# North Carolina's Mental Health Court

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- *A forty-four-year-old male African-American employed as an electrician appeared in court on charges of misdemeanor larceny, intoxication, and disruptive behavior. He had been "self-medicating" with alcohol to ease the symptoms of "bipolar disorder" (formerly called manic-depressive disorder). Under court supervision he began individual therapy and was put on psychiatric medication. Soon, however, he had undesirable side effects. He stopped taking the medication and again began to self-medicate with alcohol. After warnings and reprimands, he explained that the prescribed drugs made him sleepy, and that affected his work performance. He did not want to apply for disability income, as court personnel had suggested, because he did not believe in getting money for free. The judge encouraged him to work with his physician to get the medications adjusted. Over the next few months, he did so, began to comply with the regimen, and visibly changed from a dirty, disheveled man to a clean, neat person in control of his life. At "graduation" he was doing well and buying part*

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*of the electrical repair business where he worked.*

- *A twenty-four-year-old white male appeared in court on charges of second-degree trespass and misdemeanor larceny. He was nervous, jittery, and ashamed, and barely spoke. The onset of bipolar disorder had caused him to drop out of college and live in a disorganized manner. Under court monitoring he started treatment with a private physician and began to improve. After a few months, his insurance ran out, and he could not afford payment. He was put on the waiting list for public treatment. He stayed on the list for three months before obtaining services. Nonetheless, he continued to improve and enrolled at a local university. At "graduation" from the court, he stood straight, smiled, and said he was happy about getting his life together. The judge said, "This is thrilling. You have turned your life around."*

These unusual scenarios played out, not in a traditional criminal court, but in a relatively new type of criminal court, the mental health court. It has four defining features: (1) a separate docket for defendants with mental illness who volunteer to be under its jurisdiction, (2) handling by a designated judge, (3) a nonadversarial, team approach, and (4) a primary goal of reducing offenses by providing treatment for defendants rather than punishment.[1] This article describes North Carolina's one mental health court, located in Orange County.[2] The article begins with a discussion of trends in the larger society that led to the establishment of mental health courts throughout the nation. It then explains the organization of the Orange County mental health court, depicts its operation, and presents data from 2003 on the characteristics, the offenses, and the outcomes of defendants processed in the court. It ends with preliminary conclusions about the court's effectiveness in reducing offenses.

## A National Problem

In the 1960s, state mental hospitals throughout the United States began to relinquish their earlier role of providing long-term placement for people with mental illness. Observers soon noted an accompanying criminalization—that is, arrest and incarceration—of this population that used to be hospitalized. In recent years, on any given day, some metropolitan jails have housed more people with mental illness than any state mental hospital has.[3] A recent survey by the U.S. Department of Justice reported that American jails and prisons housed 283,800 people with mental illness in 1998. This number represented 16.2 percent of state prison inmates, 7.4 percent of federal prison inmates, and 16.3 percent of those housed in local jails.[4]

The offenses for which people with mental illness are arrested are mainly minor. They are seldom violent, despite the media's sensationalizing of violent attacks on strangers by severely disordered people. Such attacks are rare, for most people with mental illness are not violent. The violence that some people with mental illness do is mostly fighting with people they know, and it tends to be slapping, pushing, kicking, and hitting (often in response to others' slaps, pushes, kicks, and hits).

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Rather than attacks that kill or inflict major injury, most of the offenses for which people with mental illness are charged are either nuisance or survival crimes, such as trespassing and stealing small items or small amounts of money.[5] A second large group of offenses relates to misuse of alcohol and illegal drugs by offenders who also have substance abuse disorders.[6]

Although the media depict the people with mental disorders who are involved in the sensationalized attacks as being driven to crime by psychotic symptoms such as voices and compulsions, only a small proportion of the offenses of those arrested are propelled by their illness. Instead, the effect of severe mental illness is mostly indirect, through the disadvantages that it produces in the ability to function and cope with difficult situations.[7]

Mental health treatment and services can counteract those disadvantages by improving functioning and coping. Yet people with mental illness who are arrested either have never been in treatment, do not stay in treatment, or tend not to adhere to a regimen of medication and psychosocial therapy.[8] Many people with serious mental illness who are arrested find themselves stuck in a revolving door, bouncing in and out of jails, homelessness, and hospitals.[9] Without intervention to bring adequate treatment and services, people caught in this process continue to offend. In addition, the process leads to exacerbation of their symptoms, hopelessness, humiliation, and suffering.

Presumably, mandating mental health treatment would address the root of the problem of offenders who are mentally ill, which is lack of treatment, noncompliance with treatment, substance abuse, and lack of essential services. Thus it would lead to fewer offenses and fewer arrests. Unfortunately such intervention does not occur very often.

Law enforcement officers have long acted as street-corner psychiatrists, giving advice, cooling tempers, recommending helping sources, and taking people with mental illness to psychiatric emergency centers. More recently a number of police departments have initiated formal programs to divert people with mental illness out of the criminal justice system and into treatment.[10] Also, informal court practices have existed whereby defense counsel plea-bargained for dismissal of charges against clients who were mentally disordered, on the condition that the clients obtain in- or outpatient treatment.[11] Still, too many people with mental illness who have committed offenses have not been diverted to treatment or, if diverted, have not continued with treatment, so their

condition does not change and they continue to commit offenses.

Relatively recently, various jurisdictions have developed a number of new programs for offenders with special problems, not just mental illness. These programs divert offenders from the criminal justice system into treatment and attempt to ensure that they continue with treatment and other support services for some minimum time. Most relevant to mental health courts are drug courts, established to fight the drug epidemic's crime wave. Because incarceration was not stopping repeat offenses of use and procurement by drug users, these courts were created to address the root problem—illegal drug use—with intensive supervision and treatment programs. Using the full weight of all intervenors (that is, judges, probation officers, correctional and law enforcement personnel, prosecutors, defense counsel, treatment specialists, and other social service personnel), these programs attempt to force offenders to abstain from drug use and alter their behavior, or suffer consequences.[12]

Because of the widely acclaimed success of drug courts, in the late 1990s, a number of jurisdictions instituted mental health courts based on the drug court model.[13] Each is established as a criminal court with a separate docket for people with mental illness. The aim is to divert such defendants from jail or prison into community mental health treatment and thereby to reduce repeat offenses, jail and prison crowding, court workload, and criminal justice costs.

Unlike traditional criminal courts, the mental health courts are voluntary, with defendants agreeing to follow a treatment regimen and to be monitored by the court in exchange for dismissal of charges. Also, they are nonadversarial, using a team approach. That is, defense and prosecuting attorneys do not dispute guilt or innocence and steps to a verdict. Rather, they work as part of a team with judges, criminal justice personnel, mental health liaisons, and other providers to find the best treatment and services, and to provide encouragement and sanctions that will address the underlying causes of each defendant's behavior while protecting the public.[14] There now are more than 100 mental health courts across the country. Only one is in North Carolina, in Orange County.

## Establishment and Organization of Orange County's Mental Health Court

The mental health court in Orange County was launched in spring 2000 in response to advocacy by the local chapter of the National Association for Mental Illness. Under the leadership of Chief District Court Judge Joseph Buckner, a collaborative effort unfolded to commit local court personnel, treatment providers, and law enforcement officers to a coordinated response to criminal cases in which mental health problems appeared to be the primary contributors to the offenses. The organizers named the mental health court Community Resource Court (CRC) to emphasize the concerted effort of multiple community providers, the importance of accessing all necessary services (medication, psychosocial therapy, prevention of substance abuse, anger management, housing, vocational education, employment, transportation, temporary hospitalization, etc.), and to avoid additional stigma.

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To provide oversight and assist in problem solving, Judge Buckner's office established the CRC Coordinating Committee. It consists of representatives of the district attorney's office, the public defender's office, the local criminal defense bar, community corrections, pretrial services, the police department's crisis unit, the county sheriff's office, the community mental health center, the University of North Carolina Schools of Medicine and Social Work, and the local chapter of the National Association for Mental Illness. Designated representatives of each group have a particular interest in or knowledge of people with mental illness who come into contact with the criminal justice system.

To be eligible to enter the CRC, offenders must have a diagnosis of mental illness, a "dual diagnosis" of mental illness and substance abuse, or a history of treatment for mental illness. Defendants with severe and persistent mental illness who would be appropriate for long-term case management services by the community mental health center receive priority. They must be agreeable to treatment and to monthly monitoring by the court for at least six consecutive months. Also, the assistant district attorney must find that they do not raise concerns about public safety. This scrutiny by the assistant district attorney is required because, unlike most early mental health courts, which accepted only defendants who were charged with misdemeanors, the CRC accepts defendants who are charged with felonies and even violent offenses.[15] In the latter case, victims must agree to the transfer of the defendants from traditional criminal court to the CRC.

The amount and the type of treatment vary depending on each defendant's needs and the availability of services. Availability is a problem, however, for the CRC as well as for most mental health courts. Needed services are scarce. Currently in Orange County, there are waiting lists for treatment groups and individual therapists. Of particular relevance to CRC defendants are the waiting lists for groups on anger management, outpatient substance abuse treatment, and treatment of dual diagnoses.

Many professionals are part of the CRC team that seeks to develop and implement an individually based treatment plan for each offender: a judge (one of two designated judges who rotate through the CRC schedule), two designated assistant district attorneys, a designated member of the public defender's office, two private attorneys who agreed to be appointed in CRC cases, two probation officers from the Community Corrections Office, community mental health treatment providers as needed, two community mental health liaison/clinicians, a CRC mental

health project coordinator, and the court administrator. Privately retained attorneys, who may refer cases, sit as team members for their individual cases, as do representatives of various community agencies, such as Vocational Rehabilitation and the Department of Social Services when their clients are in the CRC, and the Chapel Hill Police Department. Team members understand that relapse is common during treatment, and they adjust their expectations. The collaborative effort ensures that the mandates of the criminal justice and judicial systems are met, as well as defendants' mental health needs.

Team members believe that the team approach is essential. One member remarked, "I can't see how [the CRC] would work without [the team approach]. We need the opportunity to discuss and think about the cases." Another echoed that sentiment, saying, "Even though the judge is the ultimate decision maker, it is decided by consensus. A consensus approach gives us the opportunity to make sound judgments, which are improved by the types of people we bring into the discussion." A judge said, "I am able to make better decisions and am able to justify my position if I am ever challenged."[16]

## Entry to Mental Health Court

Referrals to the CRC come mainly from court officials (the district attorney, a public defender, law enforcement personnel, judges, and personnel in pretrial services). However, referrals also may come from family members, social workers, treatment providers, or private citizens. Referrals are screened by an assistant district attorney, often on a traditional criminal court date, when law enforcement personnel and prosecution witnesses can be interviewed. For eligible defendants who are indigent, the court appoints a CRC team attorney. Eligible defendants then are referred to the next CRC session (once a month in Hillsborough for the northern part of the county and once a month in Chapel Hill for the southern part), at which they are presented to the CRC team. Unlike defendants in other mental health courts, defendants who are potential participants in the Orange County mental health court are rarely in jail at the time of referral because Orange County judges regularly screen the jail population for offenders with minor charges who cannot make bail, and release them.

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Most commonly, a defendant's counsel explains the operation of the CRC and the option to cooperate with treatment in exchange for dismissal of charges or a probationary sentence. In the first CRC hearing, the judge asks the defendant to meet with a CRC clinician, who conducts the clinical screening and makes an initial assessment for needed services. At this time the clinician also explains the CRC again and obtains signed consent indicating the defendant's voluntary participation.

## Team Meetings

Before each monthly court session, the CRC team meets to discuss every case on the docket (typically 40–60 cases). Often, court personnel know defendants from previous encounters with the criminal law. Defendants' counsel and the assistant district attorneys briefly present new cases, focusing on the charges and the events surrounding them, known psychiatric history, family and housing problems, and other pertinent information. All this information helps the team understand defendants' situations in order to assess their suitability for inclu-sion in the CRC and to prepare for monitoring.

Also at this monthly meeting of the team, a CRC clinician reviews existing cases, focusing on defendants' progress or lack thereof, behavioral changes, attendance at and cooperation in treatment, fulfillment of any legal obligations (for example, payment of court fines or compensation to victims), and needed modifications in the treatment plan.

Team members then recommend what the judge might do with the defendant in open court to ensure compliance (for example, offer praise and encouragement, issue a warning or a reprimand, or apply sanctions). In the case of continued noncompliance or new charges, the team decides whether to attempt to reengage the offender in treatment, send him or her to jail for a few days, or transfer the case back to regular criminal court. Although team members are ready to use punishment to enforce compliance, they anticipate failures among these offenders and stand ready to help them try again. Seeing the court as a partner in therapy, the team uses it to maximize participants' motivation to make positive changes.

There is no established number of failures after which a defendant is sent back to regular criminal court. The team makes such a determination on a case-by-case basis. One team member stated, "It depends on what I hear, what the underlying diagnosis is, and the efforts being made . . . All get one chance. After that, it depends on the person and the situation if they get a second chance." Both an attorney and a judge said that a defendant's level of effort and repeat offenses are the key issues to consider in determining failure. Another attorney agreed and added that the team also needs "to consider 'Is what we are doing here working?' because the only thing prison means is punishment and segregation." In general, team members think a defendant should be deemed a failure after two to three months of noncompliance.[17]

Privately retained attorneys, who now refer cases to the CRC more readily than they did in the court's first year, have clients who tend to obtain services through private sources rather than the community mental health center. The CRC allows the private attorneys to monitor their own cases, but they must report to the court and provide written proof from treatment providers about cooperation and compliance. Private attorneys attend team meetings only for discussion of their clients. The requirement for consistent compliance over six months and the procedures for determining sanctions apply.

## Court Hearings

At the monthly court sessions in the two venues, an assistant district attorney calls the cases on the docket, and defendants approach the bench with their attorneys, as in traditional criminal court. There the similarities end. Proceedings are informal, without swearing in of witnesses, examination and cross-examination of witnesses, or formal arguments by prosecutors and defense attorneys. The judge engages the defendant and delivers a clear, concise message about behavior and treatment expectations, emphasizing the defendant's responsibility in the agreement to participate.

In court the judge speaks directly to each defendant and to any family, friends, or treatment team members who may accompany him or her. Defendants have the opportunity to speak, as do those who stand with them. Often the judge encourages them to speak, by asking direct questions about appropriate behavior, well-being, compliance, and progress in accomplishing goals. Court dialogue minimizes use of psychiatric labels, focusing instead on behavior, cooperation with treatment providers, services, and improvements in quality of life. To those who are complying and making progress, the judge offers compliments and encouragement. To those who are not complying, the judge may express disappointment, ask about reasons for noncompliance, attempt to provide motivation, recognize their strong points, offer support, or give a stern lecture about what is expected and what are the consequences of noncompliance, threatening jail or a return to traditional criminal court.

After six months, if a defendant has experienced periods of noncompliance or shown indications of ongoing instability, the CRC continues court monitoring for a period. However, if a defendant has had continuous and consistent compliance with treatment recommendations and has avoided repeat offenses, he or she graduates from the court, and the case is either dismissed or otherwise disposed of with a positive outcome. For example, the defendant may receive a "prayer for judgment continued" (a disposition of his case by indefinite postponement of his sentencing date, with the result that for most purposes he is not "convicted"), or the judge may terminate his or her probation, considering it successful.[18] At graduation, in open court, the judge gives the defendant a certificate of completion, extends congratulations, and encourages the defendant to stay connected to the supports that he or she has developed in the past months. The team members applaud and are joined by others in the courtroom as each defendant receives the certificate and congratulations. Graduating defendants commonly smile in response and frequently express pleasure at what the CRC has helped them accomplish.

Table 1. **Comparison of CRC Defendants and People Arrested in North Carolina, 2003**

| | CRC | | North Carolina | |
|---|---|---|---|---|
| | No. | % | No. | % |
| Total | 92 | 100.0 | 462,718 | 100.0 |
| Gender | | | | |
| Male | 62 | 67.4 | 347,767 | 75.0 |
| Female | 30 | 32.6 | 114,951 | 25.0 |
| Race | | | | |
| White | 52 | 56.5 | 247,453 | 53.5 |
| African-American | 36 | 39.1 | 205,773 | 44.5 |
| Other | 4 | 4.3 | 9,492 | 2.0 |
| Age* | | | | |
| 25 and under | 21 | 24.7 | 145,981 | 31.8 |
| 26–35 | 17 | 20.0 | 144,247 | 31.1 |
| 36–45 | 25 | 29.4 | 110,509 | 23.9 |
| 46–55 | 15 | 17.7 | 45,579 | 10.3 |
| 56 and up | 7 | 8.2 | 14,502 | 3.1 |

*Source:* CRC numbers are from Community Resource Court, Orange County, *2003 CRC Stats* (Hillsborough, N.C.: the Court, n.d.). North Carolina arrests are from State Bureau of Investigation, N.C. Dep't of Justice, *Summary-Based Reporting: Adults 18 and Over, Arrests by Age and Sex, 2003* and *Arrests for Adult 18 and Over by Race, 2003* (Sept. 13, 2004), available at http://sbi2.jus.staate.nc.us/crp/public/Default.htm. Click on 2003 under North Carolina Crime Statistics, then on Arrests and Clearances, then on Adult Arrests by Offense by Age and Sex, 2003, and Adult Arrests by Offense by Race, 2003.

*Age groups are for CRC defendants; those for N.C. arrestees begin and end one year younger. Numbers under age do not total 92 and 462,718 because age was missing for some people.

## One-Year Review

In 2003 the CRC processed and closed the cases of ninety-two people.[19] About two-thirds were male (67.4 percent). A little more than half were white (56.5 percent), about two-fifths were black (39.1 percent), and the remainder were of another racial group (4.3 percent) (see Table 1). Defendants tended to be forty-five years of age or younger.

This CRC caseload had proportionately fewer males and fewer blacks than there were among those arrested in North Carolina generally (75.0 percent and 44.5 percent, respectively). The age distribution of those handled in the CRC was slightly older than that of those arrested in North Carolina, with more than half being older than thirty-five while more than three-fifths of all North Carolina offenders were younger than thirty-five.

As is true of State Bureau of Investigation (SBI) data on all North Carolina offenses, most offenses by CRC defendants were misdemeanors. (For a list of the charges, see Table 2.) In fact, among CRC defendants, misdemeanors constituted the overwhelming majority of offenses (88.6 percent). Of these, theft was the largest category, followed by alcohol and drug violations. As with other U.S. and Canadian populations of offenders with mental illness, the majority of offenses fell into the broad categories of nuisance, survival (much of the theft), and substance-abuse related.[20] Assaults in the misdemeanor category tended to be physical resistance of arrest.

Only 11.4 percent of the offenses of CRC defendants were felonies. Of these,

just four cases were aggravated assault. Thus, by the official FBI and SBI definition of violent crime, which includes only murder, rape, robbery, and aggravated assault, CRC violent offenses constituted 2.4 percent of the total, about half the rate of violent offenses among North Carolina offenders in the same year (4.7 percent).

Of the ninety-two defendants whose cases were processed and closed in 2003, a little more than half graduated (54.4 percent). That is, they appeared for scheduled court reviews, cooperated with treatment providers, completed their treatment regimens, improved in functioning, avoided repeat offenses, and had charges dropped and cases dismissed. Although some of these defendants were noncompliant early in their CRC participation, the team's efforts to reengage them brought about cooperation and a higher level of functioning. All graduates appeared to be on the road to a more stable life, free of repeat offenses, and thus can be considered successes of the CRC.

Time under CRC supervision for these graduates tended to be longer than the minimum of six months: 60 percent were supervised for 7–12 months, and 6 percent for more than a year. Only 34 percent graduated in six months. Noncompliance, relapses, system delays in accessing needed services, and life circumstances that brought delays in treatment were factors that extended the time under supervision. The average for all graduates was 7.45 months.

Of the 42 defendants who did not graduate and had their cases returned to traditional criminal court, 15 opted out of the CRC. That is, they decided not to participate after having the CRC explained and observing the court process. Ten others agreed to participate in the CRC but never made the first treatment appointment. Another 17 engaged in treatment but did not comply, by either persistently not making scheduled treatment appointments, not taking prescribed medications, not appearing for scheduled court review, or engaging in proscribed behaviors such as substance abuse. This last group of nongraduates spent less time under court supervision than graduates did, averaging 6.25 months. Nine failed to cooperate with the CRC and were sent back to traditional criminal court within the first six months. However, 7 remained under CRC supervision for 7–12 months, and 1 remained under CRC supervision for more than a year before having his case returned to traditional criminal court.

At the end of 2003, besides the 92 closed cases, 110 people had not completed their treatment plan and were still being monitored by the court.

## Discussion and Conclusions

What conclusions can be drawn at this time on the effectiveness of North Carolina's one mental health court? The 54.4 percent graduation rate suggests that the CRC has had little effect because the rate is barely above chance (50.0 percent). However, such a conclusion ignores the fact that offenders who are mentally ill tend to continue committing offenses and not receive treatment. Getting treatment for more than half of them and stopping their repeat offending are not small accomplishments. Thus the 54.4 percent graduation rate also suggests that the CRC has been effective, given that more than half of these offenders received much needed treatment and services and did not offend again while they were under supervision.

The CRC can be gauged even more effective if the fifteen defendants who were referred to the court but opted out are excluded from the calculation. In that case, looking only at the defendants who volunteered to work with the CRC, the graduation rate rises to 64.9 percent, which is an impressive proportion of this population.

Will this effectiveness continue beyond graduation? The answer will have to wait until completion of a study that is examining one-year outcomes of the CRC.

However, two signs suggest that the CRC experience will have a long-term positive impact on the lives of its graduates. First, for many of the CRC graduates, treatment has not stopped with the termination of court monitoring. The court encourages graduates to continue to work with the supports that they found helpful during their time in the CRC, and CRC clinicians report that they are staying in contact with a number of the graduates. Second, repeat offenses by graduates seem to be declining. The two judges and the two assistant district attorneys working with the court report that many CRC graduates who used to be repeat offenders are not reappearing on the criminal court docket. These observations are encouraging.

Only two empirical studies of the effectiveness of mental health courts in producing positive outcomes have been published thus far. One followed defendants for nine months after mental health court referral; the other, for six and twelve months. Both studies found that mental health court defendants had less criminal activity at the follow-up than they did before, and that they also improved in functioning during the follow-up period.[21]

Table 2. **Offenses Charged against Ninety-two CRC Defendants, 2003**

| Misdemeanors | | Felonies | |
|---|---|---|---|
| Assault | 16 | Assault | 4 |
| Threat | 16 | Theft | 13 |
| Weapons | 3 | Drugs | 1 |
| Theft | 43 | Other | 1 |
| Alcohol/drugs | 32 | | |
| Driving | 10 | | |
| Nuisance | 15 | | |
| Other | 13 | | |
| **Total** | **148** | | **19** |

*Source:* Community Resource Court, Orange County, *2003 CRC Stats* (Hillsborough, N.C.: the Court, n.d.).

*Note:* Offenses total more than ninety-two because defendants may have more than one charge with an arrest.

The one-year outcome study of Orange County's CRC will evaluate effectiveness according to two major comparisons: (1) CRC defendants' number of arrests, severity of arrests, and number of incarcerations one year after entering the CRC versus their number and severity of arrests and number of incarcerations one year before entering the CRC; and (2) CRC defendants' number and severity of arrests and number of incarcerations versus those of a sample of defendants who were in traditional criminal court a year before the CRC was begun, who would have been referred to the CRC had it existed. Data also will be collected on the functioning, social support, employment, and continuing contact with mental health providers of a subsample of the CRC defendants. The study's results should be available by the end of 2005.[22]

## Notes

1. JOHN S. GOLDKAMP & CHERYL IRONS-GUYNN, EMERGING JUDICIAL STRATEGIES FOR THE MENTALLY ILL IN THE CRIMINAL CASELOAD: MENTAL HEALTH COURTS IN FORT LAUDERDALE, SEATTLE, SAN BERNARDINO, AND ANCHORAGE (Washington, D.C.: Bureau of Justice Assistance, Crime and Justice Institute, 2000).

2. Although Orange County is part of a two-county judicial district and the community mental health program includes those two counties plus one more, the organizers established the mental health court only in Orange County. After the completion of this manuscript, however, the mental health court team created another mental health court, in Pittsboro, the seat of the second county (Chatham) in the judicial district. Two other North Carolina counties, Buncombe and Mecklenburg, are planning mental health courts.

3. E. Fuller Torrey, *Jails and Prisons: America's New Mental Hospitals*, 85 AMERICAN JOURNAL OF PUBLIC HEALTH 1611 (1995).

4. PAULA M. DITTON, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS (Bureau of Justice Special Report NCJ 174463, Washington, D.C.: U.S. Department of Justice, 1999).

5. Robin S. Engel & Eric Silver, *Policing Mentally Disordered Suspects: A Reexamination of the Criminalization Hypothesis*, 39 CRIMINOLOGY 225 (2001); Virginia A. Hiday, *Mental Illness and the Criminal Justice System*, in A HANDBOOK FOR THE STUDY OF MENTAL HEALTH 508 (Allan Horwitz & Teresa Scheid eds., Cambridge, Eng.: Cambridge Univ. Press, 1999); Richard Lamb & Linda Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483 (1998); Jeffrey R. Swanson et al., *Can Involuntary Outpatient Commitment Reduce Arrests among Persons with Severe Mental Illness?* 28 CRIMINAL JUSTICE AND BEHAVIOR 156 (2001); Linda A. Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 AMERICAN PSYCHOLOGIST 794 (1984).

6. Swanson et al., *Can Involuntary Outpatient Commitment Reduce Arrests?* Linda A. Teplin et al., *The Prevalence of Psychiatric Disorder among Incarcerated Women: Pretrial Jail Detainees*, 53 ARCHIVES OF GENERAL PSYCHIATRY 505 (1996).

7. James Bonta et al., *The Prediction of Criminal and Violent Recidivism among Mentally Disordered Offenders: A Meta-Analysis*, 123 PSYCHOLOGICAL BULLETIN 123 (1998); Jeffrey Draine et al., *Role of Social Disadvantage in Crime, Joblessness, and Homelessness among Persons with Serious Mental Illness*, 53 PSYCHIATRIC SERVICES 565 (2002).

8. Randy Borum et al., *Substance Abuse, Violent Behavior, and Police Encounters among Persons with Severe Mental Disorder*, 13 JOURNAL OF CONTEMPORARY CRIMINAL JUSTICE 236 (1997); Hiday, *Mental Illness and the Criminal Justice System*; Swanson et al., *Can Involuntary Outpatient Commitment Reduce Arrests?*

9. Hiday, *Mental Illness and the Criminal Justice System*; Lamb & Weinberger, *Persons with Severe Mental Illness in Jails and Prisons*.

10. Henry J. Steadman et al., *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, 51 PSYCHIATRIC SERVICES 645 (2000).

11. Hiday, *Mental Illness and the Criminal Justice System*; Teplin, *Criminalizing Mental Disorder*.

12. John Petrila et al., *Preliminary Observations from an Evaluation of the Broward County Mental Health Court*, 37 COURT REVIEW 14 (2001). The first drug court was established in 1989 in Dade County (Miami), Florida. In the following decade, more than 350 drug courts came into operation. North Carolina began in 1996 with five pilot drug courts for adults. Amy Craddock, *North Carolina Drug Treatment Court Evaluation: Final Report* (Raleigh: North Carolina Court System, 2002), available at www.nccourts.org/Citizens/CPrograms/DTC/Documents/ncdtcreport2002.pdf. As of 2002, thirteen judicial districts operated sixteen adult drug courts. In addition, five judicial districts were operating juvenile drug courts; and two, family drug courts. North Carolina Court System, *Drug Treatment Court* (last updated Aug. 4, 2003), available at www.nccourts.org/Citizens/CPrograms/DTC/.

13. Most acclamations of drug courts' success have been nonempirical, based on opinion and anecdotes. Recent data from well-designed studies indicate declines in recidivism among graduates of drug courts. Craddock, *North Carolina Drug Treatment Court Evaluation*; Roger H. Peters & Mary R. Murrin, *Effectiveness of Treatment-Based Drug Courts in Reducing Criminal Recidivism*, 27 CRIMINAL JUSTICE AND BEHAVIOR 72 (2000).

14. GOLDKAMP & IRONS-GUYNN, EMERGING JUDICIAL STRATEGIES; Petrila et al., *Preliminary Observations*; David Rottman & Pamela Casey, *Therapeutic Jurisprudence and the Emergence of Problem-Solving Courts*, NATIONAL INSTITUTE OF JUSTICE JOURNAL (July 1999), available at www.ncjrs.org/txtfiles1/jr000240.txt.; BRUCE J. WINICK & DAVID B. WEXLER, JUDGING IN A THERAPEUTIC KEY: THERAPEUTIC JURISPRUDENCE AND THE COURTS (Durham, N.C.: Carolina Academic Press, 2003).

15. Allison D. Redlich et al., *The Second Generation of Mental Health Courts*, PSYCHOLOGY, PUBLIC POLICY, AND LAW (forthcoming).

16. Interviews by Marlee E. Moore with various team members, Hillsborough and Chapel Hill, N.C. (fall 2003).

17. *Id.*

18. Some offenders with mental illness who are tried, found guilty, and sentenced to probation in traditional criminal court are sent to the CRC for additional supervision. For these, graduation is accompanied by termination of their probation as successful, rather than dismissal of their case.

19. One cannot compare the number of cases processed by the CRC with those processed by other mental health courts because most of the courts with published data are in large metropolitan areas with much larger populations and more homeless people, and they meet more often (weekly or even several days a week).

20. Nuisance, survival, and substance-abuse-related crimes are not SBI categories. They are descriptive terms of types of behavior that researchers use to categorize misdemeanors. The last two suggest causation. For example, "substance-abuse-related crimes" means crimes that occur because of the abuse, such as fighting (assault), drunken driving (DWI), and stealing to support a habit (robbery and burglary).

21. Merith Cosden et al., *Evaluation of a Mental Health Treatment Court with Assertive Community Treatment*, 26 INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY 415 (2003); Eric Trupin & Henry Richards, *Seattle's Mental Health Courts: Early Indicators of Effectiveness,* 26 INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY 33 (2003).

22. To get on a mailing list for the study's results, contact Hiday, ginnie_aldige@ncsu.edu, or Moore, mgurrera@mindspring.com.