice that goes beyond the symmetrical reaction of retribution and inquires into the subjective reality of the offender").

175. *See* ALLEN, *supra* note 96, at 47 (observing that "when there are no clear limits on what may be relevant to the treatment process and when the goals of treatment have not been clearly defined, the idea of relevance as a regulator of public authority is destroyed or impaired"); Boldt, *supra* note 96, at 1239 (tracing the origins of this critique).

176. *See* Boldt, *supra* note 96, at 1224 ("[T]he length and conditions of a criminal sentence must be tailored to effect beneficial change in those traits of the individual defendant's personality, character, or behavioral patterns associated with past untoward conduct and predicted future behavior.").

Mental health courts appear to embrace a particular version of therapeutic rehabilitation, one that is narrowly focused on the causal relationship between certain mental illnesses and crime. This brand of therapeutic rehabilitation is based on two propositions. First, mental health courts justify segregating and diverting individuals with certain mental illnesses on the ground that their illnesses likely contributed to their criminal behavior.[177] Second, mental health courts operate under the assumption that the amelioration of symptoms of these mental illnesses will reduce the likelihood of future criminal behavior. The next section details the empirical evidence on the relationship between mental illness and crime and explores its implications for mental health courts as rehabilitative institutions.

B. Central Factual Assumptions

Mental health courts understand their rehabilitative mission as a therapeutic response to the strong, causal relationship between certain mental illnesses and crime.[178] For more than eighty years, psychologists and psychiatrists have explored the extent to which mental illnesses correlate with violence. More recently, social scientists have begun to examine the degree to which mental illnesses may manifest in criminal

177. This first premise was not necessary to therapeutic rehabilitation as it was articulated in the early to mid-twentieth century. The commission of a criminal act generally was understood to be a necessary predicate for State action, *see, e.g.*, MENNINGER, THE CRIME OF PUNISHMENT, *supra* note 38, at 18 (explaining that the fact that an individual "has broken the law gives us a technical reason for acting on behalf of society to try to do something that will lead him to react more acceptably, and which will protect the environment in the meantime"), but philosophical accounts did not tie the legitimacy of rehabilitation to diagnosing a pathology for that particular criminal act. Instead, once an individual was subject to State control, therapeutic rehabilitative theory held that the State had the duty to diagnose and treat the underlying pathologies responsible for the offenders' criminal behavior (past and future). *See id.*

178. *See, e.g.*, Stefan & Winick, *supra* note 11, at 507 (statement by Bruce J. Winick) (identifying the "basic assumption underlying the mental health court model [as] that, for at least some defendants charged with minor nonviolent offenses and, in some cases, even for those charged with felonies, the problem is more a product of mental illness than of criminality"); *id.* at 511 ("Given the assumed relationship between these individuals' mental illness and their criminal behavior, these courts, by motivating and assisting them to participate in treatment, also function to protect the community from future crime."); Rita Hoover, *Mental Health Court Coming to Kane County*, CHI. TRIB., Jan. 11, 2006, at 2 (identifying untreated mental illness as "the underlying condition—the cause of the behavior" and articulating a key mental health court goal as "'stopping the revolving door' of incarceration for people whose mental illness causes them to break laws or commit crimes"); Interview with Judy Harris Kluger, Deputy Chief Admin. Judge, Center for Court Innovation (Oct. 2007), *available at* http://www.courtinnovation.org/research/judy-harris-kluger-deputy-chief-administrative-judge-court-operations-and-planning-new-york (observing that mental illness drives the crimes of some mentally ill offenders and that court-supervised treatment should make "the criminal conduct driven by the mental illness . . . stop").

behavior, including in the commission of nonviolent misdemeanors. This research, while tentative, suggests that mental health courts as presently constituted sweep too broadly to comport with the rehabilitative mission expressed by the courts.

1. Assumption that Mental Illness Contributed to Predicate Offense

At the core of mental health courts is a belief that, were it not for eligible offenders' mental illnesses, these individuals would not have engaged in the criminal behavior that prompted their arrest. According to Professor Winick, Judge Ginger Lerner-Wren created one of the nation's first mental health courts upon realizing that "many of the minor offenders in criminal court were there because they had committed nuisance offenses that were more a product of their untreated mental illness than of criminality."[179] Similarly, Judge Judy Harris Kluger has located the origin of New York's mental health court initiative in the growing recognition "that there were mentally ill defendants who did not belong necessarily in jail or prison because what drove their crime was mental illness."[180] Other mental health court judges have made similar comments.[181] Indeed, this observation is not controversial: commentators on mental health courts have universally noted the assumed nexus between mental illness and criminal behavior.[182] Even some advocates of individuals with mental

179. Bruce J. Winick, *Foreword: Therapeutic Jurisprudence Perspectives on Dealing with Victims of Crime*, 33 NOVA L. REV. 535, 538 (2009).

180. Interview with Judy Harris Kluger, *supra* note 178.

181. *See, e.g.*, Daniels, *supra* note 110, at 1 (quoting Judge Jim Fuhrmeister as stating about eligible offenders: "The root of their problem is mental illness."); James D. Cayce & Kari Burrell, *King County's Mental Health Court: An Innovative Approach for Coordinating Justice Services*, WASH. ST. BAR NEWS (June 1999) (remarking that the mental health court system exists for those interested in receiving treatment "to ameliorate the mental health conditions that contribute to their unlawful behavior"); *HOPE Court Gives Offenders an Alternative to Jail Time*, TIMES RECORDER, Oct. 23, 2008, at A3 ("Presiding Judge Eric D. Martin said the program is designed for those who may not have committed a crime if it weren't for a mental illness or behavioral issue.").

182. *See, e.g.*, ALMQUIST & DODD, *supra* note 4, at 18 (observing that "the perceived cause of the rule-breaking is mental illness"); Lurigio & Snowden, *supra* note 12, at 212–13 ("[Mental health courts] are instituted on the assumption that a serious mental illness is related to an individual's criminal behavior."); Stefan & Winick, *supra* note 11, at 507 (statement by Bruce J. Winick); Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 432 ("Mental health courts assume uncritically that criminal behavior is caused by a psychiatric problem and that the only way to stop the criminal behavior is to treat the illness causing the behavior."); Christin E. Keele, Note, *Criminalization of the Mentally Ill: The Challenging Role of the Defense Attorney in the Mental Health Court System*, 71 UMKC L. Rev. 193, 194–95 (2002) ("In almost every case, the criminal acts of the offender 'are really manifestations of their illness, their lack of treatment, and the lack of structure in their lives.'").

illnesses have assumed that the crimes committed by these individuals often stem from their disability.[183]

Many mental health courts, however, fail to ensure the existence of this causal relationship for their participants. Mental health courts vary in the extent to which they require a diagnosis—or even evidence—of a severe mental illness.[184] In addition, many courts do not require a demonstrated link between an individual's mental illness and his criminal act.[185] And, significantly, social science research demonstrates that individuals with mental illnesses, like the general offender population, have varying motivations for committing crimes.[186] Together, these data call into question the assumption that, for individuals diverted to mental health courts, their illnesses are to blame for their criminal acts.

a. Eligibility Requirements of Mental Health Courts

A substantial proportion of mental health courts do not require participants to carry a diagnosis of a severe mental illness as a prerequisite for admittance.[187] A 2006 study of 110 mental health courts, conducted by Steven K. Erickson and his colleagues, found that 21 percent of courts required the presence of a "severe" mental illness,[188] or a mental illness that seriously affects the functioning of individuals and places them in the highest category of clinical need.[189] The report found that another 38

183. *See* Seltzer, *supra* note 22, at 582 ("Public safety is not protected when people who have mental illnesses are needlessly arrested for nuisance crimes or when the mental illness at the root of a criminal act is exacerbated by a system designed for punishment, not treatment."); Bernstein & Seltzer, *supra* note 23, at 160 (same); Maura Yates, *New Mental Health Court on Staten Island Will Steer Defendants to Treatment*, STATEN ISLAND REAL TIME NEWS, June 28, 2010, http://www.silive.com/news/index.ssf/2010/06/new_mental_health_court_on_sta.html (quoting National Alliance on Mental Illness Staten Island Executive Director Linda Wilson as stating: "Very often, people with mental illness commit crimes because of their illness and not because of criminality."). *But see* Bernstein & Seltzer, *supra*, at 23 ("Certainly, not every crime committed by an individual diagnosed with a mental illness is attributable to disability or to the failure of public mental health.").

184. *See infra* notes 187–95 and accompanying text.

185. *See infra* notes 201, 206–13 and accompanying text.

186. *See infra* notes 217–33 and accompanying text.

187. *See* Redlich et al., *Patterns of Practice in Mental Health Courts*, *supra* note 22, at 349 (noting that, while some mental health courts only admit persons with serious and persistent mental illness, others only require "demonstrable mental health problems"); Wolff & Pogorzelski, *supra* note 13, at 555–56 ("[S]ome courts may require that the person have a serious mental disorder that is diagnosed by a mental health professional using clinically valid instruments and procedures, whereas others may require only that the person have a mental health problem.").

188. *See* Erickson et al., *supra* note 10, at 339.

189. ALMQUIST & DODD, *supra* note 4, at 11. Illnesses considered "severe" include schizophrenia, bipolar disorder, severe forms of depression, panic disorder, and obsessive-compulsive disorder. *Id.*

percent of courts required a diagnosis of an Axis I disorder,[190] a slightly more expansive category that includes clinical syndromes such as schizophrenia, bipolar disorder, and depression, as well as chronic brain diseases that cause extreme distress and interfere with social and emotional adjustment.[191] Almost half of surveyed courts either required a diagnosis of some "mental illness"[192] or did not require any diagnosis at all.[193] Two studies conducted in 2005 reported similar findings.[194] In short, while a majority of mental health courts require a diagnosis of serious mental illness, many do not.[195]

Mental health courts also differ in the extent to which they require, for purpose of admission, a demonstrated nexus between an offender's mental illness and his crime. The Mentally Ill Offender Treatment and Crime Reduction Act mandates, for mental health courts' receipt of federal funding, that qualified offenders have committed an offense that "is the product of the person's mental illness."[196] Relatedly, the Bureau of Justice Assistance, charged with administering the federal mental health courts program, recommends that "[m]ental health courts should . . . focus on defendants whose mental illness is related to their current offenses."[197]

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190. *See* Erickson et al., *supra* note 10, at 339.

191. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS XXIV 13–24, 28 (4th ed. rev. 2000) [hereinafter DSM-IV-TR]; *see also* Lurigio & Snowden, *supra* note 12, at 197.

192. *See* Erickson et al., *supra* note 10, at 339 (finding that 28 percent of courts required a diagnosis of "mental illness").

193. *See id.* at 339 (finding that 18 percent of mental health courts did not provide any diagnostic eligibility criteria). The rationale for allowing offenders without a diagnosed mental illness to participate in mental health courts is that, for some, the arrest for bizarre behavior will be the first indication that the person may suffer from a mental illness. *See* Bernstein & Seltzer, *supra* note 23, at 149 n.20.

194. *See* ALMQUIST & DODD, *supra* note 4, at 10 (presenting the results of a 2005 study conducted by the Criminal Justice/Mental Health Consensus Project reporting that, of the ninety mental health courts surveyed, 37 percent accepted individuals with an Axis I diagnosis, 21 percent accepted individuals with a "serious and/or serious and persistent" mental illness, 26 percent had no admissions criteria involving mental illness, and 16 percent had some specifications for the types of mental illnesses they would accept but did not report what those specifications were); Lurigio & Snowden, *supra* note 12, at 205 (discussing the findings of a 2005 study by the National Survey of Mental Health Courts, which found that one-third of the surveyed courts required an Axis I diagnosis; approximately 25 percent mandated that the offender have a "severe and persistent mental illness;" and 4 percent defined mental illness as including only the categories schizophrenia, schizoaffective disorder, bipolar disorder, and major depression).

195. *See* Bernstein & Seltzer, *supra* note 23, at 149 n.20 (mentioning the King County mental health court by name).

196. *See* 42 U.S.C. § 3797aa(a)(9)(B) (2006) (definition of "preliminary qualified offender").

197. COUNCIL OF STATE GOV'TS JUSTICE CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT 2 (2008), *available at* http://consensusproject.org/jc_publications/essential-elements-of-a-mental-health-court/mhc-essential-elements.pdf.

However, according to a 2005 report sponsored by the Bureau, "[t]here is no recognized measure to assess the degree to which an alleged offense was 'caused by' a person's illness, and courts vary widely in how they apply this standard, *if at all*."[198]

To date, there has been no comprehensive study of the extent to which mental health courts require a causal link between an offender's mental illness and his criminal act.[199] My review of the policy statements, eligibility criteria, and news coverage of mental health courts in existence in March 2010 revealed a great variance in the degree to which mental health courts require evidence of such a connection.[200]

It appears that a minority of mental health courts require evidence of a relationship between an offender's mental illness and his alleged criminal act. One set of researchers, relying on data from the 2005 National Survey of Mental Health Courts, estimated that only 8 percent of courts "limited participation to [offenders] whose mental illnesses contributed directly to the offense for which they were charged."[201] Generally, courts that call for a demonstrated relationship do not require that mental illness be the predominant cause of an offense. For example, to be eligible for admission to the Jackson County Pilot Mental Health Treatment Court in Michigan, the treatment team must determine that the individual's mental illness "contributed" to his offense.[202] Similarly, eligibility for acceptance to San Francisco's Behavioral Health Court depends upon a defendant's having been charged with or convicted of an offense "where the behavior that led to the offense was connected to mental illness."[203] To participate in the Lancaster County Adult Mental Health Court in Pennsylvania, "[t]he

198. GUIDE TO MENTAL HEALTH COURT DESIGN, *supra* note 3, at 29 (emphasis added).

199. Some researchers have studied the eligibility criteria of a select number of jurisdictions. *See, e.g.*, JOHN S. GOLDKAMP ET AL., EMERGING JUDICIAL STRATEGIES FOR THE MENTALLY ILL IN THE CRIMINAL CASELOAD: MENTAL HEALTH COURTS IN FORT LAUDERDALE, SEATTLE, SAN BERNARDINO, AND ANCHORAGE viii (Bureau of Justice Assistance 2000), *available at* http://www.ncjrs.gov/ html/bja/mentalhealth/contents.html (finding that four mental health courts only accept persons with demonstrable mental illness likely to have contributed to their criminal acts); Wolff et al., *Mental Health Courts and Their Selection Processes*, *supra* note 108, at app. (finding that two of six analyzed mental health courts screen out cases which lack a clear connection between the crime and mental illness and a third court accepts violent felonies only if the crime was strongly or directly linked to mental illness or the victim was a family member).

200. *See infra* note 212 (explicating my research methodology). Jon Bense, who served as my Public Interest Research Fellow, was of great assistance in compiling and analyzing this data.

201. *See* Lurigio & Snowden, *supra* note 12, at 205.

202. JACKSON CNTY. PILOT MENTAL HEALTH TREATMENT COURT, MEMO OF UNDERSTANDING 4, *available at* http://www.d12.com/county_courts/d12/docs/MHCMemo.pdf.

203. SUPERIOR COURT OF CAL., CNTY. OF S.F. BEHAVIORAL HEALTH COURT, POLICIES AND PROCEDURES MANUAL 2 (July 2008), *available at* http://www.sfbar.org/forms/lawyerreferrals/ida/BHC_manual.pdf.

conduct giving rise to the crime must be attributable to characteristics of the defendant's mental illness."[204] Of note, courts may be more likely to require a demonstrated nexus between an offender's mental illness and his criminal activity when the charged predicate offense was violent.[205]

Other mental health courts include a nexus concept in their policy statements or lists of professed goals but do not require, as an explicit eligibility criterion, a finding of any causal link between mental illness and an offender's criminal act. The Richland County Mental Health Court in South Carolina, for example, communicates its intent to treat the root cause of an offender's criminal behavior without, apparently, imposing an explicit nexus requirement for eligibility. The purpose of the court is "to address the inappropriate involvement of mentally ill individuals . . . in the criminal justice system, charged with misdemeanor and/or non-violent felony offenses, resulting mainly from untreated symptoms of psychiatric and co-occurring disorders."[206] The court's eligibility criteria, while detailed, do not include any relationship between mental illness and criminal behavior.[207] It remains unclear whether the goal-related language supporting the court's purpose, "to address inappropriate involvement . . . in the criminal justice system . . . resulting mainly from untreated symptoms of [mental] disorders," reflects a conceptual assumption about the relationship between mental illness and crime, or whether it signals the practical reality that an individualized determination takes place for each offender prior to admittance to the court.

Finally, some mental health courts do not even profess a goal (at least publicly) of selecting and treating offenders whose crimes derived from

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204. LANCASTER CNTY. COURT OF COMMON PLEAS, ADULT MENTAL HEALTH COURT, PARTICIPANT CRITERIA, *available at* http://www.co.lancaster.pa.us/courts/lib/courts/apps/mhc/mhc_criteria.pdf; *see also* Janet Kelley, *Mental Health Court Opens Here: Judge Hears 1st Case*, INTELLIGENCER JOURNAL/NEW ERA (Lancaster, PA), Mar. 24, 2010, at A1 (attributing this statement to a mental health court judge: "In order for a defendant to qualify for [the] mental health court . . . the crime has to have a direct connection to the mental illness.").

205. *See, e.g.*, KOOTENAI CNTY., IDAHO, MENTAL HEALTH COURT PARTICIPANT HANDBOOK 6 (May 2008), *available at* http://www.kcgov.us/departments/districtcourt/forms/20081209_Mental%20Health%20Court%20Handbook_pdf_Handbook_Mental%20Health%20Court%20Handbook.pdf (specifying that violent offenders, who may be admitted to the mental health court on a case-by-case basis, will be assessed to see whether the offense was linked to mental illness); Wolff et al., *Mental Health Courts and Their Selection Processes*, *supra* note 108, at app; SEVENTEENTH JUDICIAL CIRCUIT OF THE STATE OF ILL., WINNEBAGO CNTY. MENTAL HEALTH COURT, http://www.co.winnebago.il.us/judicial_court/WCMHC.html (last visited Jan. 8, 2012) (allowing admission for misdemeanors involving a weapon and certain felony offenses involving bodily injury if mental illness is a causative factor in the offense).

206. RICHLAND CNTY., SOUTH CAROLINA PROBATE COURT, MENTAL HEALTH COURT, http://www.richlandonline.com/departments/probate/mentalhealthcourt.asp (last visited Jan. 8, 2012).

207. *Id.*

their mental illnesses. For instance, the purpose of the mental health court in Cuyahoga County, Ohio, appears to be merely to divert offenders diagnosed with certain serious forms of mental illness from the traditional justice system. The single stated goal of the court is to identify mentally disordered or developmentally disabled offenders and link them to treatment.[208] In addition to restricting access to offenders who commit certain crimes,[209] the only other eligibility criterion consists of a recent diagnosis of a severe mental illness with a psychotic feature or a clinical diagnosis that the defendant has an "IQ of seventy-five or less and/or an adaptive skills deficit."[210] The court appears to have expressed no concern that offenses stem from participants' illnesses in any policy statement or eligibility criterion, or in practice.[211]

I was unable to locate any nexus requirement—in court rules or materials, or as reported in policy statements or secondary sources—for many mental health courts around the country.[212] For instance, mental health courts in these jurisdictions appear to lack a nexus requirement: Jefferson County, Alabama; Montgomery County, Alabama; the Delaware Court of Common Pleas; Alachua County, Florida; Brevard County, Florida; Charlotte County, Florida; Collier County, Florida; Nassau County, Florida; Polk County, Florida; Ada County, Idaho; Bannock County, Idaho; Bonneville County, Idaho; Ionia County (Eighth Circuit), Michigan; Boone County (Thirteenth Judicial Circuit), Missouri; Missoula, Montana; Clark County, Nevada; Bernalillo County, New

208. CUYAHOGA CNTY. MENTAL HEALTH COURT INITIATIVE, CUYAHOGA COUNTY MENTAL HEALTH COURT INITIATIVE BROCHURE, *available at* http://cp.cuyahogacounty.us/internet/courtdocs/mhbrochure.pdf.

209. *See* JUSTICE CTR., COUNCIL OF STATE GOVERNMENTS, CUYAHOGA COUNTY, OHIO MENTAL HEALTH COURT DOCKET INITIATIVE, http://www.consensusproject.org/program_examples/cuyahoga_county_ohio_mental_health_court_docket_initiative (last visited Jan. 8, 2012) (listing clinical and legal eligibility criteria).

210. CUYAHOGA CNTY. MENTAL HEALTH COURT INITIATIVE, *supra* note 208; CUYAHOGA COUNTY COMMON PLEAS COURT R. 30.1, ASSIGNMENT OF CRIMINAL CASES TO MENTAL HEALTH DOCKETS, *available at* http://cp.cuyahogacounty.us/internet/LocalRules.aspx?ID=34.

211. *But see* Coyne, *supra* note 129, at A1 ("Cuyahoga County Common Pleas Judge Mary Jane Boyle, one of five county judges overseeing cases with mentally ill defendants, said most crimes committed by the mentally ill happen when the individual is off his or her medications.").

212. To establish this list, my research assistant and I searched individual mental health court websites and read all program information, policy statements, local court rules, brochures, and manuals. We ran searches in Lexis and Westlaw for mental health court requirements as provided in statutes, regulations, state and local court rules, and administrative orders. We searched for data on mental health court eligibility requirements in psychological journals as well as in law reviews and periodicals. We ran a Google search for *mental health court policy and procedure manual*. We also reviewed information on mental health courts compiled by the Criminal Justice Mental Health Consensus Project, the Center for Mental Health Services' National GAINS Center, and the National Center for State Courts.

Mexico; Butler County, Ohio; Davidson County, Tennessee; and Salt Lake County, Utah. For many of these courts, information on eligibility criteria is publicly available, a fact that provides some confidence that the lack of a specified nexus requirement holds significance. There are dozens of additional mental health courts without obvious nexus requirements, but so little information is publicly available about the workings of these courts that any representation about their lack of a specific criterion would be inappropriate.[213]

The creators of mental health courts may assume that requiring eligible offenders to produce a diagnosis or other evidence of mental illness suffices to ensure that their criminal behavior was a product of that mental illness. This assumption, however, is belied by research on the psychological precursors to crime.[214]

b. The Varying Motivations for Crime of Individuals with Mental Illnesses

Individuals diagnosed with Axis I disorders[215] are able to control their behavior and engage in rational thought much of the time.[216] Thus, offenders with mental illnesses, like nondisordered offenders, may

213. It is of course possible that our searches failed to uncover some public information on mental health court eligibility criteria. It is also probable that some judges, district attorneys, or treatment teams typically require evidence of a connection between an individual's offense and his mental illness, but this practice is not mandated in a court rule or publicized on a court website or in a brochure or manual. Finally, mental health courts evolve quickly, and some of the courts listed above might have changed their procedures since my analysis was conducted in March 2010.

214. *See infra* notes 250–53, 260, and 274–99 and accompanying text.

215. *See supra* notes 190–91 and accompanying text.

216. *See* Kansas v. Crane, 534 U.S. 407, 412 (2002) (observing that "most severely ill people—even those commonly termed 'psychopaths'—retain some ability to control their behavior"); THOMAS G. GUTHEIL & PAUL S. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 221 (3d ed. 2000) ("The mere presence of psychosis, dementia, mental retardation, or some other form of mental illness or disability is insufficient in itself to constitute incompetence."); Stephen J. Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 573 (1978) (discussing a meta-analysis of 300 studies of schizophrenia and quoting the conclusion that "it is clear that *most* schizophrenics function no differently on these experimental tests from *most* normals"); Bruce J. Winick, *Ambiguities in the Legal Meaning and Significance of Mental Illness*, 1 PSYCHOL. PUB. POL'Y & L. 534, 569 (1995) ("Not all individuals suffering from the major mental illnesses will be rendered cognitively or volitionally impaired . . . . The extent of functional impairment produced by these conditions varies widely within each diagnostic category, with the result that assignment of a particular diagnosis does not imply a specific level of impairment or disability."). *See generally* Morse, *supra*, at 573. ("It is a striking clinical commonplace that crazy persons behave normally a great deal of the time and in many ways. Even when they are in the midst of a period of crazy behavior, much of their behavior will be normal. Further, between crazy periods crazy people are not reliably distinguishable from normal persons.").

experience differing motivations for committing crimes.[217] Research demonstrates that, while some individuals with mental illnesses may commit minor offenses that appear to stem from their disorders (such as disorderly conduct), others may commit "survival" crimes (such as petty theft and panhandling) because they are poor.[218] Still others may commit crimes of a more serious nature (such as burglary and assault) where their mental illnesses appear incidental or secondary to their criminality.[219] Reflecting on their experience, two professors of psychiatry have stated that

> the vast majority of the crimes committed by chronic mentally ill persons are misdemeanors . . . committed when the person is not in the psychotic phase of his or her illness. The behavior is usually goal-directed, such as wanting to acquire goods without paying for them, wanting to express anger, or wanting to go back to a psychiatric hospital.[220]

Thus, while some criminal behavior may derive from mental illness, much may simply effectuate the goals of the individual.

Building on the work of Virginia Aldigé Hiday,[221] Professor William H. Fisher and his colleagues proposed a taxonomy of offenders with mental illnesses based on how their illnesses affect their criminal behavior.[222] These authors suggest that one category of offenders with mental illnesses includes "individuals whose offenses could be seen as *directly* attributable to their mental illness, such as the individual with a psychotic disorder whose paranoid delusions lead [him] to commit acts of

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217. *See* DAN A. LEWIS ET AL., WORLDS OF THE MENTALLY ILL 118–19 (1991); Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 432 ("Different factors motivate such persons to engage in criminal behavior, and only one of these factors is untreated mental illness.").

218. *See* LEWIS ET AL., *supra* note 217, at 118–19; Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 432; *see also* J. Draine et al., *Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons with Serious Mental Illness*, 53 PSYCHIATRIC SERVICES 565, 565–67 (2003) (observing that persons with mental illness may engage in offending because they are poor, not because they have a mental illness).

219. *See* LEWIS ET AL., *supra* note 217, at 118–19; Wolff, *Courts as Therapeutic Agents*, *supra* note 20, at 432.

220. Leonard I. Stein & Ronald J. Diamond, *The Chronic Mentally Ill and the Criminal Justice System: When to Call the Police*, 36 HOSP. & COMMUNITY PSYCHIATRY 271, 272 (1985).

221. *See* Virginia Aldigé Hiday, *Mental Illness and the Criminal Justice System*, *in* A HANDBOOK FOR THE STUDY OF MENTAL HEALTH 508, 524–25 (Allen V. Horwitz & Teresa L. Scheid eds., 1999) (proposing the original taxonomy of offenders with mental illnesses).

222. *See* William H. Fisher et al., *Community Mental Health Services and Criminal Justice Involvement Among Persons with Mental Illness*, *in* COMMUNITY-BASED INTERVENTIONS, *supra* note 139, at 25, 43.

violence."[223] Researchers speculate that this cohort of offenders is small.[224] A second category of offenders with mental illnesses includes "individuals whose offenses could be characterized as indirectly attributable to their illness."[225] This group would include offenders whose mental illnesses contributed to their job loss, decline into poverty, and/or movement into environments rife with antisocial influences, all generic risk factors for criminal justice involvement.[226] The offenses of these individuals will often include misdemeanor offenses and the manifestation of so-called "survival behavior."[227] A third category of offenders with mental illnesses, according to Professor Fisher and his colleagues, includes individuals with co-occurring character disorders and substance abuse, both of which are strong risk factors for offending, and those who have a long history of involvement with the juvenile and adult criminal justice systems.[228] These researchers suggest that such individuals may have "more in common with other denizens of the county jail than with other clients of the mental health system."[229] Citing motor vehicle offenses like unlawfully attaching plates and serious charges like grand theft auto, drug trafficking, forgery, and passing bad checks, the authors opine that "[t]hese and other offenses fit neither the 'misdemeanant' nor the 'deranged perpetrator of violence' categories, but instead suggest criminal activity that may go forward independently or, indeed, in spite of the offenders' mental illness."[230]

Recently, one set of social scientists has estimated the percentage of all offenders with mental illnesses whose criminal activity is attributable to their disorders. In an April 2010 article, Professor Jennifer L. Skeem and her colleagues hypothesized, based on their review of psychological literature, that mental illnesses may directly contribute to the criminality of only about 10 percent of the mentally disordered offending population.[231] They predict that, for the remaining 90 percent of offenders with mental illnesses, the effect of mental illness on criminal activity is fully mediated

223. *Id.* at 43.

224. *See* Hiday, *supra* note 221, at 525 (observing the existence of "a very small group" of seriously disordered individuals whose delusions lead them to commit violent crimes); Skeem, Manchak & Peterson, *supra* note 15, at 117–19.

225. Fisher et al., *supra* note 222, at 43.

226. *Id.*

227. *Id.* (stating that this category would correspond roughly to Hiday's first category of "those committing misdemeanor offenses, some of which might not result in the arrest of a non-disordered person, and some which may involve so-called 'survival behavior'").

228. *Id.* at 43–44.

229. *Id.* at 44.

230. *Id.*

231. *See* Skeem, Manchak & Peterson, *supra* note 15, at 118.

by factors such as poverty or social learning that similarly affect the general population.[232] For the vast majority of offenders with mental illnesses, then, the correlation between their mental illnesses and criminal activity may be illusory.[233]

Consequently, it appears illegitimate for mental health courts to assume, without case-specific evidence, that an offender's crimes were driven by his mental illness. This holds important ramifications for the potential of therapeutic rehabilitative theory to justify mental health courts. Mental health courts are predicated on the belief that the provision of mental health services reduces social risk because symptomatic mental illnesses contribute to criminal behavior. If mental illness contributed to the criminal act that brought an offender within the jurisdiction of the court, as a matter of logic one may deduce that providing mental health treatment to that individual should reduce his likelihood of committing a similar act in the future.[234] If an offender's mental illness was *unrelated* to his predicate criminal act, however, then, for mental health courts to serve a rehabilitative function for that individual (and others like him), evidence should show that certain mental illnesses, as a general matter, are predictive of recidivism. The next section reviews available empirical evidence on the degree to which mental illnesses affect recidivism.

2. Assumption that Symptomatic Mental Illness Directly Contributes to Recidivism

A central and oft-expressed assumption of mental health courts is that mental illness drives the recidivism of individuals with mental illnesses. For instance, Probate Judge Jim Fuhrmeister, one of the founders of the Shelby County Mental Health Court in Alabama, has stated that, when an offender with mental illness does not receive treatment, "what happens is recidivism"—"[i]t just turns, basically, into a revolving door"—and that providing treatment should "lead to a turnaround in [participants'] lives."[235] Similarly, the judge of the mental health court in Jackson County, Michigan, has explained that mental health courts provide treatment to offenders with mental illnesses because "[t]hey're just going

232. *See id.* at 116, 118.

233. *See id.* at 120 (emphasizing that "[e]ven among those with psychosis, symptoms directly cause crime for only a small fraction of offenders").

234. *See id.* at 111, 120.

235. Amy Jones, *County to Start Mental Health Court*, SHELBY COUNTY REPORTER, June 24, 2010, http://www.shelbycountyreporter.com/2010/06/24/county-to-start-mental-health-court/.

to recidivate if you don't address the underlying pathology."[236] This sentiment has been repeated by mental health court judges across the country.[237]

The prevalence of the belief that symptomatic mental illness fuels recidivism is understandable. Certainly, individuals with mental illnesses are disproportionately represented in the criminal justice system. A 2009 study of more than 20,000 adults entering five local jails found serious mental illness in 14.5 percent of male and 31.0 percent of female inmates.[238] These rates are three to six times higher than those found in the general population.[239] The phenomenon of incarcerating individuals with mental illnesses has coincided with deinstitutionalization: according to Dr. Fuller Torrey of the National Institute of Mental Health, "approximately ninety-two percent of the people who would have been living in public psychiatric hospitals in 1955 were not living there in 1994."[240] Today, jails are the nation's largest providers of mental health services.[241]

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236. Chris Gautz, *Mental-Health Court Celebrates Its First Anniversary, Honors First Two Graduates*, JACKSON CITIZEN PATRIOT, Saturday Ed., Nov. 14, 2009, at A1, *available at* http://www.mlive.com/news/jackson/index.ssf/2009/11/mental-health_court_celebrates.html.

237. *See, e.g.*, Brian Brueggemann, *Mental Health Court to Open in October*, BELLEVILLE NEWS DEMOCRAT, Aug. 24, 2006 (quoting Chief Judge Ann Callis as stating, "If we can identify people with mental illnesses when they first enter the criminal justice system and get them connected to a mental health program, we can help them manage their mental illness without further criminal activity in the future"); Hoover, *supra* note 178 (quoting Chief Judge Donald Hudson as stating that a key goal of the court is to "'[stop] the revolving door' of incarceration for people whose mental illness causes them to break laws or commit crimes"); *HOPE Court Gives Offenders an Alternative to Jail Time*, *supra* note 181 (quoting Presiding Judge Eric D. Martin as stating that without treatment "many persons with mental illness churn through the system over and over" and that his "[c]ourt is designed to get at the genesis of these problems [in providing treatment], to break that cycle, [and] reduce the crime rate"); Kathleen Brady Shea, *Mental Health Courts on Horizon: Local Counties Want to Steer Ill Defendants into Treatment Instead of Jail*, PHILA. INQUIRER, June 30, 2008, at B1 (quoting Delaware County Court Judge Frank T. Hazel as expressing that offenders with mental illnesses often reoffend because they don't receive adequate treatment for their mental illnesses); *see also supra* note 37.

238. Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVICES 761, 764 (2009). This study has been touted as providing the "most reliable estimates of rates of serious mental illness for adults entering jails in the last 20 years." COUNCIL OF STATE GOV'TS JUSTICE CTR., *Council of State Governments Justice Center Releases Estimates on the Prevalence of Adults with Serious Mental Illnesses in Jails* (June 1, 2009), *available at* http://consensusproject.org/jc_publications/council-of-state-governments-justice-center-releases-estimates-on-the-prevalence-of-adults-with-serious-mental-illnesses-in-jails/MH_Prevalence_Study_brief_final.pdf.

239. R.C. Kessler et al., *The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization*, 66 AM. J. ORTHOPSYCHIATRY 17–31 (1996) (estimating that 5.4 percent of individuals in the United States have a serious mental illness).

240. E. FULLER TORREY, OUT OF SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 8–9 (1997).

241. *See* Gregory L. Acquaviva, Note, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 978 (2006) (observing that, "in 1992, the Los Angeles County jail became the nation's largest mental institution, with Cook County Jail, Illinois, and Riker's Island, New York, as second and third respectively").

In 1972, Marc F. Abramson offered a theory—coined "criminalization"—to explain the disproportionate involvement of individuals with mental illnesses in the criminal justice system.[242] The criminalization theory is premised on the belief that persons with mental illnesses become inappropriately involved with the criminal justice system because of failed mental health policy and service delivery.[243] In particular, Dr. Abramson argued that law enforcement will arrest individuals with mental illnesses for their disordered behavior partially as a means to compensate for the limited ability of the civil commitment system to detain them involuntarily.[244] While the criminalization theory was developed in response to heightened standards for civil commitment, some believe his hypothesis holds even greater promise for predicting the likely consequences of deinstitutionalization in the context of few community treatment options.[245] According to adherents of the criminalization theory, the criminal behavior of individuals with mental illnesses is a product of inadequate mental health services and the expression of psychiatric symptoms.[246] Adequate mental health treatment, then, should reduce the recidivism of these individuals.[247] Recently, psychology and criminology scholars have pointed to a dearth of evidence

242. Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101, 103 (1972).

243. Fisher, Silver & Wolff, *supra* note 126, at 546.

244. *See* Abramson, *supra* note 242, at 103.

245. *See* Fisher, Silver & Wolff, *supra* note 126, at 546 ("Mentally ill offenders are often arrested because jails lack adequate procedures to divert them into community-based treatment programs." (quoting SOROS FOUND., RESEARCH BRIEF, MENTAL ILLNESS IN U.S. JAILS: DIVERTING THE NON-VIOLENT, LOW-LEVEL OFFENDER 2 (1996))); Carole Morgan, *Developing Mental Health Services for Local Jails*, 8 CRIM. JUST. & BEHAV. 259, 261 (1981) ("A substantial number of the individuals currently warehoused in jails are those 'forfeited' patients who were previously institutionalized in psychiatric hospitals. It would seem that the social control of these 'deviants' has shifted from the mental health to the criminal justice system.").

246. *See* Bernstein & Seltzer, *supra* note 23, at 143 ("For most [offenders with mental illnesses], the underlying issue is their need for basic services and supports that public systems have failed to deliver in meaningful ways."); H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483, 485 (1998) ("[M]any uncared-for mentally ill persons may be arrested for minor criminal acts that are really manifestations of their illness, their lack of treatment, and the lack of structure in their lives."); *see also* John Junginger et al., *Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses*, 57 PSYCHIATRIC SERVICES 879, 879 (2006) (explaining that adherents of the criminalization theory apparently believe that "symptoms of serious mental illness motivate or otherwise cause actual criminal offenses").

247. *See* Fisher, Silver & Wolff, *supra* note 126, at 546; Lamb & Weinberger, *supra* note 246, at 490.

that supports the criminalization hypothesis,[248] but others continue to ascribe to this theory.[249]

Despite the popularity and current cache of the criminalization theory, no research exists demonstrating that mental illness is a principal or proximate cause of criminal behavior for most offenders with mental illnesses.[250] Instead, the preponderance of scientific evidence indicates that, while offenders with mental illnesses may be at an elevated risk for reoffending (an issue of correlation),[251] their disorders typically do not directly contribute to their re-arrest (an issue of causation).[252] For the vast majority of offenders with mental illnesses, criminal behavior actually appears to be motivated by the same risk factors—such as substance abuse, procriminal attitudes, criminal associates, and unstable lifestyle—that motivate nondisordered offenders.[253]

a. Trivial Role of Mental Illness in Recidivism

For much of the twentieth century, researchers' attention was focused on the relationship between mental illness and violence.[254] While some studies found that individuals with mental illnesses are no more likely to

248. *See, e.g.*, Fisher, Silver & Wolff, *supra* note 126, at 547–48 (marshalling evidence in support of, and challenging, the criminalization theory and concluding that the body of evidence is "at best equivocal in its support of the 'criminalization due to inadequate mental health services' model); John Junginger et al., *supra* note 246, at 879 ("In fact, what little empirical research exists on this particular interpretation of the criminalization hypothesis has produced no consensus."); Skeem, Manchak & Peterson, *supra* note 15, at 116 ("There is no evidence for the basic criminalization premise that decreased psychiatric services explain the disproportionate risk of incarceration for individuals with mental illness.").

249. *See, e.g.*, Keele, *supra* note 182, at 194–95 (2002); Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1183 (1997); Marlee E. Moore & Virginia Aldigé Hiday, *Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants*, 30 LAW & HUM. BEHAV. 659, 660 (2006).

250. Wolff, *Courting the Court*, *supra* note 139, at 155, 163.

251. *See, e.g.*, A. Murray Ferguson, James R.P. Ogloff & Lindsay Thomson, *Predicting Recidivism by Mentally Disordered Offenders Using the LSI-R:SV*, 36 CRIM. JUST. & BEHAV. 5, 5 (2009) (listing studies showing that individuals with major mental disorder are at an "elevated risk" for engaging in criminal behavior compared to members of the general population); Eric Silver, *Understanding the Relationship Between Mental Disorder and Violence: The Need for a Criminological Perspective*, 30 LAW & HUM. BEHAV. 685, 685–86 (2006) (listing studies and concluding that risk of violence is "modestly elevated" for persons with mental illness, particularly when paired with substance abuse).

252. *See infra* notes 274–79.

253. *See infra* notes 291–99.

254. *See* LEWIS ET AL., *supra* note 217, at 110; Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 393, 401 nn.1–2 (1998).

be violent than their non-ill neighbors,[255] others have indicated that mental illness is a modest risk factor for violence,[256] especially for individuals experiencing psychotic symptoms[257] and co-occurring substance abuse.[258]

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255. *See, e.g.*, Rani A. Desai, *Jail Diversion Services for People with Mental Illness: What Do We Really Know?*, *in* COMMUNITY-BASED INTERVENTIONS, *supra* note 139, at 99, 102 (listing studies); Jane Byeff Korn, *Crazy (Mental Illness Under the ADA)*, 36 U. MICH. J.L. REFORM 585, 612 & n.188 (2003) (same).

256. *See, e.g.*, John Monahan, *Clinical and Actuarial Predictions of Violence*, *in* MODERN SCIENTIFIC EVIDENCE, § 7-2.2.1, at 314 (David Faigman et al. eds., 1997) ("Mental disorder may be a statistically significant risk factor for the occurrence of violence."); John Monahan & Jean Arnold, *Violence by People with Mental Illness: A Consensus Statement by Advocates and Researchers*, 19 PSYCHIATRIC REHABILITATION J. 67, 70 (1996) ("The results of several recent large-scale projects conclude that only a weak association between mental disorders and violence exists in the community."); Edward P. Mulvey & Jess Fardella, *Are The Mentally Ill Really Violent?*, PSYCHOL. TODAY, Nov./Dec. 2000, at 39 ("[R]ecently, . . . researchers . . . have concluded that there is a statistically significant association between mental illness and violence: Overall, the mentally ill are more likely to act out violently than the general public. However, this association is not very strong. . . . Also, the manner in which mental illness contributes to violence, when it does, varies considerably and is often far from clear."); *see also* MICHAEL L. PERLIN, THE HIDDEN PREJUDICE 24 n.20, 40, 82 (2000) (discussing evidence regarding the relationship between mental illness and violence).

257. A 2009 meta-analysis of 204 studies and samples found a small correlation between psychosis and violence. *See* Kevin S. Douglas, Laura S. Guy & Stephen D. Hart, *Psychosis as a Risk Factor for Violence to Others: A Meta-Analysis*, 135 PSYCHOL. BULL. 679, 688 (2009) (discussed in Skeem, Manchak & Peterson, *supra* note 15, at 117). The study authors found no meaningful correlation, however, between psychosis and violence for offenders with mental illness or for general offenders. *See* Douglas, Guy & Hart, *supra*, at 688. Other studies have found a more robust correlation. *See* Jeffrey W. Swanson et al., *Alternative Pathways to Violence in Persons with Schizophrenia: The Role of Childhood Antisocial Behavior Problems*, 32 LAW & HUM. BEHAV. 228, 235, 237 (2008) (finding a relationship between positive psychotic symptoms, such as persecutory ideation, and serious violence in schizophrenic patients not also manifesting childhood conduct problems); Bruce G. Link, Howard Andrews & Francis T. Cullen, *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 286–88 (1992) (finding higher rates of violence—measured by arrests and self-reports—in a sample of mental patients than in residents who had never received psychiatric treatment, after controlling for socio-demographic and community context variables, and finding that this association was partially accounted for by the presence of current psychotic symptoms); *see also* Junginger et al., *supra* note 246, at 881 (highlighting a small proportion of offenders whose violent criminal acts appeared directly or indirectly related to delusions). *But see* Paul Appelbaum, Pamela Clark Robbins & John Monahan, *Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study*, 157 AM. J. PSYCHIATRY 566, 571 (2000) (finding that delusions are not associated with a higher risk of violent behavior). For a recent summary of the literature examining the relationship between psychotic symptoms and violence, see Kevin S. Douglas & Jennifer L. Skeem, *Violence Risk Assessment: Getting Specific About Being Dynamic*, 11 PSYCHOL. PUB. POL'Y & L. 347, 362 (2005).

258. The MacArthur Violence Risk Assessment Study, perhaps the most authoritative analysis of the relationship between violence and mental illness, found the prevalence of violence of patients discharged from acute psychiatric inpatient facilities, so long as they did not exhibit symptoms of substance abuse, was *statistically indistinguishable* from that of non-substance-abusing residents in the same neighborhoods. *See* Steadman et al., *Violence by People Discharged*, *supra* note 254, at 400. However, among those individuals who reported symptoms of substance abuse, patients were more likely to be violent than their substance-abusing neighbors. *Id.* For a more recent discussion on the relationship of mental illness, substance abuse, and violence, see Mulvey & Fardella, *supra* note 256,

This caveat is not trivial: individuals with mental illnesses disproportionately abuse alcohol and drugs,[259] perhaps as a way to manage their symptoms. A substantial body of evidence establishes, however, that any independent contribution made by mental illness to violence pales in comparison to risk factors shared by the general population such as sex, age, and educational achievement.[260]

Research on mental illness and violence suggests that, consistent with Professors Skeem's and Fisher's analyses,[261] mental illness may play a direct role in the criminality of a minority of individuals, particularly those experiencing positive psychotic symptoms or engaging in substance abuse. If this relationship holds, treating the mental illnesses (and any co-occurring substance abuse) of these individuals may be effective in reducing recidivism.[262] However, mental health courts are largely beyond the reach of individuals with mental illnesses who commit violent acts. Most mental health courts exclude persons with a history of violence or who are otherwise determined to be a public safety threat.[263] So, while mental illness may be a causal factor for some violent crimes, mental health courts are unlikely to provide treatment in those situations.

More recently, psychologists and other social scientists have looked beyond violence to explore the relationship between mental illness and crime.[264] This area of research is challenging for a number of reasons.[265]

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at 50 ("New research . . . suggests that individuals who have less serious forms of mental illness but who engage in substance abuse have the highest risk for violence among the mentally ill. People with more severe mental disorders but no substance abuse problems, however, are no more likely to be violent than their 'normal' neighbors.").

259. *See* Steadman et al., *Violence by People Discharged*, *supra* note 254, at 400; E. Fuller Torrey et al., *The MacArthur Violence Risk Assessment Study Revisited: Two Views Ten Years After Its Initial Publication*, 59 PSYCHIATRIC SERVICES 147, 149 (2008) ("Mental disorder has a significant effect on violence by increasing people's susceptibility to substance abuse.").

260. *See, e.g.*, Link & Stueve, *supra* note 52, at 179; Link, Andrews & Cullen, *supra* note 257, at 290; Skeem, Manchak & Peterson, *supra* note 15, at 116–17.

261. *See supra* notes 222–33.

262. *See* Skeem, Manchak & Peterson, *supra* note 15, at 119.

263. *See* Redlich et al., *Second Generation*, *supra* note 4, at 534 (observing that newer mental health courts may be more tolerant of violent offenders but still consider public safety in a "'totality of the circumstances' approach"); Nancy Wolff, *Courting the Court*, *supra* note 139, at 166 ("Mental health courts as they are currently formulated accept only the good risks. Cases are limited to those where the crimes are minor and the risk of violence minimal. This selection rule is . . . driven strictly by political exigencies. . . . Mental health court judges know that if someone under supervision commits a violent crime, their court will be closed down."); *id.* at 167 (noting that "[m]ental health courts avoid cases [involving] previous charges of violence"). In addition, the insanity defense may be applicable to the subset of offenders whose actions were the product of delusions. *See id.* at 175.

264. These researchers, building off of seminal work by D.A. Andrews and James Bonta, include Jennifer L. Skeem, William H. Fisher, Jeffrey Draine, and Nancy Wolff.

265. For a discussion of the difficulties inherent in elucidating the relationship between mental illness and criminal activity, see Desai, *supra* note 255, at 101.

First, individuals with mental illnesses commit a wide array of crimes. Contrary to the stereotype underlying the criminalization theory of an offender with mental illness as a petty misdemeanant,[266] individuals with mental illnesses commit misdemeanors, felonies, and violent felonies.[267] Indeed, a recent study of the offending patterns of 13,816 individuals with severe mental illnesses over a ten-year period found that such individuals were arrested for serious violent crimes, such as nonnegligent homicide or aggravated battery, nearly as often as for crimes against the public order.[268] Mental health courts, reflecting this reality, are increasingly expansive in the criminal acts they allow,[269] making it harder to make meaningful generalizations about the criminal activity of eligible offenders.

Other complexities exist as well. For instance, the contribution of mental illness to an individual's likelihood of reoffending, as with violence, will vary with the type of mental illness that he has and the ebb and flow of his symptoms. In addition, a number of variables may modify or confound the effect of mental illness on criminal activity, such as history of trauma, poverty, antisocial cognitions, or substance abuse.[270] These variables may exist independent of an individual's mental illness or may be a partial product of his illness. Finally, as proponents of criminalization have observed, individuals with mental illnesses may be arrested at a higher rate than non-ill individuals who behave in a similar

266. *See* Fisher et al., *supra* note 222, at 42 (recognizing a "criminalization stereotype" of offenders with mental illnesses as committing low-level misdemeanors as a result of receiving inadequate mental health services); Lynette Feder, *A Comparison of the Community Adjustment of Mentally Ill Offenders with Those from the General Prison Population: An 18-Month Followup*, 15(5) LAW & HUM. BEHAV. 477, 487 (1991) ("[S]ome researchers have argued that deinstitutionalization had led to the criminalization of the mentally ill. This leads to the implicit assumption that this group will be comprised of less serious offenders than those found in the general prison population.").

267. *See* William H. Fisher et al., *Categorizing Temporal Patterns of Arrest in a Cohort of Adults with Serious Mental Illness*, 37 J. BEHAV. HEALTH SERVICES & RES. 477 (2010); William H. Fisher et al., *Patterns and Prevalence of Arrest in a Statewide Cohort of Mental Health Care Consumers*, 57 PSYCHIATRIC SERVICES 1623, 1625 (2006) (Table 2).

268. *See* Fisher et al., *Patterns and Prevalence*, *supra* note 267, at 1625 (Table 2). Specifically, 16.1 percent of cohort members were charged with crimes against public order, defined as "[b]eing a disorderly person, disturbing the peace, setting a false alarm, instigating a bomb hoax, trespassing, and consuming alcohol in a public place in violation of [an] open-container law." *Id.* at 1625–26. On the other hand, 13.6 percent of cohort members were charged with serious violence against persons, defined to include "[m]urder; nonnegligent manslaughter; forcible rape; robbery (including armed robbery); aggravated assault and battery with a dangerous weapon, against a person over age 65, against a disabled person, and to collect a debt." *Id.* In the aggregate, 27.9 percent of cohort members were charged with any offense over the ten-year period. *Id.* at 1625 (Table 2).

269. *See* ALMQUIST & DODD, *supra* note 4, at 7–9.

270. *See* Desai, *supra* note 255, at 101.

manner, either because they are targeted by law enforcement[271] or because they have a decreased ability to avoid detection.[272] In summary, the likelihood that mental illness may contribute to an individual's recidivism may depend upon the nature of his crimes, his diagnosis, the course of his symptoms, his characteristics and circumstances, and the degree to which law enforcement selectively targets individuals with mental illnesses in his community.

Despite these complexities, a growing body of evidence suggests that the types of mental illnesses targeted by many mental health courts—severe mental illness or Axis I disorders[273]—are insignificant predictors of criminal behavior for most offenders. A landmark 1998 meta-analysis conducted by James Bonta, Professor Moira Law, and Karl Hanson found that the effect of clinical variables—such as diagnosis, intellectual dysfunction, and treatment history[274]—on recidivism[275] was largely insignificant and paled in comparison to dozens of other factors.[276] The meta-analysis of fifty-eight studies dated between 1959 and 1995 revealed that intellectual dysfunction, diagnosis of a mood disorder, and treatment history were nonsignificant variables, while psychosis and schizophrenia were *negatively* related to recidivism.[277] The study's authors concluded that many of the clinical factors emphasized within the mental health community "have little relevance to the assessment of long-term risk for recidivism."[278] Subsequent studies have confirmed the negligible role that major mental illness seems to play in recidivism.[279]

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271. *See* Mark R. Pogrebin & Eric D. Poole, *Deinstitutionalization and Increased Arrest Rates Among the Mentally Disordered*, 15 J. PSYCHIATRY & L. 117, 118–19 (1987); Linda Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 AM. PSYCHOLOGIST 794, 798 (1984) (presenting data from 1,382 police-citizen encounters to show law enforcement's response to individuals with mental illnesses).

272. *See* Desai, *supra* note 255, at 101.

273. *See supra* notes 190–91 and accompanying text.

274. James Bonta, Moira Law & Karl Hanson, *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis*, 123 PSYCHOL. BULL. 123, 125 (1998).

275. Recidivism was defined as including "any evidence of a new criminal offense" (like an arrest or conviction), "including a recommitment to a psychiatric hospital because of law-breaking behavior." *Id.* at 125–26.

276. *See id*. at 127–28 (general recidivism); *id*. at 132 (violent recidivism).

277. *Id.* at 128, 132, 136. These researchers found that major mental disorder was at least unrelated to violent and nonviolent recidivism and, in some cases, may have even been negatively associated with reoffending. *See id.* at 135, 136, 139.

278. *Id.* at 135; *see also id.* at 137 ("Clinical variables and clinical judgments contribute minimally in the prediction of recidivism.").

279. *See* Feder, *supra* note 266, at 485–86, 488 (finding, in a study of the postprison adjustment patterns of 147 offenders with mental illnesses and 400 non-ill offenders, that psychiatric variables (number of criminal hospitalizations, number of civil hospitalizations, age at first hospitalization) were not significant in predicting recidivism among offenders with mental illnesses); Paul Gendreau, Tracy

One type of mental disorder that would *not* satisfy the eligibility criteria of most mental health courts[280]—antisocial personality disorder—

Little & Claire Goggin, *A Meta-Analysis of the Predictors of Adult Offender Recidivism: What Works!*, 34 CRIMINOLOGY 575, 589 (1996) (finding, in a meta-analysis of 131 studies with 1,141 effect sizes, that psychiatric symptomology did not correlate with recidivism); *see also* Kevin M. Cremin et al., *Ensuring a Fair Hearing for Litigants with Mental Illnesses: The Law and Psychology of Capacity, Admissibility, and Credibility Assessments in Civil Proceedings*, 17 J.L. & POL'Y 455, 481 (2009) ("[I]ndividuals having a primary psychiatric diagnosis alone (i.e., a mood, anxiety or psychotic disorder) are not more likely to exhibit psychopathic or antisocial behavior than those who have not been so diagnosed."); Jeffrey Draine, *Where is the 'Illness' in the Criminalization of Mental Illness?*, *in* COMMUNITY-BASED INTERVENTIONS, *supra* note 139, at 16–18 (reviewing relevant literature and concluding that, although representing a limited empirical base, studies to date do not demonstrate that mental illness plays an important role in reoffending); Wolff, *Courting the Court*, *supra* note 139, at 156 ("The preponderance of evidence shows that there is no reliable or predictive connection between mental illness and crime.").

280. *See* ALMQUIST & DODD, *supra* note 4, at 11 (stating that most mental health courts require a diagnosis of an Axis I disorder, but many also accept individuals who have a co-occurring Axis II disorder); Lurigio & Snowden, *supra* note 12, at 205 (reporting that only 3 percent of mental health courts in a national survey allowed defendants with an Axis II diagnosis to participate).

There are many good reasons to support mental health courts' decision not to allow a primary diagnosis of antisocial personality disorder to establish eligibility. First, criminal law generally does not recognize antisocial personality disorder as reducing culpability. *See, e.g.*, Bruce J. Winick, *The Supreme Court's Evolving Death Penalty Jurisprudence: Severe Mental Illness as the Next Frontier*, 50 B.C. L. REV. 785, 843 (2009) ("Those diagnosed with [antisocial personality disorder] or psychopathy 'may have problems fully appreciating the emotional meaning or consequences of their actions and using their emotions to make choices and plans,' but the law considers that 'they ought to know better than to commit serious crime and violence.' Those with this diagnosis who commit heinous murders thus are worthy of retribution, and their conduct is sufficiently voluntary that it is subject to deterrence." (quoting Stephen D. Hart, *Psychopathy, Culpability, and Commitment*, *in* MENTAL DISORDER AND CRIMINAL LAW 159, 169 (Robert F. Schopp et al. eds., 2009)); Stephen J. Morse, *Culpability and Control*, 142 U. PA. L. REV. 1587, 1637 (1994) (commenting on the complex challenge psychopaths present for issues of culpability, observing that a "psychopath knows what he is up to, what the rules are, and what will happen to him if he is caught for breaking them," *id.* at 1636, and seeming to indicate that the proper moral response is to hold psychopaths responsible for their behavior); *see also* MODEL PENAL CODE § 4.01(2) (arguably precluding psychopaths from pleading the insanity defense by stating that "the terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct"). Indeed, some of the most heinous criminals likely carry this diagnosis. *See* Winick, *The Supreme Court's Evolving Death Penalty Jurisprudence*, *supra*, at 840–41 (observing that Ted Bundy, Adolf Hitler, and Saddam Hussein probably had antisocial personality disorder); *see also* Grant T. Harris, Tracey A. Skilling & Marnie E. Rice, *The Construct of Psychopathy*, 28 CRIME & JUST. 197, 198 (2001) ("[M]any of the most serious and persistent offenders would be identified as psychopathic."). Second, allowing a primary diagnosis of antisocial personality disorder to establish eligibility for diversion to a mental health court would eliminate a key limiting function of the mental illness eligibility criterion. Some studies have found that over half—and perhaps as many as 90 percent of incarcerated criminals—could carry this diagnosis. *See* Paul Moran, *The Epidemiology of Antisocial Personality Disorder*, 34 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 231, 234 (1999) ("[A]ntisocial personality disorder is extremely common in prisons with prevalence rates as high as 40–60% among the male sentenced population."); Jennifer L. Skeem, John Monahan & Edward P. Mulvey, *Psychopathy, Treatment Involvement, and Subsequent Violence Among Civil Psychiatric Patients*, 26 LAW & HUM. BEHAV. 577, 578 (2002) (indicating that up to 90 percent of offenders likely qualify for an antisocial personality disorder diagnosis). Finally, some evidence suggests that antisocial personality disorder may be less amenable to treatment than Axis I disorders such as schizophrenia, bipolar disorder, or

likely contributes to recidivism.[281] Antisocial personality disorder is an Axis II disorder whose symptoms are behavioral rather than associated with cognitive impairment.[282] This personality disorder is defined in the *Diagnostic and Statistical Manual of Mental Disorders* as "a pervasive pattern of disregard for, and violation of, the rights of others."[283] Studies indicate that a diagnosis of antisocial personality disorder correlates with violence and criminal activity.[284] Reflecting the fact that one criterion of the disorder is that individuals "fail to conform to social norms with respect to lawful behaviors" as indicated by "repeatedly perform[ing] acts that are ground for arrest,"[285] some research has suggested that the predictive power of a diagnosis of antisocial personality disorder for recidivism is fully mediated by an individual's past antisocial or criminal acts as well as by socio-demographic risk factors.[286] The weight of recent

depression. *See, e.g.*, James R. P. Ogloff, Stephen Wong & Anthony Greenwood, *Treating Criminal Psychopaths in a Therapeutic Community Program*, 8 BEHAV. SCI. & L. 181, 186 (1990) ("Psychopaths tend to show less clinical improvement, they are less motivated in trying to change their behaviors and they have a higher attrition rate [in treatment programs]."). *But see* Randall T. Salekin, *Psychopathy and Therapeutic Pessimism: Clinical Lore or Clinical Reality?*, 22 CLINICAL PSYCHOL. REV. 79, 105 (2002) (conducting a meta-analysis of forty-two studies and concluding that "there is little scientific support" for the belief that psychopaths are untreatable); Skeem, Monahan & Mulvey, *supra*, at 594 ("Patients with psychopathic traits appeared as likely to benefit from *adequate* doses of treatment by becoming less violent as those without such traits.").

281. For a synopsis of evidence regarding the relationship between antisocial personality disorder, psychopathy, violence, and recidivism, see CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM 481–82 (5th ed. 2009). The terms *antisocial personality disorder* and *psychopathy* are sometimes used interchangeably in psychological literature, but an individual may be considered a "psychopath" based on assessment tools such as the Psychopathy Checklist (PCL or PCL-R) but not actually be diagnosed with antisocial personality disorder in a clinical sense. *See* Morse, *Culpability and Control*, *supra* note 280, at 1635 n.133; Winick, *The Supreme Court's Evolving Death Penalty Jurisprudence*, *supra* note 280, at 826 n.296, 840–43 (defining and distinguishing antisocial personality disorder from psychopathy).

282. *See* Jennifer L. Skeem et al., *Are There Ethnic Differences in Levels of Psychopathy? A Meta-Analysis*, 28(5) LAW & HUM. BEHAV. 505, 505 (2004) ("Psychopathy represents a constellation of affective, interpersonal, and behavioral features . . . ."); Winick, *The Supreme Court's Evolving Death Penalty Jurisprudence*, *supra* note 280, at 826 n.296 ("As defined in the DSM-IV-TR, [antisocial personality disorder] is exclusively behavioral in nature, involving certain behavioral manifestations and personality traits.").

283. DSM-IV-TR, *supra* note 191, at 701.

284. *See, e.g.*, Grant T. Harris, Marnie E. Rice & Catherine A. Cormier, *Psychopathy and Violent Recidivism*, 15 LAW & HUM. BEHAV. 625, 634 (1991) (finding that those offenders who were also psychopaths "exhibited much higher rates of violent recidivism than those who were not" in an empirical study); Robert D. Hare & Leslie M. McPherson, *Violent and Aggressive Behavior by Criminal Psychopaths*, 7 INT'L J.L. & PSYCHIATRY 35, 43 (1984) ("[T]here is a strong and consistent relationship between the assessment of psychopathy and various indices of violence."); Moran, *supra* note 280, at 238 ("[A]ntisocial personality disorder has . . . been found to be strongly associated with crime, and in particular, violent crime." (citations omitted)).

285. DSM-IV-TR, *supra* note 191, at 706.

286. *See* Marnie E. Rice et al., *Recidivism Among Male Insanity Acquittees*, 18 J. PSYCHIATRY & L. 379, 380–81 (1990) ("The finding that antisocial personality disorder is related to recidivism is

research, however, demonstrates that behavioral traits associated with antisocial personality disorder are indicators of risk.[287] Along these lines, Bonta and Professor D.A. Andrews have identified major mental disorder as a "minor" risk factor[288] but posit that its predictive validity is mediated by the general risk factors of antisocial cognition and antisocial personality pattern, as well as substance abuse.[289]

Indeed, antisocial cognition and behavior are highly correlated with recidivism for both mentally disordered and nondisordered offenders. Bonta and Andrews, drawing upon social psychological models of criminality and social learning theory,[290] have codified an influential list of major *criminogenic need factors*—dynamic risk factors that, when changed, are associated with changes in recidivism[291]—coined the "Big

problematic, because criminal behavior is one of the symptoms of the disorder; therefore it is unclear . . . whether diagnosis contributes anything more to the prediction of recidivism than does criminal history alone."); Zach Walsh & David S. Kosson, *Psychopathy and Violent Crime: A Prospective Study of the Influence of Socioeconomic Status and Ethnicity*, 31 LAW & HUM. BEHAV. 209, 224 (2007) (reporting that socio-demographic variables have a moderating impact on the relationship between psychopathy and violent crime). While the 1998 meta-analysis conducted by Bonta, Law, and Hanson found that antisocial personality disorder was a significant clinical predictor for both general and violent recidivism, Bonta, Law & Hanson, *supra* note 274, at 128, 132, the researchers stressed that the extent to which the noncriminal aspects of this disorder may contribute to criminal risk assessment is unclear, *id.* at 138 ("Whether the noncriminal aspects of antisocial personality disorder significantly contribute to criminal risk assessment remains an open question . . . .").

287. *See* John F. Edens, John Petrila & Jacqueline K. Buffington-Vollum, *Psychopathy and the Death Penalty: Can the Psychopathy Checklist-Revised Identify Offenders Who Represent 'A Continuing Threat to Society'?*, 29 J. PSYCHIATRY & L. 433, 434 (2001) ("[I]n many of the samples and settings in which it has been investigated, the presence of psychopathic traits . . . indicates an increased tendency toward violent and other criminal behavior."); Skeem et al., *supra* note 282, at 505 ("Those high in psychopathic traits . . . . appear to be at risk for community violence, general and violent criminal recidivism, institutional adjustment problems, and slow treatment response.").

288. D.A. Andrews, James Bonta & J. Stephen Wormith, *The Recent Past and Near Future of Risk and/or Need Assessment*, 52 CRIME & DELINQ. 7, 11 (2006).

289. *Id.* at 10 (stating, "the predictive validity of mental disorder [for criminal justice involvement] most likely reflects antisocial cognition, antisocial personality pattern, and substance abuse").

290. Social psychological theories of criminality posit that, to reduce recidivism, programs should target needs closely related to criminality, such as antisocial attitudes, criminal associates, and unstable lifestyle. D.A. ANDREWS & JAMES BONTA, THE PSYCHOLOGY OF CRIMINAL CONDUCT 296–97 (2d ed. 1998) (exploring social psychological theories of criminality and implications for treatment); Bonta, Law & Hanson, *supra* note 274, at 138. A key component of social psychological theories of criminality is social learning, a theory holding that criminal behavior is largely learned through early modeling and reinforcement patterns. *See* Skeem, Manchak & Peterson, *supra* note 15, at 116; *see also* Silver, *supra* note 251, at 691–92 (describing social learning theory in the context of violence). Explanatory elements of social learning theory include differential association (group influence on behavior), definitions (an individual's attitudes and beliefs, learned and reinforced through differential association), differential reinforcement (the balance of actual and anticipated consequences for engaging in criminal behavior), and imitation or modeling (learning by observing others). *Id.* at 691.

291. Bonta, Law & Hanson, *supra* note 274, at 138. There are two types of risk factors: static and dynamic. Static risk factors are historical markers that are unchangeable and related to criminal

Four" and "Central Eight."[292] These factors appear to affect recidivism among disordered and nondisordered offenders alike.[293] The Big Four risk/need factors, which have the greatest ability to predict criminal behavior,[294] include a history of antisocial behavior, antisocial personality pattern, antisocial cognition,[295] and antisocial attitudes[296]—all aspects of antisocial personality disorder. These variables involve poor socialization, restless energy, risk-taking, impulsivity, egocentrism, poor problem-solving skills, hostility, and a disregard for responsibilities and others.[297] The four additional risk/need factors that comprise the Central Eight, which are moderately correlated with recidivism, include family and/or marital problems, low levels of social and/or work performance, low levels of involvement and satisfaction in anticriminal leisure pursuits, and substance abuse.[298] Subsequent studies, including large-scale meta-analyses, have confirmed the importance of criminogenic risk factors in predicting recidivism.[299]

While major mental illness may not be a causal factor in the criminal behavior of most offenders with mental illnesses, mental illness may play an indirect role in generating socio-demographic conditions linked with

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offending. *See* Ferguson, Ogloff & Thomson, *supra* note 251, at 7. Static risk factors proven to be modestly correlated with recidivism include past criminal history, family structure, history of juvenile delinquency, age, and gender. *Id.* at 7.

292. Andrews, Bonta & Wormith, *supra* note 288, at 10, 11; *see also* ANDREWS & BONTA, *supra* note 290, at 296–97.

293. *See* Andrews, Bonta & Wormith, *supra* note 288, at 11, 16.

294. CTR. FOR BEHAVIORAL HEALTH SERVS. & CRIMINAL JUSTICE RESEARCH, POLICY BRIEF: CRIMINAL THINKING: DO PEOPLE WITH MENTAL ILLNESSES THINK DIFFERENTLY? 2 (2010), *available at* http://cbhs.rutgers.edu/pdfs/Policy_Brief_April_2010.pdf.

295. Recent research on antisocial cognition has found that offenders with mental illnesses exhibit criminal thinking patterns and content comparable to non-ill inmates. *See* Robert D. Morgan et al., *Prevalence of Criminal Thinking Among State Prison Inmates with Serious Mental Illness*, 34 LAW & HUM. BEHAV. 324, 332 (2010). This research supports the theory that offenders with mental illnesses possess characteristics that predispose them to criminal behaviors that co-occur with, but are largely independent of, their mental illnesses. *Id.* at 334.

296. Andrews, Bonta & Wormith, *supra* note 288, at 11.

297. *See* ANDREWS & BONTA, *supra* note 290, at 356.

298. Andrews, Bonta & Wormith, *supra* note 288, at 11.

299. *See* D.A. ANDREWS & JAMES BONTA, THE PSYCHOLOGY OF CRIMINAL CONDUCT (4th ed. 2006) (a quantitative study of eight meta-analyses demonstrating the importance of criminogenic risk factors to recidivism); Craig Dowden & D.A. Andrews, *Effective Correctional Treatment and Violent Reoffending: A Meta-Analysis*, 42 CANADIAN J. CRIMINOLOGY 449, 451–53, 459–60 (2000) (a meta-analysis finding strong support for the categorization of criminogenic and noncriminogenic needs and concluding that programs targeting criminogenic needs produced greater treatment effects than those that did not); Gendreau, Little & Goggin, *supra* note 279, at 582, 588 (a meta-analytic study finding that criminogenic needs are significant and potent predictors of recidivism); *see also* D.A. Andrews & James Bonta, *Rehabilitating Criminal Justice Policy and Practice*, 16 PSYCHOL. PUB. POL'Y & L. 39 (2010) (summarizing the empirical base for programs that decrease recidivism by targeting criminogenic needs).

criminal activity.[300] Mental illness may contribute, for instance, to a loss of employment, movement into disadvantaged neighborhoods, gain of antisocial acquaintances, and loss of prosocial support—all criminogenic risk factors that heighten risk of criminality.[301] Offenders with mental illnesses are also more prone to homelessness and substance abuse, two factors highly correlated with recidivism.[302] Evidence suggests that individuals with mental illnesses may also enjoy fewer social supports than non-ill individuals.[303] Indeed, some research suggests that offenders with mental illnesses may enter the criminal justice system with a higher concentration of criminogenic risk factors, on average, than non-ill offenders.[304]

Consistent with research showing that mental illness is not a dynamic risk factor for reoffending, evidence shows that the provision of mental health treatment alone is not an effective strategy for reducing the recidivism of offenders with mental illnesses.[305] Studies have found that

300. *See* Draine et al., *supra* note 218 (arguing that poverty moderates the relationship between serious mental illness and criminal behavior).

301. *See* Fisher et al., *Community Mental Health Services*, *supra* note 222, at 38 ("[A] conceptual model . . . would see severe mental illness as generating a set of social and economic statuses which in turn place individuals with those illnesses at risk for criminal justice involvement. Indeed, they experience the same kind of risk encountered by others of similar socioeconomic status who do not have serious mental illness.").

302. *See* SCHNEIDER ET AL., *supra* note 36, at 57; Jeffrey Draine, *Mental or Criminal?*, 356 LANCET s48 (2000); *see also* Fred C. Osher & Henry J. Steadman, *Adapting Evidence-Based Practices for Persons with Mental Illness Involved with the Criminal Justice System*, 58 PSYCHIATRIC SERVICES 1472, 1473 (2007) ("In jails 30.3% of inmates with mental illnesses were homeless in the year before arrest, compared with 17.3% of other inmates. Not having a home upon release from jail or prison also increases the risk of rearrest.").

303. *See* Feder, *supra* note 266, at 483 ("Regardless of whether the [mentally ill offenders] were released from the prison or from the hospital, they were significantly less likely . . . to receive support from family or friends upon release into the community (56% vs. 80% for those in the general prison population.")).

304. *See* Draine, *Mental or Criminal?*, *supra* note 302; Skeem, Manchak & Peterson, *supra* note 15, at 117 (discussing studies and suggesting that "offenders [with mental illnesses] are at risk not because they are mentally ill, but because they disproportionately experience key factors (*e.g.*, antisocial pattern) that proponents [of the social/personality theory] believe establish and maintain ongoing criminal activity"). William H. Fisher, Eric Silver, and Nancy Wolff have identified some of the ways in which offenders with mental illnesses might develop a greater constellation of criminogenic risk factors than nondisordered individuals. *See* Fisher, Silver & Wolff, *supra* note 126, at 551–54; *see also* Fisher et al., *Community Mental Health Services*, *supra* note 222, at 38–41 (exploring the role of poverty and social environments as risk factors for criminal justice involvement among persons with mental illness).

305. *See* Morgan et al., *supra* note 295, at 334 ("Intensive, targeted treatment and service delivery approaches have not proven to be sufficiently preventive, nor has psychiatric treatment by itself."); Fisher et al., *Community Mental Health Services*, *supra* note 222, at 37 (discussing a series of findings suggesting "that 'generic' community mental health services of the kind provided to persons with severe mental illness, while providing important treatment and support services, may not in and of themselves reduce the risk of criminal justice involvement or re-involvement for some individuals in

providing intensive mental health services, and not addressing broader criminogenic needs, does not reduce rates of criminal behavior for individuals with mental illnesses.[306] Even evidence-based mental health services—those proven to have a reliable effect on clinical outcomes—have not reduced recidivism in programs designed to decrease the involvement of individuals with mental illnesses in the criminal justice system.[307] Such findings prompted Professor Skeem and her colleagues to report that "no evidence" supports the assumption that the control or reduction of mental illness symptoms will reduce recidivism.[308]

Studies show that the most effective programs for reducing recidivism are those that target the specific risks and needs predictive of criminality, such as procriminal attitudes, criminal associates, and substance abuse.[309] One researcher recently concluded that clear empirical evidence demonstrates that appropriate offender rehabilitation programs addressing criminogenic variables can reduce recidivism by 30 percent.[310] In light of this evidence, Bonta and Andrews have issued this opinion:

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this population"); Skeem, Manchak & Peterson, *supra* note 15, at 120 (explaining that "even if mental illness contributed to downward socioeconomic drift, it is unlikely that symptom improvement will reverse poverty or associated criminogenic factors that are more socioeconomic than medical" and that "factors that originally *caused* criminal behavior may differ from those that *maintain* it").

306. *See, e.g.*, Robin E. Clark, Susan K. Rickets & Gregory J. McHugo, *Legal System Involvement and Costs for Persons in Treatment for Severe Mental Illness and Substance Use Disorders*, 50(5) PSYCHIATRIC SERVICES 641, 644 (1999) (finding that arrest rates of participants in assertive community treatment and those in standard case management did not differ significantly); Jennifer L. Skeem & Jennifer Eno Louden, *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment*, 57 PSYCHIATRIC SERVICES 333, 339 (2006) (finding, in an evaluation of a probation program and jail diversion programs, that increased access to and use of mental health services did not lead to a significant decrease in recidivism); Phyllis Solomon, Jeffrey Draine & Arthur Meyerson, *Jail Recidivism and Receipt of Community Mental Health Services*, 45 HOSP. & COMMUNITY PSYCHIATRY 793, 795 (1994) (finding that "a greater proportion of the clients assigned to receive intensive case management services from the [assertive community treatment] team returned to jail compared with clients assigned to individual case managers or referred to a [community mental health center]").

307. Skeem, Manchak & Peterson, *supra* note 15, at 114.

308. *Id.* According to these researchers, existing data show that "offenders who (for whatever reason) show symptom improvement during a treatment program are *no less likely to recidivate* than those whose symptoms remain unchanged or worsen." (emphasis added). *Id.*

309. *See, e.g.*, Bonta, Law & Hanson, *supra* note 274, at 138; D.A. Andrews & James Bonta, *Rehabilitating Criminal Justice Policy and Practice*, 16 PSYCHOL. PUB. POL'Y & L. 39 (2010); *see also* Skeem, Manchak & Peterson, *supra* note 15, at 121 ("Specifically, the effectiveness of correctional programs in reducing recidivism is positively associated with the number of criminogenic needs they target (i.e., dynamic risk factors for crime, like procriminal attitudes), relative to noncriminogenic needs (i.e., disturbances that impinge on an individual's functioning in society, like depression . . .). Because mental illness is not a criminogenic need for this subgroup, it is important to target stronger factors for crime.").

310. Ferguson, Ogloff & Thomson, *supra* note 251, at 8.

> Our argument is that if [mental health] treatment services are offered with the intention of reducing recidivism, changes must be encouraged on criminogenic need factors. Offenders also have a right to the highest quality service for their other needs, but that is not the focus of correctional rehabilitation. Striving to change noncriminologic needs is unlikely to alter future recidivism significantly unless it indirectly impacts on a criminogenic need. We may make an offender feel better, which is important and valued, but this may not necessarily reduce recidivism.[311]

Some researchers have speculated that, when programs directed at offenders with mental illnesses (such as mental health courts) do reduce recidivism, they do so by addressing offenders' criminogenic risks, engaging in problem-solving strategies, and targeting situational factors that get an offender in trouble.[312]

C. Implications

The research on mental illness and crime is instructive for suggesting which populations should participate in mental health courts. First, a theory of therapeutic rehabilitation (premised on the belief that criminal behavior is symptomatic of mental illness) could justify mental health courts if the courts were limited to the small subset of offenders whose crimes actually stemmed from mental illnesses. In theory, treating the mental illnesses of these individuals should tend to decrease their likelihood of reoffending.[313]

Second, a more capacious understanding of rehabilitation, based in part on social learning theory,[314] may justify treating a broader cohort of individuals with mental illnesses. Instead of conceptualizing crime as simply the result of symptomatic mental illness, for instance, mental health courts could operate on the premise that the criminal behavior of individuals with mental illnesses is often motivated *either* by mental illness or by criminogenic needs related to mental illness. This understanding would support inviting offenders with mental illnesses to participate in mental health courts, regardless of the existence of a causal

311. ANDREWS & BONTA, *supra* note 290, at 244; *see also* Silver, *supra* note 251, at 689 ("If mental disorder is only a small part of the problem, services aimed at its control can only be a small part of the solution.").

312. Skeem, Manchak & Peterson, *supra* note 15, at 121.

313. *See id*. at 119–20.

314. *See supra* note 290.

link between their criminal act and mental illness symptoms, to address their criminogenic needs as well as to provide mental health treatment. This option may hold normative appeal, since individuals with mental illnesses may be as blameless for the generation of their criminogenic needs as for their illnesses.[315]

Third, an even more capacious form of rehabilitation, conceptualizing crime as the product of criminogenic risks and needs, would support the creation of a newly constituted specialty court system devoted to addressing the dynamic risk factors of all high-risk offenders, mentally ill or not. Directing services to those offenders most at risk for recidivism is a central principle of effective correctional treatment.[316] As Andrews and his colleagues have explained, "the effects of treatment typically are . . . greater among higher risk cases than among lower risk cases."[317] Reserving intensive and extensive service for high-risk offenders should yield the greatest dividend in crime reduction.[318]

Fourth, by broadening the stated goals of mental health courts beyond decreasing arrests or incidents of reconviction—which some mental health courts do[319]—a theory of rehabilitation could potentially justify mental

315. As explained above, mental illness often leads to the generation of socio-demographic conditions linked with criminal activity, such as homelessness, unemployment, gain of antisocial acquaintances, and loss of prosocial support. *See supra* notes 225–27, 301–03. But the criminogenic risk factors of many, if not most, non-ill offenders also originate from sources beyond their control. *See* Lurigio & Snowden, *supra* note 12, at 197 ("[Persons with serious mental illness] often reside in highly criminogenic and impoverished environments that exert pressures on them to engage in criminal behaviors. The factors that characterize these environments (e.g., joblessness, gang influences, failed educational systems, and residential instability) also affect poor persons with no serious mental illness."); John Monahan, *The Psychiatrization of Criminal Behavior: A Reply*, 24 HOSP. & COMMUNITY PSYCHIATRY 105, 107 (1973) (observing that "being born in a ghetto is more crimonogenic than being 'mentally ill'"). It is unclear on what basis we should hold individuals with mental illnesses less responsible for their criminal acts (assuming mental illness was not a direct cause of their crimes), but not similarly excuse the acts of criminals born into poverty or subjected to pervasive discrimination. *See* Morse, *supra* note 216, at 627 ("Craziness is only a predisposing cause of other legally relevant behavior. If the law is unwilling to consider the relevance of other predisposing causes, such as poverty, to legal questions such as dangerousness or criminal responsibility, it is difficult to maintain a compelling argument that craziness is different and therefore should be relevant.").

316. *See* Dowden & Andrews, *supra* note 299, at 451 (outlining three principles of effective correctional treatment); Skeem, Manchak & Peterson, *supra* note 15, at 122.

317. D.A. Andrews et al., *Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis*, 28 CRIMINOLOGY 369, 374 (1990).

318. For empirical support of the risk principle, see, *e.g.*, D.A. Andrews et al., *supra* note 317; D.A. Andrews & Jerry J. Kiessling, *Program Structure and Effective Correctional Practices: A Summary of the CaVIC Research*, *in* EFFECTIVE CORRECTIONAL TREATMENT 439 (R.R. Ross & Paul Gendreau eds., 1980); Craig Dowden & D.A. Andrews, *What Works for Female Offenders: A Meta-Analytic Review*, 45 CRIME & DELINQ. 438 (1999).

319. *See, e.g.*, *N.H. Mental Health Pilot Program PURPOSE*, New Hampshire Court Rules (2010), *available at* http://www.courts.state.nh.us/supreme/orders/20020224_mhcp.htm (identifying

health courts as currently constituted. Rates of recidivism are often considered the most tangible and suitable outcome measures of rehabilitative treatment (and perhaps the most politically palatable), but other measures of social welfare—such as improvement in aspects of offenders' psychological health, conduct, and life-style—could also serve as viable measures of success.[320] Mental health courts may succeed at enhancing the human potential, psychological health, or welfare of offenders, even in the face of static re-arrest rates.[321] Very little data has been collected on the extent to which the well-being of offenders is enhanced, beyond their capacity to conform to law-abiding behavior in the short-term.[322]

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the purpose of the Keene District Court PILOT project as including improved access to mental health treatment, improved well-being of identified defendants with mental illnesses, reduced recidivism, and public safety); JMHCP Grantee (2010)—Josephine County Community Justice and Mental Health Collaboration Project, http://www.consensusproject.org/program_examples/josephine_county_community_justice_and_mental_health_collaboration_project (last visited Jan. 8, 2012) (defining the goals of the project as "1) to improve collaboration among the adult criminal justice system, the juvenile justice system and the mental health system; 2) to better address the needs of people with mental illness; and 3) to increase public safety and promote positive outcomes for people with mental illnesses"); McHenry County, MCHENRY COUNTY MENTAL HEALTH COURT—22ND JUDICIAL CIRCUIT, http://www.co.mchenry.il.us/departments/courtadmin/Pages/MHealthCourtHome.aspx (last visited Jan. 8, 2012) ("The goals of the MHC program are to enhance public safety, reduce recidivism, improve participants' mental health and promote self-sufficiency by offering cost effective [sic] alternatives to incarceration and hospitalization by connecting the defendants with community treatment services.").

320. *See* DOUGLAS LIPTON, ROBERT MARTINSON & JUDITH WILKS, THE EFFECTIVENESS OF CORRECTIONAL TREATMENT: A SURVEY OF TREATMENT EVALUATION STUDIES 12–14 (1975) (listing a number of dependent variables used to measure the effectiveness of rehabilitation, including recidivism, vocational adjustment, educational achievement, drug and alcohol addiction abatement, personality and attitude change, and community adjustment); ROTMAN, *supra* note 41, at 121–22; *Introduction*, *in* A READER ON PUNISHMENT 1, 24 (R.A. Duff & David Garland eds., 1994); *id.* ("We need to ask not just 'what works' to bring about for instance a reduction in the frequency of future offending, but also what we should count as 'working'. Should the penal system be concerned only with reducing future offending, or also with other kinds of improvement in offenders' conduct and circumstances? Should attention focus on individual offenders, and the attempt to change their behavior; or should more attention be paid to the social and economic circumstances which encourage crime, and upon which remedial efforts are too rarely focused?"); *see also* Interview with Stephen V. Manley, Judge, Mental Health Treatment Court, Santa Clara Cnty., Cal., Ctr. for Court Innovation (Jan. 2005), *available at* http://www.courtinnovation.org/research/stephen-v-manley-judge-adult-criminal-drug-court-mental-health-treatment-court-and-family-d?url=research%2F39%2Finterview&mode=39&type=interview ("Success is small things: clients who are able to function, who learn how to take the bus, who learn to find a place to live that is somewhat permanent, who are able to get social security or their disability reinstated. I have different expectations and goals for every group of clients.").

321. *See* ROTMAN, *supra* note 41, at 122 ("Enhancing the human potentialities of the offender is a specific feature of rehabilitative action, which is independent of its ultimately measurable outcome.").

322. For a summary of evidence collected to date on measures of treatment compliance and improved mental health, see ALMQUIST & DODD, *supra* note 4, at 25.

Finally, theories unrelated to rehabilitation might justify mental health courts. For instance, one could extrapolate from the Supreme Court's 1997 decision of *Kansas v. Hendricks*[323] an argument that a separate system of justice is warranted for offenders with mental illnesses because of their diminished ability to control their behavior.[324] Alternatively, one could argue that mental health courts serve as a means to eliminate the incidental suffering that offenders with mental illnesses experience when incarcerated,[325] and that the elimination of that suffering is mandated by theories of proportionate punishment.[326] In addition, it is possible (though perhaps unlikely) that mental health courts could have specific or general deterrent effects and could be supported by a theory of deterrence.[327]

The viability of many of these theories, like the narrow form of therapeutic rehabilitation embraced by mental health courts, depends on the actual functioning and effect of mental health courts. Currently, very little data exists on the extent to which mental health courts are effective and why. To this end, I join the chorus of governmental bodies and commentators urging the collection of data on the extent to which mental health courts are successful in reducing recidivism and improving the psychological health and well-being of participants, as well as data on the eligibility requirements, procedures, and options of assistance offered by courts around the country.[328] Data is essential both to assess the practical

323. 521 U.S. 346 (1997).

324. *Cf.* Christopher Slobogin & Mark R. Fondacaro, *Juvenile Justice: The Fourth Option*, 95 IOWA L. REV. 1 (2009) (arguing that *Hendricks* provides a basis for juvenile courts aimed at preventing criminal behavior). I am grateful to Professor Christopher Slobogin for sharing this insight.

325. *See, e.g.*, Nancy Wolff & Jing Shi, *Victimization and Feelings of Safety Among Male and Female Inmates with Behavioural Health Problems*, 20(1) J. FORENSIC PSYCHIATRY & PSYCHOL., Supplement 1, S56 (2009); Nancy Wolff, Cynthia Blitz & Jing Shi, *Rates of Sexual Victimization in Prison for Inmates with and Without Mental Disorders*, 58(8) PSYCHIATRIC SERVICES 1087 (2007); HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS (2003), http://www.hrw.org/reports/2003/usa1003/.

326. *See* John Bronsteen, Christopher Buccafusco & Jonathan Masur, *Happiness and Punishment*, 76 U. CHI. L. REV. 1037 (2009) (arguing that sentencing decisions should take into account findings about human adaptability to punishment to achieve actual proportionality in punishment severity); E. Lea Johnston, *Mental Illness, Suffering, and the Distribution of Deserved Punishment* (draft on file with author); Adam J. Kolber, *The Comparative Nature of Punishment*, 89 B.U. L. REV. 1565 (2009) (arguing that the severity of punishment should be measured by deviance from subjects' baseline states); Adam J. Kolber, *The Subjective Experience of Punishment*, 109 COLUM. L. REV. 182 (2009) (arguing that a successful justification of punishment must take into account offenders' subjective experiences and that judges should consider actual or anticipated punishment experience at sentencing). *But see* David Gray, *Punishment as Suffering*, 63 VAND. L. REV. 1619 (2010) (responding to these arguments); Dan Markel & Chad Flanders, *Bentham on Stilts: The Bare Relevance of Subjectivity to Retributive Justice*, 98 CALIF. L. REV. 907 (2010) (same).

327. *See supra* notes 141–46 and accompanying text. Whether mental health courts deter crime is an open empirical question.

328. *See, e.g.*, ALMQUIST & DODD, *supra* note 4, at 21, 29; Lurigio & Snowden, *supra* note 12, at

benefit and cost-effectiveness of these courts and to identify best practices for emulation.

CONCLUSION

The decision to create a separate system of justice for a historically stigmatized population should be justified by a coherent and compelling theory of punishment or social welfare. This Article examines the efficacy of the two theories proposed by mental health court advocates—therapeutic jurisprudence and a narrow form of therapeutic rehabilitation—and finds neither adequate to justify mental health courts as currently constituted. Therapeutic jurisprudence cannot justify the existence of mental health courts because, by definition, it is unable to resolve normative conflict. Therapeutic rehabilitation, on the other hand, fails to provide a coherent theory to support mental health courts because empirical evidence belies its central assumptions about the predictive link between mental illness and criminal behavior.

While this Article contends that the two theories identified by mental health court advocates are inadequate to justify the current incarnation of mental health courts, other theories may fill the void. Some theories may justify the courts as they currently exist; others may support the diversion and treatment of a limited cohort of offenders with mental illnesses; still others may support treating a broader population if the purported ends of the courts were broadened beyond decreasing specific recidivism of offenders with mental illnesses. The viability of each of these theories depends on empirical data on the effect and workings of mental health courts. These courts potentially hold great promise, but more analysis is needed to examine whether a coherent and compelling theory can be offered to justify their existence.

213–14; Erickson et al., *supra* note 10, at 342 ("Further studies would elucidate the similarities and differences among these courts, assess the efficacy of different approaches, and allow for more broad-based conclusions regarding the benefits and areas of concern that mental health courts bring to the community.").