Drug Courts and Diversion

In this section, we review the available empirical evidence on the four factors identified above—capacity constraints, eligibility criteria, legal consequences, and sentencing laws—that limit the potential for drug courts to conserve aggregate prison and jail space by serving as a true alternative to incarceration. ... Nationally, Bhati, Roman, and Chalfin (2008) estimated that there were 55,365 adult drug court participants in 2005 relative to the 1.47 million arrestees who were at risk of drug abuse or dependence, or about 27 at-risk arrestees per drug court slot. ...

**TABLE 4 Estimating the Size of the At-Risk Population Excluded from Drug Courts for Various Reasons**

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2004</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineligible due to restrictive entry criteria Joint probability</td>
<td>233,654</td>
<td>90.5</td>
<td>94,447</td>
</tr>
<tr>
<td>Revoked for program failure</td>
<td>22,671</td>
<td>8.8</td>
<td>14,384</td>
</tr>
<tr>
<td>Failed drug diversion program</td>
<td>15,141</td>
<td>5.9</td>
<td>37,984</td>
</tr>
<tr>
<td>Strickly sentencing laws</td>
<td>133,644</td>
<td>30.9</td>
<td>37,055</td>
</tr>
<tr>
<td>Minimum probability</td>
<td>222,027</td>
<td>86.0</td>
<td>205,718</td>
</tr>
</tbody>
</table>

*Note: *2004 *2*Combined *2*Jail Cohort *2*Prison Cohort *2*Cohort N % N % N %

**Total at-risk population**

258,192 100 259,549 100 517,741 100

Panel A Ineligible due to restrictive entry criteria

Joint probability a 233,654 90.5

*Minimum probability a 222,027 86.0 205,718 79.3 427,745 82.6 Panel B Revoked for program failure 28,695 11.1 8,351 3.2 37,046 7.2 Failed drug diversion program 8,244 3.2 -- -- 8,244 1.6 Failed probation drug treatment 22,504 8.7 8,351 3.2 30,855 6.0 Panel C Subject to overriding sentencing 26,128 10.1 133,644 30.9 laws Mandatory/presumptive -- -- 94,447 36.4 94,447 18.2 sentence Firearm sentence 4,231 1.6 13,139 5.1 17,370 3.4 enhancement Habitual offender 15,141 5.9 37,984 14.6 53,125 10.3 enhancement Drug law 51.5 159,772 30.9 laws Minimum probability a 32,424 12.6 26,151 10.1 38,575 11.3 Drug court-eligibles not restricted by program failure or sentencing laws Joint probability a 22,671 8.8 14,384 5.5 37,055 7.2 Minimum probability a 32,424 12.6 26,151 10.1 58,575 11.3 Drug court-ineligibles not restricted by program failure or sentencing laws Joint probability a 182,751 70.8 106,592 41.1 289,343 55.9 Minimum probability a 172,997 67.0 94,825 36.5 267,822 51.7 a. ... Our findings also indicate that drug court access was blocked for many recently incarcerated at-risk inmates because they recently failed similar offender-based treatment programs (7 percent) and/or were subject to overriding sentencing laws that precluded drug court entry (31 percent). ... We estimated that more than half the recently incarcerated offenders who were at risk of drug abuse or dependence—upwards of one-quarter million individuals—were excluded from drug courts solely because of restrictive eligibility criteria. ... To obtain more meaningful reductions in state prison populations, any restructuring of drug court eligibility criteria would have to be accompanied by sentencing reform, as 84 percent of at-risk offenders subject to strict sentencing laws were incarcerated in state prisons.

**HIGHLIGHT:** Drug courts have been widely praised as an important tool for reducing prison and jail populations by diverting drug-involved offenders into treatment rather than incarceration. Yet only a small share of offenders presenting with drug abuse or dependence are processed in drug courts. This study uses inmate self-report surveys from 2002 and 2004 to examine characteristics of the prison and jail populations in the United States and assess why so many drug-involved offenders are incarcerated. Our analysis shows that four factors have prevented drug courts from substantially lowering the flow into prisons and jails. In descending order of importance, these are: drug courts’ tight eligibility requirements, specific sentencing requirements, legal consequences of program noncompliance, and
constraints in drug court capacity and funding. Drug courts will only be able to help lower prison and jail populations if substantial changes are made in eligibility and sentencing rules.

Keywords: drug courts; eligibility criteria; prison and jail populations; alternatives to incarceration

TEXT:

[*190] The U.S. "war on drugs" has markedly increased incarceration rates since the 1980s, as a greater number of drug-using offenders were sent to prison and jail for increasingly long periods of time (Blumstein and Beck 1999; Caulkins and Chandler 2006). The repercussions of this buildup remain with us today in the form of historically large incarcerated populations. What is more, a majority of offenders incarcerated for both drug and nondrug crimes either abused or were addicted to illegal drugs (Karberg and James 2005; Mumola and Karberg 2006), and there is reasonable evidence that substance use--especially frequent and heavy use--is associated with greater criminality (Bennett, Holloway, and Farrington 2008).

Against this backdrop, interest has grown in programs that combine community-based drug treatment with justice system oversight as an alternative to incarceration. Drug courts, in [*191] particular, have emerged as the dominant national model of therapeutic jurisprudence. What began as a single drug court in Miami, Florida, in 1989 now encompasses (as of 2009) 2,459 programs that operate in every state and almost half of all U.S. counties (Franco 2010; Huddleston and Marlowe 2011). Although other diversion programs exist--including Treatment Alternatives to Street Crime (TASC), Drug Treatment Alternatives to Prison (DTAP), and Breaking the Cycle (Belenko 1999; Bull 2003)--no other model has been implemented to the national scale of drug courts, and in many cases these other programs have been incorporated into the growing drug court system (Anglin, Longshore, and Turner 1999; Bull 2003). Drug courts now operate in a wide cross-section of U.S. communities, and the model has successfully expanded into other domains, including juvenile, drunk driving, reentry, mental health, domestic violence, and veterans courts (Huddleston and Marlowe 2011).

As locally initiated interventions, drug courts vary greatly in their specific strategies, focus, and populations served. In general, drug courts couple community-based drug treatment with judicial supervision as an alternative to either prosecution (for pre-adjudication programs) or sentencing (for post-adjudication programs) (General Accounting Office 1997). The typical drug court operates by initially screening recent arrestees for program eligibility. Eligible arrestees are then offered entry into the drug court with the incentive of reduced or dismissed charges upon successful program completion. Drug courts generally consist of drug treatment, judicial monitoring of program progress, regular drug testing, and the use of graduated sanctions for program noncompliance.

Drug courts emerged and proliferated because they had broad appeal across the range of stakeholders concerned with drug policy. Originated during the crack epidemic when the population of drug-involved offenders was expanding rapidly, these programs offered some promise to judges and policymakers as a [*192] strategy to conserve prison and jail bed space while retaining close community monitoring of criminal offenders (Fluellen and Trone 2000). Drug courts also held considerable appeal to treatment and public health communities, offering the possibility of closer coordination between criminal justice agencies and treatment providers that served the same offending populations. Finally, drug courts held considerable appeal to public defenders and to advocates of less punitive drug policies who wished to support credible alternatives to incarceration.

Buoyed by such collective support, drug courts have also fostered more expansive aspirations for correctional system reform. However, drug courts, like many other social service innovations, face familiar challenges associated with serving (or monitoring) severely disadvantaged or criminally active populations. For one, these aspirations are seldom fully matched by expanded organizational capacities or by suitable infusions of external resources. As with Aid to Families with Dependent Children (AFDC) and later Temporary Assistance to Needy Families (TANF), drug courts face especially complex challenges in serving a highly varied population of new (and returning) entrants into the criminal justice system. Moreover, as with job training and substance abuse treatment, drug courts face incentives to cream-skim clients, thereby avoiding individuals who pose the greatest risks. This presents a complex challenge for high-level policymakers who seek to sponsor and regulate drug courts in addressing broader crime and correctional problems.

Finally, although coercion exists in other social service contexts (e.g., drug testing welfare recipients), drug courts uniquely straddle boundaries between coercive criminal justice and social service interventions. This combination makes it especially pertinent that drug courts avoid the pitfalls inherent in each of these service areas. Drug courts offer greater opportunities for therapeutic interventions than are found among purely coercive criminal justice interventions.
Drug courts also elicit greater compliance from clients and may provide greater public safety benefits than is possible in wholly voluntary interventions for criminally active populations. At the same time, drug courts raise broader normative concerns in that they may actually increase intrusive monitoring and confinement relative to conventional probation or parole, especially when applied to low-level offenders. In such cases, therapeutic jurisprudence may provide rhetorical cover for coercive policies. Mark Kleiman's (2009) evocative term, "outpatient incarceration," encapsulates well both the hopes and the fears of the contending parties.

Empirical research conducted over the past two decades indicates that, on balance, drug courts are more effective than conventional correctional options at reducing the drug use and criminal activity of drug-involved offenders (Belenko 2001; Brown 2010; Drake, Aos, and Miller 2009; Government Accountability Office 2005; Lowenkamp, Holsinger, and Latessa 2005; Rossman et al. 2011; Shaffer 2006; Wilson, Mitchell, and MacKenzie 2006; Mitchell et al. 2012; Shaffer 2011). The National Institute of Justice (NIJ)-sponsored Multi-Site Adult Drug Court Evaluation (MADCE), for example, found that drug court participants relapsed significantly less often and, among those that did, reported significantly fewer days of drug consumption than a comparison group of offenders at an 18-month follow-up (Rossman et al. 2011). Likewise, meta-analyses [*193] confirm that drug courts reduce recidivism rates by 8 to 14 percent over other criminal justice interventions (Drake, Aos, and Miller 2009; Shaffer 2006; Wilson, Mitchell, and MacKenzie 2006).

While drug courts may effectively reduce drug use and recidivism among individual offenders, there has been considerable debate about the ability of drug courts to reduce aggregate prison and jail populations, that is, to effectively serve as an alternative to incarceration at the population level (Drug Policy Alliance 2011; Fluellen and Trone 2000; Huddleston and Marlowe 2011; Justice Policy Institute 2011; Miller 2004). Some observers credit drug courts with helping to "bend the curve" of incarceration downward (Huddleston and Marlowe 2011, 16); others suggest drug courts and similar programs have a "low ceiling of possible impact on correctional populations" (Clear and Schrantz 2011, 151S). Still others claim that drug courts "may ultimately serve not as an alternative but as an adjunct to incarceration" (Drug Policy Alliance 2011, 14).

There are four components to this critique. First, resource constraints limit the ability of drug courts to reach all drug-involved offenders; the demand for services simply outstrips available court resources and treatment slots. Second, most drug courts have restrictive eligibility criteria that routinely exclude high-risk offenders, many of whom are likely to end up behind bars. Third, for those fortunate enough to gain access to drug courts, the legal consequences of program failure can be severe, and the criminal justice system often loses any initial savings in custodial resources due to high rates of program failure. Finally, many drug-involved offenders are precluded from drug courts because of overriding sentencing laws, including sentencing guidelines, mandatory minimums, habitual offender laws, and other sentence enhancements.

In light of the racial disparities inherent in the criminal justice system, the articulated concerns have particular salience for minority populations. Arrests for drug offenses remain highly concentrated in urban African American and Hispanic communities beset with high poverty rates and other forms of concentrated disadvantage. With incarceration rates for drug offenses even more disparate than those for other crimes, the success or failure of drug courts has important implications for these populations and neighborhoods.

To date, relatively little empirical research has investigated these various concerns. In an earlier article that focused on several broader questions (Pollack, Reuter, and Sevigny 2011), we examined why drug courts might not serve as an effective alternative to incarceration from the single perspective of restrictive eligibility criteria. In expanding upon this earlier work, the present study estimates the size of the drug-involved incarcerated population likely to have been excluded from drug courts because of several factors: capacity constraints, restrictive eligibility criteria, client failure in program, and overriding sentencing laws. Specifically, we use data from the 2002 Survey of Inmates in Local Jails (SILJ) and the 2004 Survey of Inmates in State Correctional Facilities (SISCF) to examine why recently incarcerated offenders at risk of drug abuse or dependence might have ended up behind bars rather than being diverted into community-based drug treatment courts.

[*194] We begin by reviewing the available evidence on the diversionary impact of drug courts. Then, we present our empirical analysis of the inmate survey data, which reveals that, even if they were brought to scale, drug courts are unlikely to substantially affect incarceration levels under current drug court eligibility rules and existing sentencing laws. This finding is consistent with our earlier work; the present expanded analysis provides more robust support for this conclusion. We end by discussing the policy implications of these findings.
In this section, we review the available empirical evidence on the four factors identified above--capacity constraints, eligibility criteria, legal consequences, and sentencing laws--that limit the potential for drug courts to conserve aggregate prison and jail space by serving as a true alternative to incarceration.

**Drug court capacity constraints**

The most proximate factor impeding the diversionary impact of drug courts is their limited capacity to fully serve the population of drug-abusing offenders who enter the criminal justice system. More than half (52 percent) of adult drug courts surveyed in 2004, for instance, could not accept eligible clients due to resource constraints (Zweig et al. 2011), and four in five (80 percent) state drug court coordinators reported in 2008 that inadequate funding was the primary obstacle to further expansion (Huddleston and Marlowe 2011). Importantly, nearly every state coordinator acknowledged that drug court capacity could be "appreciably expanded."

Although the national daily population of drug court enrollees more than quadrupled (from 26,465 to 116,300) between 1996 and 2008 (General Accounting Office 1997; Huddleston and Marlowe 2011), overall capacity is still only a small fraction of the overall number of drug-abusing offenders entering the criminal justice system. Nationally, Bhati, Roman, and Chalfin (2008) estimated that there were 55,365 adult drug court participants in 2005 relative to the 1.47 million arrestees who were at risk of drug abuse or dependence, or about 27 at-risk arrestees per drug court slot. In short, the apparent demand for drug court services greatly outpaces the available supply, resulting in a smaller diversionary impact--hence, the calls for "taking drug courts to scale" (Huddleston and Marlowe 2011; National Association of Drug Court Professionals 2009).

**Restrictive eligibility criteria**

Drug courts screen defendants and limit participation based on specific legal and clinical criteria (Government Accountability Office 2005; Knight, Flynn, and Simpson 2008; Zweig et al. 2011). These criteria stem from two primary sources: federal funding requirements, and local needs and political realities. Federal law [*195] requires courts receiving funds from the Drug Court Discretionary Grant Program to exclude offenders with a current or prior violent offense (Franco 2010; Government Accountability Office 2005; Saum and Hiller 2008). The scope of this statutory restriction is potentially quite large, as one study found that 78 percent of active drug courts in 1996 had received federal funding (General Accounting Office 1997).  

National surveys of drug court operations confirm that the vast majority of programs exclude offenders with a current or prior violent offense (General Accounting Office 1997; Zweig et al. 2011). These surveys also reveal that drug courts commonly restrict access based on the type of charge, criminal history, the severity of the drug problem, prior treatment history, lack of motivation for treatment, severe medical conditions or mental disorders, gang membership, and citizenship status. For example, the Hamilton County (Ohio) Drug Court maintains the following set of eligibility criteria: criminal behavior that is drug-driven, no history of violent behavior, no active mental illness, no acute health conditions, and demonstrated readiness for treatment (Listwan et al. 2003).

A consequence of these restrictive eligibility criteria is that many offenders are denied access to drug court programming (Rossman et al. 2011; Saum and Hiller 2008). Bhati, Roman, and Chalfin (2008) estimate that of the 1.47 million U.S. arrestees at risk of drug abuse or dependence in 2005, just 109,921 (7.5 percent) were drug court-eligible. Moreover, in Florida, 74 percent of the 1,653 nonviolent probationers who tested positive for drugs in FY2010 were ineligible for the state's expansion drug courts because they had additional technical violations, contributing to the programs running under expected capacity (Office of Program Policy Analysis and Government Accountability 2010). Findings such as these have spurred recent state efforts to expand drug court eligibility--especially to a higher-risk population of otherwise prison- and jail-bound offenders (New Jersey Administrative Office of the Courts 2010).

**Legal consequences of program failure**

The diversionary impact of drug courts also rests on their ability to successfully retain and graduate enrolled offenders. Unfortunately, research on drug courts reveals that a large share of program participants end up being terminated unsuccessfully (General Accounting Office 1997; Government Accountability Office 2005; Hepburn and Harvey 2007; Rempel et al. 2003). Rempel et al.'s (2003) evaluation of eleven drug courts in New York State, for example, revealed a three-year failure rate of 50 percent across all programs.  

\[ \text{Failure rate} = \frac{\text{Number of offenders who failed}}{\text{Total number of offenders}} \times 100 \]
High rates of program failure, in turn, tend to offset any initial savings in custodial resources, because the noncompliant offenders are saddled with lengthy terms of confinement that equal, and sometimes exceed, the incarceration times of conventionally sentenced defendants (Gottfredson, Najaka, and Kearley 2003; Gottfredson et al. 2006; Rempel et al. 2003; Rossman et al. 2011). Gottfredson, Najaka, and Kearley (2003) examined two-year outcomes for the Baltimore City Drug Treatment Court and found that program participants served significantly fewer incarceration days on average than the controls on both the predisposition commitment and original sentence, but significantly more days due to noncompliance. As a consequence, there was no significant difference between the two groups in overall time served.

Rossman et al. (2011) also examined two-year outcomes from the MADCE and found that drug court graduates were incarcerated for significantly fewer days on average than drug court failures (25 vs. 273). Consequently, Rossman et al. (2011, 80) concluded that "drug courts nearly eliminate custodial time among those who graduate, but those benefits are counterbalanced by the high sentences imposed on those who fail the program." Whether the overall number of individual-level failures across drug court programs is sizable enough to affect aggregate prison and jail populations remains an open question.

Overriding impact of sentencing laws

Drug laws, mandatory sentencing, habitual offender statutes, and other laws often put drug courts out of reach of many drug-abusing offenders. Simply put, drug courts are often "barred from enrolling prison-bound people because the laws forbid it" (Weissman 2009, 247). This has led some observers to conclude that sentencing reform is the only sure way of reducing prison and jail populations (Clear and Austin 2009). However, few empirical studies have directly investigated the role of mandatory sentencing laws on drug court operations. One study analyzed 8,443 Florida prison admissions in 2007; it found that 1,972 (or about 23 percent) were nonviolent offenders with recognized drug treatment needs but who were nevertheless excluded from drug courts because their sentencing guideline scores required a mandatory prison term (Office of Program Policy Analysis and Government Accountability 2009). Another study found that many recently incarcerated heavy drug users had extensive criminal records that not only excluded them from drug courts, but also exposed them to punitive habitual offender laws (Pollack, Reuter, and Sevigny 2011).

The Current Study

We reviewed four key factors that potentially limit the ability of drug courts to conserve custodial resources--capacity constraints, restrictive eligibility criteria, consequences of program failure, and overriding sentencing laws. The current study uses data from the 2002 SILJ and the 2004 SISCF to estimate the number of recently incarcerated at-risk inmates who might have been excluded from drug courts for one or more of these reasons. With these estimates in hand, we provide an assessment of the annual flow of drug-abusing arrestees into other parts of the correctional system, including prisons, jails, drug courts, and probation. In performing these analyses, we aim to provide a systemic, national-level assessment of drug court outcomes.

Methods

Data and analytic sample

The 2002 SILJ (Bureau of Justice Statistics 2006) and 2004 SISCF (Bureau of Justice Statistics 2007) are nationally representative surveys that collected inmate self-report data on a wide array of topics, including conviction and sentencing information, offense characteristics, criminal history, and socioeconomic status. The 2002 SILJ completed 6,982 interviews for an 84 percent response rate, and the 2004 SISCF completed 14,499 interviews for an 89 percent response rate. Both surveys employed a stratified two-stage sampling design, first selecting facilities and then inmates within the selected facilities. All analyses accounted for these design features and were performed using Stata 12.0 (Stata Corporation 2011). In the presentation of our results and the discussion that follows, we report the weighted point estimates. For presentation purposes, we do not report the associated confidence intervals.

Table 1 shows the sample sizes and weighted estimates for the stock population of inmates and select subpopulations. The main analytic subsample of interest for the present study is the cohort of convicted and recently incarcerated inmates who were at risk of drug abuse or dependence. We focused on convicted inmates because unconvicted jail detainees were not asked many of the pertinent crime and drug use questions. We also focused on the cohort of recently incarcerated inmates--defined as those inmates who were admitted to prison or jail in the 12 months preceding the date of their interview--so that our analysis reflects contemporaneous sentencing practices and mitigates the
potential bias toward more serious offenders inherent in cross-sectional samples. We further restricted our analysis to the subpopulation of offenders likely to be targeted for drug court interventions, that is, offenders who abused or were dependent on illegal drugs. We refer to this group as the population at risk of drug abuse or dependence, or simply the at-risk population.

As shown in Table 1, after applying these delimitations, we obtained analytic subsamples of 2,897 jail inmates and 3,333 prison inmates. All told, these numbers reflect a population estimate of more than a half million \( N = 517,741 \) convicted and recently incarcerated inmates who were at-risk of drug abuse or dependence.

**Measures**

As described in Table 2, we operationalized key measures of drug court eligibility, program failure, and mandatory sentencing laws. To identify common drug court eligibility criteria, we relied on the results reported from the MADCE project (Zweig et al. 2011). The MADCE project, which sought to provide a national picture of drug court operations, identified and surveyed all 593 adult drug courts that had been in operation for at least one year as of February 2004, receiving responses from 380 (for a 64 percent response rate). Using the [198] MADCE results as a guide, we operationalized a core set of twelve drug court eligibility criteria that could be measured using the inmate survey data.

**TABLE 1**

<table>
<thead>
<tr>
<th>Study Sample Sizes and Population Counts</th>
<th>2002 Jail Inmates</th>
<th>2004 Prison Inmates</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stock population of inmates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample n</td>
<td>6,982</td>
<td>14,499</td>
<td>21,481</td>
</tr>
<tr>
<td>Population N</td>
<td>631,241</td>
<td>1,226,171</td>
<td>1,857,412</td>
</tr>
<tr>
<td>Cohort of convicted and recently-incarcerated inmates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample n</td>
<td>4,582</td>
<td>5,052</td>
<td>9,634</td>
</tr>
<tr>
<td>Population N</td>
<td>415,354</td>
<td>397,188</td>
<td>812,542</td>
</tr>
<tr>
<td>Cohort of convicted and recently-incarcerated inmates at-risk of drug abuse or dependence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample n</td>
<td>2,897</td>
<td>3,333</td>
<td>6,230</td>
</tr>
<tr>
<td>Population N</td>
<td>258,192</td>
<td>259,549</td>
<td>517,741</td>
</tr>
</tbody>
</table>


Drug courts typically base eligibility on a clinical assessment of the nature and extent of the offender's drug problem. Accordingly, we measured drug problem intensity to differentiate drug dependence from drug abuse in the population of at-risk offenders. Some drug courts also exclude lower-risk offenders; thus, we also measured whether offenders reported marijuana-only abuse. Virtually all drug courts also base eligibility on the offender's current charges and prior record. We operationalized five such measures: controlling offense, major drug trafficking, active criminal justice status, prior violent conviction, and number of prior convictions. Drug courts also commonly refuse entry to offenders who previously failed or are not currently invested in treatment. Accordingly, we operationalized measures of prior offender-based treatment and lack of treatment motivation. Finally, drug courts commonly exclude offenders for other specified criteria. We measured three common factors: noncitizenship and the presence of a severe mental disorder or severe medical condition.

We measured program failure in two ways. First, failed drug diversion program indicates whether offenders were in alcohol or drug diversion counseling prior to incarceration. Since this item was asked only of jail inmates, we also created a measure of failed probation drug treatment, which indicates whether offenders were incarcerated for a technical violation (but not a new arrest or conviction) while serving a probation term that included alcohol or drug treatment as part of the sentence.

We measured the impact of overriding sentencing laws with four variables. First, mandatory/presumptive sentence indicates whether the judge was required by law or sentencing guidelines to impose the offender's sentence. This item
was [200] asked only in the prison survey. The other three variables capture the effect of various sentence enhancements: firearm sentence enhancement, habitual offender enhancement, and drug law enhancement. For this last measure, the survey does not indicate the specific type of drug law violation, but we suspect drug-free school zone ordinances, laws against selling to minors, and the like are captured by this category.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug court eligibility criteria</td>
<td>Drug dependence if experienced at least three of seven risk factors in the year before admission as outlined in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). Drug abuse if not dependent and (1) experienced at least one of four DSM-IV risk factors for drug abuse in the year prior to admission, (2) committed the precipitating offense for money to buy drugs, (3) used illegal drugs daily or near-daily in the month prior to arrest, or (4) under the influence of illegal drugs at the time of the offense.</td>
</tr>
<tr>
<td>Drug problem intensity</td>
<td></td>
</tr>
<tr>
<td>Marijuana-only abuse</td>
<td>Used marijuana, but no other illegal drugs, in the month before the arrest or at the time of the offense.</td>
</tr>
<tr>
<td>Controlling offense</td>
<td>Primary conviction offense (i.e., violent, property, drag, other).</td>
</tr>
<tr>
<td>Major drug trafficking</td>
<td>Engaged in importing or growing/producing drugs, or money laundering when arrested, or was a leader or middle man in a drag organization in the year prior to arrest.</td>
</tr>
<tr>
<td>Active criminal justice status</td>
<td>On escape or under community supervision (e.g., probation, parole, electronic monitoring) when arrested.</td>
</tr>
<tr>
<td>Prior violent conviction</td>
<td>Prior sentence to probation or incarceration for a violent offense.</td>
</tr>
<tr>
<td>Number of prior convictions</td>
<td>Number of prior sentences to probation or incarceration (maximum of three).</td>
</tr>
<tr>
<td>Prior offender-based treatment</td>
<td>Previously admitted to a substance abuse detoxification, inpatient, out-patient, or maintenance program while incarcerated or on probation or parole.</td>
</tr>
<tr>
<td>Lack of treatment motivation</td>
<td>Parole or probation revoked for failing to report for substance abuse treatment.</td>
</tr>
<tr>
<td>Severe mental disorder</td>
<td>Admitted to a mental hospital in year before arrest, or had a diagnosis within past year of depression, bipolar disorder, schizophrenia, post-traumatic stress disorder, or anxiety disorder.</td>
</tr>
<tr>
<td>Severe medical condition</td>
<td>Currently suffers from cancer, stroke or brain injury, diabetes, heart disease, kidney disease, or liver disease.</td>
</tr>
<tr>
<td>Noncitizen</td>
<td>Not a legal U.S. resident.</td>
</tr>
<tr>
<td>Program failure</td>
<td></td>
</tr>
<tr>
<td>Failed drag diversion program a</td>
<td>In alcohol or drug diversion counseling when arrested.</td>
</tr>
</tbody>
</table>
TABLE 2
Description of Study Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed probation drug treatment</td>
<td>Probation revoked for technical violation while in mandated alcohol or drug treatment program.</td>
</tr>
<tr>
<td>Sentencing laws</td>
<td></td>
</tr>
<tr>
<td>Mandatory/presumptive sentence</td>
<td>Judge required by law or sentencing guidelines to give imposed sentence.</td>
</tr>
<tr>
<td>b</td>
<td></td>
</tr>
<tr>
<td>Firearm sentence enhancement</td>
<td>Received sentence increase because of a firearms violation.</td>
</tr>
<tr>
<td>Habitant offender enhancement</td>
<td>Received sentence increase as habitual offender, or because of a second or third strike.</td>
</tr>
<tr>
<td>Drag law enhancement</td>
<td>Received sentence increase because of the type of drug offense.</td>
</tr>
</tbody>
</table>

a. This item is only measured in the jail survey.
b. This item is only measured in the prison survey.

Findings

We report three sets of findings. First, we calculate the probability of drug court eligibility for each inmate based on the specified eligibility criteria. Second, we estimate how many recently incarcerated at-risk inmates were likely to have been excluded from drug courts due to eligibility restrictions, program noncompliance, sentencing laws, and capacity constraints. Finally, we rely on both our estimates and other estimates in the literature to describe the flow of drug-abusing arrestees into the criminal justice system.

Estimating the drug court eligibility of recently incarcerated at-risk inmates

In this section, we estimate the probability of drug court eligibility for recently incarcerated at-risk inmates. As the basis for these calculations, Table 3 shows the number and percentage of inmates with respect to key drug court eligibility criteria, as well as the expected likelihood of eligibility for offenders with these indicated characteristics. Specifically, the first through fourth columns present the distributions of the jail and prison cohorts across these eligibility criteria (based on the SILJ and SISCF), and the fifth shows the corresponding eligibility probabilities (based on the MADCE), reflecting the percentage of U.S. drug courts that accept these types of offenders (Bhati, Roman, and Chalfin 2008, 28-30; Zweig et al. 2011, 25-32). According to the MADCE, for instance, drug courts universally accept offenders with a drug dependence diagnosis ($P = 1.00$) and less than two-thirds enroll those experiencing less severe drug abuse ($P = .62$), whereas most drug courts also admit offenders who only abuse marijuana ($P = .88$).

To account for differing assumptions regarding the independence of these eligibility criteria, we derive inmate-specific estimates of eligibility using two approaches. First, assuming independence, we calculated the joint probability of eligibility for each inmate, using the marginal probabilities reported in column 5 (for an analagous approach, see Bhati and Roman 2010). For example, we derive an estimated eligibility probability of .45 for individuals with the following characteristics: dependence (1.00) on heroin (1.00), a controlling property offense (.94), no trafficking involvement (1.00), not on active criminal justice status (1.00), no prior violent convictions (1.00), three or more prior convictions (.93), prior offender-based treatment (.51), motivated for treatment (1.00), no severe mental (1.00) or physical (1.00) disorders, and U.S. citizenship (1.00). Second, because the assumption of independence is strong (e.g., the likely correlation [*201] between a drug court's acceptance of offenders with a current and prior violent behavior), we took the minimum reported eligibility probability as a sensitivity check. Continuing with the preceding example, we would obtain an eligibility probability of .51. Thus, we would expect an inmate with this profile to have had a probability of drug court eligibility between .45 and .51 prior to entering prison or jail. Overall, the median joint and minimum eligibility probabilities ranged, respectively, between .15 and .50 for the jail cohort and .17 and .37 for the prison [*202] cohort, suggesting that the typical recently incarcerated at-risk offender faces considerable obstacles to drug court entry.

TABLE 3
Drug Court Eligibility of Recently Incarcerated Inmates
At-Risk of Drug Abuse or Dependence

<table>
<thead>
<tr>
<th>Eligibility Criteria</th>
<th>2002 Jail Cohort</th>
<th>2004 Prison Cohort</th>
<th>Eligibility Probability a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total at-risk population</td>
<td>258,192</td>
<td>259,549</td>
<td>1.00</td>
</tr>
<tr>
<td>Drug problem intensity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug dependence</td>
<td>153,311</td>
<td>159,966</td>
<td>0.62</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>104,880</td>
<td>99,583</td>
<td>0.88</td>
</tr>
<tr>
<td>Marijuana-only abuse</td>
<td>21,834</td>
<td>22,056</td>
<td></td>
</tr>
<tr>
<td>Controlling offense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent</td>
<td>44,376</td>
<td>53,718</td>
<td>0.37</td>
</tr>
<tr>
<td>Property</td>
<td>72,256</td>
<td>67,836</td>
<td>0.94</td>
</tr>
<tr>
<td>Drug</td>
<td>82,278</td>
<td>93,934</td>
<td>0.99</td>
</tr>
<tr>
<td>Other</td>
<td>59,282</td>
<td>44,061</td>
<td>0.93</td>
</tr>
<tr>
<td>Major drug trafficking</td>
<td>5,696</td>
<td>13,188</td>
<td>0.22</td>
</tr>
<tr>
<td>Active criminal justice status</td>
<td>192,289</td>
<td>141,259</td>
<td>0.50</td>
</tr>
<tr>
<td>Prior violent conviction</td>
<td>80,067</td>
<td>70,728</td>
<td>0.12</td>
</tr>
<tr>
<td>Number of prior convictions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>46,268</td>
<td>71,533</td>
<td>1.00</td>
</tr>
<tr>
<td>One</td>
<td>41,776</td>
<td>55,901</td>
<td>0.98</td>
</tr>
<tr>
<td>Two</td>
<td>47,573</td>
<td>40,151</td>
<td>0.96</td>
</tr>
<tr>
<td>Three or More</td>
<td>122,575</td>
<td>91,963</td>
<td>0.93</td>
</tr>
<tr>
<td>Prior offender-based treatment</td>
<td>90,921</td>
<td>98,365</td>
<td>0.51</td>
</tr>
<tr>
<td>Lack of treatment motivation</td>
<td>7,331</td>
<td>5,702</td>
<td>0.61</td>
</tr>
<tr>
<td>Severe mental disorder</td>
<td>38,370</td>
<td>38,970</td>
<td>0.30</td>
</tr>
<tr>
<td>Severe medical condition</td>
<td>40,985</td>
<td>40,358</td>
<td>0.51</td>
</tr>
<tr>
<td>Noncitizen</td>
<td>7,134</td>
<td>7,144</td>
<td>0.65</td>
</tr>
</tbody>
</table>

a. MADCE (Bhati, Roman, and Chalfin [2008]; Zweig et al. [2011]).

Estimating the size of the at-risk population excluded from drug courts

In this section, we attempt to parse out in greater detail the likely reasons why recently incarcerated at-risk inmates were excluded from drug courts. The results are presented in Table 4, both separately and combined for the jail and prison cohorts.

Panels A through C present our initial set of findings regarding the exclusionary impact of restrictive eligibility criteria, prior treatment program failure, and overriding sentencing laws, respectively. Panel D focuses on those offenders not restricted by program failure or sentencing laws to assess the unique contribution of eligibility rules on drug court accessibility.

Panel A shows our first set of results, which suggests that overall 83 to 89 percent of the roughly half million (N = 517,741) recently incarcerated at-risk inmates were excluded from drug courts due to restrictive eligibility criteria. As discussed above, this bounded estimate is based on differing assumptions regarding the independence of drug court eligibility criteria. In addition, in generating these estimates, we adopted an eligibility probability threshold of .50, where we defined inmates with a calculated eligibility of [<=] < .50 as being excluded from drug courts due to strict entry criteria. Thus, based on these assumptions, our results suggest that restrictive drug court eligibility criteria barred program access for upwards of eight in ten drug-abusing offenders who ultimately ended up being sentenced to prison or jail.
The legal consequences of program failure are examined in panel B. These data show that about 7 percent of the combined cohort was incarcerated consequent to failing drug diversion counseling or some other probation treatment program. Given our focus on drug courts, there are two caveats regarding this figure. On one hand, it is probably an underestimate of drug court failure because the question about drug diversion programming was not asked in the prison survey. On the other hand, it is probably an overestimate because the offenders on probation treatment were not necessarily enrolled in drug courts. Either way, it appears that drug court failures contribute relatively little to aggregate prison and jail populations. Indeed, just 3 percent of inmates in the jail cohort were admitted directly from a drug diversion program. That said, those 8,244 jail inmates represent 15 percent of the estimated 55,365 drug court entrants nationally (Bhati, Roman, and Chalfin 2008). Thus, due to differences in scale, these findings suggest at once that drug court failures contribute sizably to incarceration from the level of the individual program but only minimally from the level of the aggregate incarcerated population.

The effect of overriding sentencing laws on drug court diversion is examined in panel C. Overall, these laws affected nearly one in three (31 percent) at-risk offenders. More than one in six (18 percent) received a mandatory or guideline sentence (despite this question not being asked of the jail inmates), and one in ten were incarcerated as a result of a habitual offender law involving a second or third strike. Smaller percentages were subject to drug law (7 percent) or firearm (3 percent) sentence enhancements. The collective effect of these various sentencing laws was to keep drug courts beyond the reach of almost one-third of recently incarcerated at-risk offenders--most of whom (N = 133,644, or 84 percent) were sentenced to state prison.

<table>
<thead>
<tr>
<th>TABLE 4</th>
<th>Estimating the Size of the At-Risk Population Excluded from Drug Courts for Various Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002</td>
</tr>
<tr>
<td></td>
<td>Jail Cohort</td>
</tr>
<tr>
<td>Total at-risk population</td>
<td>258,192</td>
</tr>
<tr>
<td>Panel A</td>
<td>Ineligible due to restrictive entry criteria</td>
</tr>
<tr>
<td>Joint probability a</td>
<td>233,654</td>
</tr>
<tr>
<td>Minimum probability a</td>
<td>222,027</td>
</tr>
<tr>
<td>Panel B</td>
<td>Revoked for program failure</td>
</tr>
<tr>
<td>Failed drug diversion program</td>
<td>28,695</td>
</tr>
<tr>
<td>Failed probation drug treatment</td>
<td>22,504</td>
</tr>
<tr>
<td>Panel C</td>
<td>Subject to overriding sentencing laws</td>
</tr>
<tr>
<td>Mandatory/presumptive sentence</td>
<td>--</td>
</tr>
<tr>
<td>Firearm sentence enhancement</td>
<td>4,231</td>
</tr>
<tr>
<td>Habitual offender enhancement</td>
<td>15,141</td>
</tr>
<tr>
<td>Drug law enhancement</td>
<td>9,535</td>
</tr>
<tr>
<td>Panel D</td>
<td>Drug court-eligibles not restricted by program failure or sentencing laws</td>
</tr>
<tr>
<td>Joint probability a</td>
<td>22,671</td>
</tr>
<tr>
<td>Minimum probability a</td>
<td>32,424</td>
</tr>
<tr>
<td>Drug court-ineligibles not restricted by program failure or sentencing laws</td>
<td></td>
</tr>
<tr>
<td>Joint probability a</td>
<td>182,751</td>
</tr>
<tr>
<td>Minimum probability a</td>
<td>172,997</td>
</tr>
</tbody>
</table>
Estimating the Size of the At-Risk Population Excluded from Drug Courts for Various Reasons

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jail Cohort</td>
<td>2004</td>
<td>Prison Cohort</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
</tbody>
</table>
| A. Estimates are based on a threshold of p [<=] .50 defining ineligibility

[204] The last part of this analysis, presented in panel D, estimates the number of at-risk inmates, stratified by drug court eligibility, whose drug court access was not restricted by program failure or sentencing laws. By focusing on this latter subgroup of at-risk offenders, we can better assess the unique contribution of eligibility rules on drug court accessibility. As shown in the first part of panel D, between 7 and 11 percent of the combined cohort consisted of drug court-eligible inmates who were not recent program failures or mandatorily sentenced to a period of custody. This represents an incarcerated population that appears uniquely suitable for drug court diversion. That they were not diverted suggests that these inmates might have been incarcerated because of drug court capacity constraints. That is, we suspect they were incarcerated not because they failed to fit the drug court profile but because no drug court alternative was available to them. Diverting this group of offenders might require nothing more than a corresponding expansion of drug court capacity and utilization. The last part of panel D presents information on the group of drug court-eligible offenders who were not also restricted by program failure or sentencing laws. Within the constraints of program capacity, this group represents a large subset of at-risk offenders (52-56 percent) who could readily be targeted for drug courts simply by expanding current eligibility rules.

To summarize, we examined several reasons why recently incarcerated at-risk offenders might have ended up behind bars rather than being diverted to a drug court. Our findings suggest that the majority (52-56 percent) of these offenders were likely excluded from drug courts due to restrictive eligibility criteria, and that a smaller subset (7-11 percent) possibly ended up behind bars because of insufficient drug court capacity. Our findings also indicate that drug court access was blocked for many recently incarcerated at-risk inmates because they recently failed similar offender-based treatment programs (7 percent) and/or were subject to overriding sentencing laws that precluded drug court entry (31 percent).

Estimating the flow of at-risk arrestees through the criminal justice system

As a final analysis, we provide a simple accounting of how at-risk offenders flow through the criminal justice system. As shown in Table 5, we begin with Bhati, Roman, and Chalfin's (2008) estimate of 1.47 million arrestees who were "probably guilty" and at risk of drug abuse or dependence. Drawing on our previous analyses, we estimate that 17.5 percent of these at-risk arrestees were admitted to local jails, with another 17.6 percent admitted to state prisons. Then, drawing on annual enrollment figures reported in the MADCE (Zweig et al. 2011, 24), we estimate a flow of 52,777 annual new drug court entrants -- equal to about 3.6 percent of at-risk arrestees.

Most of the remaining 900,820 (61.2 percent) at-risk offenders likely ended up on probation. These at-risk probationers represent about 40 percent of the 2.2 million state probation entries in 2003. One implication of this analysis is that there is a serious possibility of net-widening in "taking drug courts to scale" if the expansion courts target these lower-risk probationers rather than the otherwise prison- and jail-bound offenders. [205]

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Percentage</th>
<th>Reference Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total at-risk population of</td>
<td>1,471,338</td>
<td>100.0</td>
<td>2005</td>
</tr>
<tr>
<td>guilty arrestees a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number admitted to local jails b</td>
<td>258,192</td>
<td>17.5</td>
<td>2002</td>
</tr>
<tr>
<td>Number admitted to state prisons c</td>
<td>259,549</td>
<td>17.6</td>
<td>2004</td>
</tr>
<tr>
<td>Number admitted to drug courts</td>
<td>52,777</td>
<td>3.6</td>
<td>2003</td>
</tr>
<tr>
<td>Number admitted to probation</td>
<td>900,820</td>
<td>61.2</td>
<td>--</td>
</tr>
</tbody>
</table>

Estimating the Flow of At-Risk Arrestees through the Criminal Justice System

<table>
<thead>
<tr>
<th>N</th>
<th>Percentage</th>
<th>Reference Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Authors’ estimate based on 2002 SILJ.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Authors’ estimate based on 2004 SISCF.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Authors’ estimate based on Zweig et al. (2011).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Percentages do not sum to 100 due to rounding.

Net-widening refers to the unintended consequence of criminal justice reforms that are aimed at reducing levels of punishment to instead expand the number who receives some punishment. This has, for example, been noted as a subversive influence of marijuana decriminalization. If marijuana possession becomes a civil infraction rather than a criminal misdemeanor, the burden on the individual police officer of making an arrest is reduced. Studies have repeatedly found that police respond to this alleviation by making more arrests (e.g., Christie and Ali 2000). Our concern here is that if drug courts permit the criminal justice system to cheaply impose more severe punishments on those who currently receive only probation, a large-scale expansion of drug courts will increase rather than reduce the extent of punishment handed out.

Discussion and Conclusions

Diverting drug-involved offenders into treatment instead of jail or prison has long been a major goal of the criminal justice system. The drug court movement has been a prominent and important innovation in this regard, almost universally praised by policymakers and practitioners alike. As a result, the number of drug courts has increased exponentially over the past two decades to become the standard model of therapeutic jurisprudence in the United States. Attitudes toward drug courts, which have also been adopted in other countries such as Australia and Britain, have been strongly positive. Hence, it is surprising that these efforts still reach a very small share of the potentially eligible population. We can only speculate as to why there has not been more growth.

Many factors may be important, ranging from the mundane (a limited number of judges want to take on the task of hands-on offender supervision that is so different from normal judicial duties) to the complex systemic (drug courts require the challenging coordination of social service and criminal justice agencies). Drug court advocates may also seek to keep the eligibility requirements tight because these increase the likelihood of successful evaluations. Moreover, drug courts, whatever the long-term gains from reduced offending, require upfront budgetary outlays that are relatively more costly than are the status quo supervision strategies. Many of these outlays are required for administrative infrastructure that yields no obvious or immediate benefits for public safety. All this means that expanding drug courts substantially to include higher-risk offenders will be a difficult challenge, and one that poses political and organizational challenges throughout the criminal justice system.

Our study shows that drug courts, as currently designed and operated, have only modest potential to reduce incarcerated populations, primarily because so few offenders entering jail or prison clearly meet existing eligibility requirements. Just 11 to 17 percent of recently incarcerated offenders at risk of drug abuse or dependence had better than a 50/50 chance of being eligible for drug court. On top of this, strict sentencing laws--mandatory minimums, sentencing guidelines, three-strikes laws, zero-tolerance drug zones, firearm sentence enhancements, and the like--precluded upwards of three in ten at-risk offenders from drug courts regardless of their eligibility. Drug court failures and limited drug court capacity (in the absence of other restrictions) also impeded diversion from prison and jail, albeit to a much lesser extent.

A key policy-relevant insight to follow from our analysis is that expanding access to drug courts could markedly increase their reach and, in turn, help to reduce incarcerated populations. This could, of course, be achieved in various ways and to different degrees. Straightaway, guaranteeing drug court access to the pool of eligible offenders who are incarcerated because of insufficient capacity is attractive, not because it would drastically cut prison and jail admissions but because its implementation would not require a great policy shift. We estimated there were roughly 37,000 to 59,000 such offenders in prison and jail, which represents an additional two-thirds increase to a doubling of adult drug court capacity (circa 2004). Given that resource limitations have been the main obstacle to drug court expansion...
Increasing access to drug courts by expanding eligibility criteria has a much greater potential to reduce incarceration levels. We estimated that more than half the recently incarcerated offenders who were at risk of drug abuse or dependence--upwards of one-quarter million individuals--were excluded from drug courts solely because of restrictive eligibility criteria. Given the size of this population, a pragmatic first question for drug court planners pursuing expansion is which eligibility criteria can be relaxed. A number of observers, for instance, have argued that drug courts can safely enroll many drug-involved violent offenders without undue public safety risks (National Center on Addiction and [*207] Substance Abuse 1998; Rossman et al. 2011; Saum and Hiller 2008; Saum, Scarpetti, and Robbins 2001). In particular, there are many aging drug-involved offenders whose violent crimes are long past and who are at little risk of such offenses in the foreseeable future (Pollack, Reuter, and Sevigny 2011). In this instance, the key to drug court expansion is for Congress to amend the authorizing legislation of the Drug Court Discretionary Grant Program to allow funded programs to accept violent offenders (Franco 2010; Saum and Hiller 2008).

Whatever specific criteria are targeted, expanding drug court eligibility would have a relatively greater effect on jail than prison populations because nearly two-thirds of drug court-ineligibles were housed in local jails. To obtain more meaningful reductions in state prison populations, any restructuring of drug court eligibility criteria would have to be accompanied by sentencing reform, as 84 percent of at-risk offenders subject to strict sentencing laws were incarcerated in state prisons. Florida adopted this strategy in 2009 when it raised the maximum allowable sentencing guidelines score for drug court admittance from 44 to 52 as part of the state's effort to enroll more prison-bound offenders (Office of Program Policy Analysis and Government Accountability 2010).

We have to this point avoided one critical issue: Diverting even a portion of the half million recently incarcerated at-risk offenders into drug courts by lessening restrictions on eligibility or by mitigating the exclusionary effects of strict sentencing laws would require a massive increase in current drug court capacity. Our analyses suggest that annual drug court enrollments stand at about one-tenth the annual number of at-risk offenders admitted to prison and jail. Bhati, Roman, and Chalfin (2008) estimated that it would cost $ 13.7 billion to expand drug courts to fully meet this demand, and the National Association of Drug Court Professionals (NADCP) suggested it would take an investment of $ 1.5 billion over six years to make drug courts available to every nonviolent, drug-addicted offender (NADCP 2009).

One potentially viable approach to increase the reach of drug courts in tight fiscal times is to merge drug courts with other more scalable and less costly alternative-to-incarceration programs (Fluellen and Trone 2000). California's Substance Abuse and Crime Prevention Act, otherwise known as "Prop 36," provides one possible example. Prop 36 mandates treatment referral rather than a standard criminal justice disposition for all those arrested for the first or second time for a drug possession offense, providing the arrestee does not have a conviction for another serious crime. With Prop 36 annually enrolling seventeen times as many offenders as California's drug courts, one recent study concluded that the two programs might function on a continuum whereby "Prop 36 is tried first, as a kind of 'drug court-lite' experience for offenders with a lower severity level, and only the more severe drug offenders, identified by program noncompliance, are moved into drug court" (Evans et al. 2010, 21).

A similar triaged approach would merge drug courts and coerced abstinence programs, such as in the case of the Hawaii Opportunity Probation with Enforcement (HOPE) initiative (Hawken and Kleiman 2009; Kleiman 2009; Kleiman and Hawken 2008). Although the HOPE model does not uniformly [*208] require drug treatment for all offenders, it promises a swift and certain response toward those who use drugs or otherwise violate the conditions of their probation. In this scenario, only the high-risk, chronically addicted offenders who cannot remain abstinent would be referred to drug court.

A necessary caution that needs to be part of this discussion is that "taking drug courts to scale" greatly increases the risk of net-widening. We estimated that 61 percent of at-risk arrestees were sentenced to probation. As noted above, if expansion drug courts draw from this sizable noncustodial population rather than the population of at-risk offenders likely to end up in prison or jail, drug courts will have little impact on incarcerated populations while increasing the overall number of offenders supervised by the criminal justice system. Avoiding this pitfall will likely require careful program oversight and review alongside any expansion (Miller 2004; Roberts and Indermaur 2006).

Our findings should be interpreted in light of several limitations. First, our results are based on the self-reports of criminal offenders serving time in prison or jail. Offender self-reports are not only subject to the universal biases of recall and social desirability, but also to the sensitive nature of the questions typically asked of offenders. Nevertheless,
the self-report methodology in criminological research has proven to be a valuable data collection approach that provides acceptable levels of reliability and validity (Junger-Tas and Marshall 1999).

Second, because relatively more serious offenders are captured in "one-day" samples of inmates, our reported estimates are likely to be undercounts of the total number of offenders who could be diverted into drug courts from prisons and, especially, jails. That is, the stock population of inmates is "sentence-length biased" relative to the annual admission population. Our focus on recently incarcerated cohorts should mitigate this effect.

Third, although we based our analyses on the most recently available inmate surveys, these data are now 8 to 10 years old. The number of drug courts has increased considerably in this time, and the populations served and eligibility rules employed are likely to have changed in cross-cutting ways. Replication of these results is therefore warranted with more recent data sources, including the next release of the Bureau of Justice Statistics inmate survey data.

Despite these limitations, our results provide the first systematic account of the various reasons recently incarcerated at-risk offenders were likely to have been excluded from drug courts. Recognizing that there are both humanitarian and policy reasons for reducing the number of drug-involved offenders held behind bars, we highlighted various courses of action policymakers could consider to increase the diversionary impact of drug courts.

We conclude by noting that, even without our analysis, it was obvious that drug courts were capable of serving only a tiny fraction of all drug-involved offenders. Proponents have been understandably concerned with ensuring that drug court clients have a high probability of success, and tight eligibility requirements help in that respect. Relaxing those requirements to admit populations that are at higher risk of recidivism will surely lead to higher failure rates. However, if drug courts are to achieve their full potential, and in particular help to deal with the nation’s [*209] massive incarceration problem, there must be a willingness to experiment with broader eligibility requirements for certain currently excluded client groups.

References


**Legal Topics:**

For related research and practice materials, see the following legal topics:

Criminal Law & Procedure
Sentencing
Alternatives
Substance Abuse Programs
Criminal Law & Procedure
Sentencing
Guidelines
Adjustments & Enhancements
Criminal History
Three Strikes
Criminal Law & Procedure
Postconviction Proceedings
Imprisonment

**FOOTNOTES:**

n1 Although other federal grant programs do not carry this violent offender restriction (e.g., the Center for Substance Abuse Treatments [CSAT's] *Drug Treatment Court* Initiative), the majority of congressional appropriations continue to pass through the Drug Court Discretionary Grant Program (Franco 2010; Huddleston and Marlowe 2011).

n2 Authors' calculation based on the reported number of program enrollees (range: 107 to 1,837) and failure rates (range: 18 to 69 percent) across the eleven programs.
These are the most recent state prison and local jail inmate surveys in a series periodically fielded by the Bureau of Justice Statistics (BJS). We do not focus on federal inmates because drug courts are primarily state- and local-led initiatives.

Perhaps the survey designers did not think these questions would be answered truthfully by offenders still awaiting the disposition of their cases.

Our operationalization of drug abuse and dependence is discussed in the section on drug court eligibility criteria.

It was not possible to create direct measures of drug court capacity using the inmate survey data. However, in our analyses, we attempt to indirectly estimate the contribution of limited drug court capacity to prison and jail populations.

Note that the 593 drug courts reported here differs from the earlier cited number of 2,459 for several reasons, including a different reference year (2004 vs. 2009); the latter figure’s inclusion of juvenile, family, and other types of drug courts; and the former’s focus on mature drug courts (i.e., operational for at least one year).

Our use of the MADCE survey assumes the data are representative of the universe of adult drug courts circa 2004. According to Rossman et al. (2011), the MADCE survey obtained a representative sample based on the region of the country; however, slight variation occurred by the size of the metropolitan area, with urban areas somewhat more represented than suburban and rural areas. We suspect, however, that the MADCE’s overweighting of urban settings is consistent with the inmate populations.

Although we believe the point at which offenders are more likely than not to be excluded from drug court is a reasonable threshold, our results are sensitive to this choice. For example, using an eligibility cut point of \( P \leq .40 \) lowers our estimates of drug court ineligibility to 49 to 78 percent (based respectively on the minimum and joint probabilities). Conversely, using a cut point of \( P \leq .60 \) raises our estimates of drug court ineligibility to 89 to 93 percent.

Specifically, courts responding to the MADCE survey reported a mean of eighty-nine new entrants in 2003. We multiplied this figure by the overall number of adult drug courts \((N = 593)\) to obtain our estimate of 52,777.
n13 There were 52,982 federal prison admissions in 2004. Even if all these offenders abused illegal drugs (which is certainly not the case), probation would still be the outcome for 57.6 percent of at-risk arrestees.

n14 With about 9 million unique annual admissions, local jails admit about thirteen times as many inmates as state prisons every year (Beck 2006).
In June 2010, the Board of Directors of the National Association of Drug Court Professionals (NADCP) passed a unanimous resolution directing drug courts to examine whether unfair disparities exist in their programs for racial or ethnic minority participants, and if so, to take reasonable corrective measures to eliminate such disparities. The resolution places an affirmative obligation on drug courts to continuously monitor whether minority participants have equal access to the programs, receive substantially equivalent services in the programs, and successfully complete the programs at equivalent rates to non-minorities. The resolution further directs drug courts to adopt evidence-based assessment tools and clinical interventions that are scientifically proven to be valid and effective for minority participants, and to instruct staff members to attend up-to-date training events on the provision of culturally sensitive and culturally proficient services.

As a professional membership and training organization, the NADCP has no enforcement authority over drug courts, which are typically governed by the administrative office of the courts, Supreme Court, or attorney disciplinary board in each state or territory. However, the NADCP is widely regarded as a leading national organization on best practices and evidence-based practices in drug courts, and its word carries considerable weight in the field. When the NADCP speaks definitively on an issue such as this, practitioners, policymakers, and funding agencies may come to view the recommendations as indicative of appropriate standards of practice for drug courts.

This article provides a backdrop to the NADCP Board Resolution and reviews what is currently known, and not yet known, about racial- and-ethnic-minority impacts in drug courts. After briefly describing what drug courts are and why they came to be, research is presented on minority access to drug courts, the services received by minorities in drug courts, and the outcomes produced. Virtually all of the empirical research to date has focused on African-American participants and those of Hispanic and Latino/Latina ethnicity. This is largely due to the fact that these groups have been represented in sufficient numbers in many studies for evaluators to conduct separate analyses on their behalf. Additional efforts are needed to examine drug-court impacts on other racial and ethnic minority groups.

I. DRUG COURTS

The "War on Drugs" of the 1980s emphasized incarceration as a principal response to drug-related crime. It is now evident that this policy had a minimal effect on criminal recidivism, was prohibitively costly, and disproportionally harmed racial and ethnic minorities and the poor. Nearly one out of every 100 adult citizens is now behind bars in the United States, and the rates are substantially higher for minorities: approximately one out of every 15 African-American adult males and one out of every 36 Hispanic adult males are behind bars.
Drug courts emerged as one alternative to the War on Drugs that emphasizes community-based treatment and rehabilitation in lieu of prosecution or incarceration. The drug-court judge leads a multidisciplinary team of professionals that commonly includes representatives from the prosecutor’s office, defense bar, treatment agencies, case-management agency, and probation department. The team members meet frequently to review participants’ progress and offer recommendations to the judge about suitable consequences to impose. The consequences may include desired rewards such as verbal praise, reduced supervision requirements, or token gifts; punitive sanctions such as verbal reprimands, community service, or brief intervals of jail detention; or adjustments to participants’ treatment regimens. The consequences are typically administered during regularly scheduled status hearings in which the judge discusses the matter with the participant in open court. In pre-adjudication drug courts, the ultimate incentive is to have the criminal charge(s) dropped or withdrawn, and in post-adjudication drug courts the ultimate incentive is to avoid incarceration or reduce the length or conditions of probation.

Several scientific meta-analyses and a large-scale national study have concluded that drug courts significantly reduce crime and return an average of more than $2 in direct financial benefits to the criminal justice system for every $1 invested. The success of adult drug courts has spawned a wide variety of other types of problem-solving courts, including juvenile drug courts, family drug courts, driving-while-impaired (DWI) courts, mental-health courts, and prisoner-reentry courts. Although research has not advanced nearly as much for these newer programs as it has for adult drug courts, evidence is promising to support the effectiveness of several of the newer models.

Controversy has surrounded the question of what impacts, if any, drug courts might have on preexisting racial or ethnic disparities in the criminal justice system. Almost from their inception, controversy has surrounded the question of what impacts, if any, drug courts might have on preexisting racial or ethnic disparities in the criminal justice system. Researchers and commentators have variably concluded that drug courts reduce disparities, exacerbate disparities, or that insufficient evidence exists to know what effects they may have. This confusion stems from at least two sources. First, many researchers have sorely neglected the issue. Most evaluations have not reported outcomes separately by race or ethnicity; and among those that have, few evaluators performed the type of detailed inquiry and analyses that are required to validly interpret the findings. For example, as will be discussed, when racial or ethnic differences have been detected, evaluators rarely sought to determine whether those differences might have been influenced by extraneous factors, such as participants’ socioeconomic status (SES) or drug of choice—which may have been coincidentally correlated with race and truly responsible for the differential effects.

It is imperative for serious-minded and duly trained scientists to carefully examine what is confidently known about minority impacts in drug courts.

Second, some advocacy groups have seized upon the possibility of disparate racial impacts as a wedge issue to wield against drug courts and in favor of their alternative policy proposals, such as drug decriminalization or a restorative-justice philosophy. Putting aside for the moment the correctness of their alternative proposals, some of these advocates have marshaled weak and contradictory "evidence" against drug courts, including unverifiable anecdotes, biased correlations, and mischaracterizations of what researchers have reported in their publications. Given the potential for this hot-button issue to inflame passions on all sides of the conversation, it is imperative for serious-minded and duly trained scientists to carefully examine what is confidently known about minority impacts in drug courts and what matters require further exploration and deliberation.

II. MINORITY ACCESS TO DRUG COURTS

Drug courts have been alternately accused of unfairly excluding minority citizens from participation in the programs and over-targeting minorities—thus drawing them deeper into the criminal justice system—a phenomenon known as net-widening. Virtually all of these assertions have been anecdotal because representative data are sparse and very difficult to come by.

A 2008 survey of all state and territorial drug-court coordinators in the U.S. estimated that African-Americans comprised approximately 21% of drug-court participants nationally, and Hispanic and Latino/Latina citizens comprised approximately 10% of drug-court participants (see Table 1). There was wide variability around these averages, with some drug courts reporting less than 1% minority participants in their programs and others reporting more than 95% minorities.

TABLE 1: MINORITY REPRESENTATION IN DRUG COURTS COMPARED WITH OTHER CRIMINAL JUSTICE PROGRAMS IN 2008
As points of reference, these figures were contrasted against those derived from national studies of arrestees, probationers and parolees, prison inmates, and jail inmates. Representation of African-Americans was estimated to be approximately 7 percentage points lower in drug courts than in the arrestee and probation-and-parole populations (21% vs. 28% and 28%), and approximately 20 percentage points lower than in jails and prisons (21% vs. 39% and 44%). Representation of Hispanic and Latino/Latina citizens was estimated to be nearly equivalent to the probation-and-parole population (10% vs. 13%), and approximately 6 to 10 percentage points lower than in jails and prisons (10% vs. 16% and 20%).

Taken together, these national statistics suggest that drug courts may be under serving racial and ethnic minority citizens, but the magnitude of the problem appears to be far smaller than that asserted by some critics. Based on these findings, a reasonable benchmark for improvement in drug courts would be to increase minority representation by approximately 7 percentage points so as to be equivalent with the arrestee and probationer populations.

A much greater concern relates to the disproportionate confinement of minorities, particularly African-Americans, in jails and prisons. As can be seen from the above table, African-Americans were considerably less likely to be on community supervision than in jail or prison (28% vs. 39% or 44%). In contrast, Caucasians were more likely to be on community supervision than in jail or prison (56% vs. 43% or 34%).

Fortunately, a national study recently found that the number of African-Americans in state prisons for drug-related crimes has declined by nearly 22% since the advent of drug courts and similar treatment-oriented diversion programs. After ruling out several alternative explanations for this development, such as changing drug-use rates among minorities, the report credited the rapid expansion of drug courts as one likely contributor to the precipitous decline.

Drug courts offer an evidence-based alternative to incarceration that defense attorneys can propose and judges and prosecutors can take into consideration during the plea bargaining and sentencing processes. If drug courts were to disappear, minority representation in jails and prisons would be expected to rise as opposed to decline, contrary to what some policy advocates have asserted.

Nevertheless, drug courts cannot and do not accept disproportionate minority representation in their programs, no matter how small the magnitude. Therefore, drug courts have set for themselves an obligation to make all reasonable efforts to bring minority representation in line with the applicable arrestee population in their respective jurisdictions. Examples of reasonable steps to be taken include ensuring that all assessment tools used for determining eligibility are equally valid and predictive for minorities as for non-minorities. In addition, drug courts should ensure that their eligibility and exclusion criteria are objective and race-neutral both in intent and effect. If an eligibility requirement has the unintended consequence of differentially restricting access for minorities, then extra assurances should be required that it is a necessary prerequisite for the program to achieve effective outcomes and protect public safety. Where less restrictive adjustments can be made to a drug court’s eligibility criteria to increase minority representation without jeopardizing safety or efficacy, it should be incumbent upon the program to implement such adjustments.
Drug courts should ensure that their eligibility and exclusion criteria are objective and race-neutral both in intent and effect.

III. MINORITY OUTCOMES IN DRUG COURTS

Numerous studies have reported that a considerably smaller percentage of minority participants graduated successfully from drug courts as compared to non-Hispanic Caucasians. In several of the studies, the magnitudes of the differences were quite large—as high as 25 to 40 percentage points. This problem may be particularly pronounced among African-American males between the ages of 18 and 25 years. Being young and male are well-documented risk factors for failure in drug courts and other correctional rehabilitation programs, and it appears that combining these two risk factors with racial-minority status may multiply the likelihood of failure.

A critical unanswered question is whether this disparity is a function of race per se or whether it might reflect the influence of other factors that are correlated with race.

These findings are by no means universal, however, as a smaller but growing number of evaluations has found no racial differences in outcomes or superior outcomes for minorities as compared to Caucasians, including for those between the ages of 18 and 25 years. Nevertheless, there does appear to be a plurality trend that African-Americans are less likely to succeed in many drug courts as compared to their non-racial-minority peers.

A critical unanswered question is whether this disparity is a function of race per se or whether it might reflect the influence of other factors that are correlated with race. Many studies have found that participants' drug of choice (particularly cocaine or heroin), employment status, and criminal history also predicted poorer outcomes in drug courts, and racial groups differed significantly on these variables. For example, in some communities African-Americans were more likely than Caucasians to be abusing crack cocaine, and it is possible that the severely addictive and destructive nature of this particular drug could have been largely responsible for their poorer outcomes. This possibility requires evaluators to statistically take into account the influence of variables that are correlated with race, such as participants' drug of choice, and then determine whether race continues to predict poorer outcomes after such extraneous variables have been factored out. Only then might it be justified to conclude there are disparate racial impacts in drug courts.

In fact, a statewide study of ten drug courts in Missouri suggested that other factors might be responsible for some of the apparent racial differences in outcomes. In that study, 55% of Caucasian participants graduated from the drug courts as compared to only 28% of African-Americans. However, greater proportions of the African-American participants were also unemployed (56% vs. 39%), unmarried (91% vs. 83%), living with unrelated individuals (51% vs. 37%), childless (69% vs. 56%), abusing cocaine as their primary drug of choice (45% vs. 13%), experiencing low levels of family support (38% vs. 29%), and of a lower SES. After taking these variables into account, race was no longer predictive of outcomes. The top three factors predicting graduation from the drug courts were participants' employment status at entry, SES, and cocaine as the primary drug of abuse.

The results of this study suggest that racial disparities in drug-court-graduation rates (at least in Missouri) might be explained by broader societal burdens, which may be borne disproportionately by minorities, such as lesser educational or employment opportunities or a greater infiltration of crack cocaine into some minority communities. If this finding holds true in further research, it would point to obvious and concrete measures that drug courts could take to increase minority completion rates. For example, drug courts might enhance vocational rehabilitation or educational services in their programs to offset any related disadvantages experienced by minority participants. They might also focus on delivering interventions that are proven to be successful for treating cocaine and other stimulant addictions.

IV. TREATMENT SERVICES FOR MINORITIES IN DRUG COURTS

There is ample evidence that racial-and-ethnic-minority citizens may receive lesser-quality treatment in the criminal justice system than non-minorities. A commonly cited example of this phenomenon relates to California's Proposition 36, a statewide diversion initiative for nonviolent drug-possession offenders. A several-year study of Proposition 36 by researchers at UCLA found that Hispanic participants were significantly less likely than Caucasians to be placed in residential treatment for similar patterns of drug abuse, and African-Americans were less likely to receive medically assisted treatment for addiction. Not surprisingly, treatment outcomes were also significantly poorer for these minority groups.
No quantitative data have yet been reported on whether such disparities exist within drug courts.  

Qualitative interviews with minority participants in drug courts do not suggest they perceived themselves as receiving lesser-quality treatment. To the contrary, in at least one study, minority participants were seemingly exasperated by receiving the same services as non-minorities and expressed a preference for a more individualized and less one-size-fits-all approach. Some minority participants in that study were particularly resentful about being required to attend 12-step meetings, such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). They reported feeling uncomfortable sharing their feelings in groups and being encouraged to accept the label of "addict." Instead, they expressed a predilection for receiving employment and educational services.

**[I]t is not possible to conclude at this juncture whether treatment services . . . are or are not appropriately suited to the needs of minority participants.**

Given how little research has addressed this question, it is not possible to conclude at this juncture whether treatment services in drug courts are or are not appropriately suited to the needs of minority participants. Future studies must empirically examine this issue in a more objective manner. Until such direct evidence is garnered, drug courts should, at a minimum, apply generic principles of evidence-based treatment in their programs. For example, several studies have demonstrated improved outcomes, including for minority participants, when drug courts administered manualized, structured, cognitive-behavioral curricula. Cognitive-behavioral interventions focus less on the expression of feelings and instead take a more active, problem-solving approach to managing drug-related problems. Several resources are available to help clinicians in drug courts select manualized cognitive-behavioral curricula that are proven to produce positive benefits for minority participants.

**[T]here is some evidence that providing culturally proficient or culturally sensitive interventions may improve results for minorities . . . .**

In addition, there is some evidence that providing culturally proficient or culturally sensitive interventions may improve results for minorities in drug courts. At least one drug-court program run by an experienced African-American clinician and utilizing culturally tailored interventions demonstrated superior effects for young male African-American participants over Caucasian participants. Efforts are underway to examine the intervention used in that study—presently named Habilitation, Empowerment & Accountability Therapy (H.E.A.T.)—in a controlled experimental study.

**V. SANCTIONS AND INCENTIVES FOR MINORITIES IN DRUG COURTS**

A commonly expressed concern about drug courts is that minority participants might be sanctioned more severely than non-minorities for comparable infractions. Anecdotal observations have typically been proffered to support this allegation, and minority participants in at least one focus group did report feeling more likely than other participants to be ridiculed or laughed at during court sessions in response to violations. No empirical study, however, has borne out the assertion. To the contrary, what little research has been conducted suggests that problem-solving courts, including drug courts, appear to administer sanctions in a racially and ethnically even-handed manner. Considerably more research is required, however, to study this important issue in a more systematic manner and in a representative range of drug-court programs.

A related concern is that minority participants might be sentenced more harshly than non-minorities for failing out of drug court. This is a particularly important matter because, as previously discussed, minorities may be more likely to be terminated from drug court than non-minorities. Although this issue is far from settled, there is some evidence that participants who were terminated from a few drug courts did appear to receive relatively harsher sentences than traditionally adjudicated defendants charged with comparable offenses. There is no evidence, however, to suggest whether this practice differentially impacts minorities as compared to non-minorities. Moreover, no information is available on whether there might have been a rational basis for the judges in those cases to augment the sentences as they did.

How and when augmented sentences are imposed in drug courts is among the most important questions that need to be carefully studied by researchers. Currently, there appears to be no clear consensus about whether, or under what circumstances, it is appropriate to increase a presumptive sentence for one who fails a diversion opportunity, such as drug court; however, participants must be informed of the possibility of an augmented sentence when they execute waivers to enter the program.

Ideally, defense attorneys and potential participants should be armed with more than just the mere knowledge that an augmented sentence could be imposed. Where possible, they should be armed with data about how likely this is to occur
and what factors the judge is apt to take into account when rendering such a decision. Researchers need to enlighten the
drug-court field about how these important matters are determined and, most important, whether these decisions may
unfairly or disproportionately impact racial-or-ethnic-minority participants.

VI. CONCLUSIONS

Much of the discourse surrounding racial- and ethnic-minority experiences in drug courts has shed more heat on the
matter than light. Anecdotal impressions have been miscast as scientific data, simple correlations have been
misinterpreted as proof of causality, and simplistic, even nihilistic solutions have been proffered to address complex
problems of crime and drug policy.

Here is what is known:

. African-Americans appear to be underrepresented in adult drug courts by an average of a few percentage points.

. African-American participants, and to a lesser extent Hispanic and Latino/Latina participants, are considerably less
likely than Caucasians to graduate from a plurality of drug courts, but not all drug courts. This difference does not
appear to be a function of race or ethnicity per se, but rather a function of other socio-demographic characteristics
which may be correlated with race or ethnicity.

. Evidence suggests graduation rates for African-American and Hispanic participants may be substantially increased by:

. providing vocational services and assistance;

. administering structured, cognitive-behavioral treatment curricula;

. administering treatments that are focused on the prevalent drugs of choice in minority communities (e.g.,
cocaine and heroin);

. better preparing minority participants for what to expect before referring them to 12-step meetings; and

. administering culturally tailored interventions for young African-American males.

. Empirical evidence does not support the assertion that minority participants receive different sanctions for comparable
infractions in drug courts; however, insufficient research has addressed this question.

. No valid research has investigated whether minority participants are sentenced more harshly than non-minorities for
failing drug court.

Clearly, the drug-court field is left with more questions than answers. More research is needed to determine what
services minority participants typically receive in drug courts, how to enhance minority outcomes in drug courts, and
what consequences typically ensue from program failure. Moreover, little is known about the impacts of drug courts on
minority groups other than African-Americans and Hispanics. Researchers need to make extra efforts to recruit a
diverse range of citizens into their studies and validly assess disparate impacts across the full spectrum of racial and
ethnic subgroups that are enrolled in drug-court programs or charged with drug-related offenses.

Drug courts are, first and foremost, courts, and the most fundamental principles of due process and equal protection
continue to apply to their operations. Thus Drug courts came into being to solve some of our most dire social ills, and it
would be a tragedy if programs designed to help people exacerbated their problems. Moreover, drug courts were created
to correct certain social injustices emanating from the War on Drugs, and they must not turn a blind eye to the faintest
possibility that they might be exacerbating some of those self-same injustices. It is incumbent upon drug courts to take a
fearless inventory of their actions, admit their shortcomings where applicable, and continue striving to perform their
vital work ever more effectively and humanely.

Legal Topics:
For related research and practice materials, see the following legal topics:
Criminal Law & Procedure
Criminal Offenses
Controlled Substances
Possession
Simple Possession
General Overview
Criminal Law & Procedure
Sentencing
Alternatives
Probation
Conditions
Criminal Law & Procedure
Sentencing
Alternatives
Substance Abuse Programs

FOOTNOTES:


n2 Id. at 2.

n3 Id. at 2-3.

n4 See generally Donald P. Green & Daniel Winik, Using Random Judge Assignments to Estimate the Effects of Incarceration and Probation on Recidivism Among Drug Offenders, 48 CRIMINOLOGY 357, 381 (2010) (concluding incarceration had little effect on likelihood of re-arrest for drug offenders); Cassia Spohn & David Holleran, The Effect of Imprisonment on Recidivism Rates of Felony Offenders: A Focus on Drug Offenders, 40 CRIMINOLOGY 329, 346 (2002) (finding incarcerated drug offenders were more likely to recidivate than those sentenced to probation); Jonathan P. Caulkens & Sara Chandler, Long-Run Trends in Incarceration in the United States, 52 CRIME & DELINQ. 619, 630 (2006) (finding incarceration does not dramatically reduce drug use and is not cost-effective).

n5 See generally E. L. Jensen et al., Social Consequences of the War on Drugs: The Legacy of Failed Policy, 15 CRIM. JUST. POL'Y REV. 100 (2004) (reviewing harmful impacts of War on Drugs on minorities and minority communities); Martin Y. Iguchi et al., How Criminal System Racial Disparities May Translate into Health Disparities, 16 J. HEALTH CARE FOR POOR & UNDERSERVED 48 (2005) (linking disproportionate confinement of minorities for drug offenses to severe health and mental-health impairments).

n6 HIGH COST, Low RETURN, supra note 5, at 1 (finding 1 in 104 American adults was behind bars in 2011); PEW CTR. ON STATES, ONE IN 100: BEHIND BARS IN AMERICA 2008 (2008) [hereinafter ONE IN 100] (finding 1 in 100 American adults behind bars in 2008).

n7 ONE IN 100, supra note 7, at 6.
n9 See generally NAT'L ASS'N DRUG CT. PROF., DEFINING DRUG COURTS: THE KEY COMPONENTS (1997) (describing the core ingredients of and services delivered in drug courts).

n10 See, e.g., David S. Festing et al., Expungement of Arrest Records in Drug Court: Do Clients Know What They're Missing?, 5 DRUG CT. REV. 1, 5 (2005) (reviewing the legal benefits of successful graduation from drug court).


n12 See generally Michael Rempel et al., The Impact of Adult Drug Courts on Crime and Incarceration: Findings From a Multi-Site Quasi-Experimental Design, J. EXPERIMENTAL CRIMINOLOGY, available at DOI: 10.1007/s11292-012-9143-2 (finding probability of re-offending reduced by almost one quarter in national study of 23 adult drug courts).

n13 See generally AVINASH S. BHAH ET AL., URBAN INST., To TREAT OR NOT TO TREAT: EVIDENCE ON THE PROSPECTS OF EXPANDING TREATMENT TO DRUG-INVOLVED OFFENDERS 56 (2008) (finding drug courts returned an average of $2.21 for every $1 invested, for net benefit to society of $624 million in 2006).

n14 See generally WEST HUDDLESTON & DOUGLAS B. MARLOWE, NAT'L DRUG CT. INST, PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES (2011) (defining and tallying the number of various types of problem-solving courts in the U.S. and internationally).

n15 See generally Douglas B. Marlowe, The Verdict on Drug Courts and Other Problem-Solving Courts, 2 CHAPMAN J. CRIM. JUST. 53 (2011) (reviewing research on various types of problem-solving courts).

n16 See Michael Wright, Reversing the Prison Landscape: The Role of Drug Courts in Reducing Minority Incarceration, 8 RUTGERS RACE & L. REV. 79, 81 (2006) (stating drug courts have the "potential, not only to reduce minority incarceration, but also to heal minority communities"); MARC MAUER, SENTENCING PROJ., THE CHANGING RACIAL DYNAMICS OF THE WAR ON DRUGS 2, 14 (2009) (concluding drug courts, especially those in urban communities, are likely to be disproportionately benefiting African-Americans by diverting them from prison).
n17 See NAT'L ASSOC. CRIM. DEFENSE LAWYERS, AMERICA'S PROBLEM-SOLVING COURTS: THE CRIMINAL COSTS OF TREATMENT AND THE CASE FOR REFORM 42 (2009) [hereafter NACDL REPORT] (concluding racial prejudice pervades the criminal justice system, and drug courts are no exception); JUST. POL'Y INST., ADDICTED TO COURTS: HOW A GROWING DEPENDENCE ON DRUG COURTS IMPACTS PEOPLE AND COMMUNITIES 23 (2011) (concluding people of color are more likely to be kicked out of drug courts); Michael M. O'Hear, Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice, 20 STAN. L. & POL'Y REV. 463, 479-480 (2009) (concluding drug courts exacerbate racial disparities).

n18 See Robert V. Wolf, Race, Bias, and Problem-Solving Courts, 21 NAT'L BLACK L.J. 27, 44 (2009) (noting "dearth of data" on race and drug courts; rather than answers, researchers have only questions).

n19 See infra notes 44-50 and accompanying text.

n20 See NACDL REPORT, supra note 17, at 20-21 (advocating for the decriminalization of all controlled substances in lieu of supporting drug courts); DRUG POL'Y ALLIANCE, DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE 19 (2011) (advocating for the removal of all criminal penalties for drug use in lieu of providing diversion opportunities within the criminal justice system, as in drug courts); JUST. POL'Y INST., supra note 17, at 26 (advocating for voluntary community-based treatment in lieu of drug courts).

n21 See O'Hear, supra note 17, at 125-136 (advocating for a restorative justice model in lieu of drug courts).

n22 See, e.g., NACDL REPORT, supra note 17, at 42-43 (asserting drug courts were developed for middle-class teens and minorities are rarely accepted); JUST. POL'Y INST., supra note 17, at 21 (asserting people of color are more likely to have prior felony convictions making them ineligible for drug court).

n23 See, e.g., DRUG POL'Y ALLIANCE, supra note 20, at 8 (asserting drug courts may increase the number of people of color brought into the criminal justice system).

n24 See, e.g., NACDL REPORT, supra note 17, at 42-43 (quoting one public defender's anecdotal experiences in one Utah drug court as evidence that drug courts discriminate).

n25 Id. at 42 (acknowledging the extent of the problem cannot be adequately analyzed because relevant data "simply does not exist"); Wolf, supra note 18, at 30 (noting "virtually nothing" written about specialized courts has addressed the issues of race and bias).

n26 HUDDLESTON & MARLOWE, supra note 14, at 28-29. These figures represent best estimates because the data were collected at the state level and the quality of statewide statistics on minority impacts was variable.
n27 Id. at 28-29, Tables 4, 5.

n28 The sources for the comparison data were: FEDERAL BUREAU OF INVESTIGATION, FBI CRIME REPORTING DATA, 2008; BUREAU OF JUSTICE STATISTICS, JAIL INMATES AT MIDYEAR 2007 (NCJ #221945); BUREAU OF JUSTICE STATISTICS, PROBATION AND PAROLE IN THE UNITED STATES, 2008 (NCJ #228230); BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2008 (NCJ #228417).

n29 See supra notes 6-8 and accompanying text.

n30 HUDDLESTON & MARLOWE, supra note 14, at 30, Table6.

n31 See generally MAUER, supra note 16.

n32 Id. at 14 (concluding "it is likely that at least in some jurisdictions there are people charged with a drug offense who are diverted from a prison term due to drug court programming").

n33 Cf. Wolf, supra note 18, at 46-47 (noting studies show minorities express more support than Caucasians for alternatives to incarceration, such as problem-solving courts).

n34 See supra note 23 and infra notes 69-72 and accompanying text.

n35 See NADCP MINORITY RESOLUTION, supra note 1, at 2.

n36 Id.

n37 Although an unintended discriminatory impact may not always be constitutionally objectionable, Washington v. Davis, 426 U.S. 229, 239-242 (1976), it is inconsistent with best practices for drug courts.
See, e.g., Mary P. Brewster, An Evaluation of the Chester County (PA) Drug Court Program, J. DRUG ISSUES 177, 194 (2001) (finding African-American participants were less likely to graduate from a drug court than Caucasians); Roger E. Hartley & Randy C. Phillips, Who Graduates from Drug Courts?: Correlates of Client Success, 26 AM. J. CRIM. JUST. 107, 113 (2001) (finding minorities significantly less likely to graduate from drug court than non-minorities); KATHARINA L. WIEST ET AL., NPC RESEARCH, VANDERBURGH COUNTY DAY REPORTING DRUG COURT EVALUATION: FINAL REPORT 32 (2007), available at http://www.npcresearch.com/Files/Vanderburgh_Adult_Eval_Final.pdf (finding Caucasians graduated from drug court 1.74 times more often than non-Caucasians); M. Schiff & C. Terry, Predicting Graduation From Broward County's Dedicated Drug Treatment Court, 19 JUST. SYS. J. 291 (1997) (finding minorities significantly less likely to graduate from drug court than non-minorities); Dale K. Sechrest & David Shicor, Determinants of Graduation from a Day Treatment Drug Court in California: A Preliminary Study, 31 J. DRUG ISSUES 129, 139 (2001) (finding African-American and Hispanic participants less likely to graduate from drug court than Caucasians); Christine A. Saum & Matthew L. Hiller, Should Violent Offenders Be Excluded from Drug Court Participation?, 33 CRIM. J. REV. 291, 300 (2008) (finding Caucasian participants in drug court less likely to recidivate than non-Caucasians); SHELLI B. ROSSMAN ET AL., NAT'L INST. JUST., THE MULTI-SITE ADULT DRUG COURT EVALUATION: THE IMPACT OF DRUG COURTS 75 (2011), available at https://www.ncjrs.gov/pdfiles/nij/grants/237112.pdf (finding in a national study of 23 adult drug courts that African-Americans were less likely to show reductions in recidivism than Caucasians); David M. Stein et al., Predicting Success and Failure in Juvenile Drug Treatment Court: A Meta-Analytic Review, J. SUBSTANCE ABUSE TREATMENT, available at http://dx.doi.org/10.1016/j.jsat.2012.07.002 (finding non-Caucasian participants had lower graduation rates and higher recidivism rates than Caucasians in juvenile drug courts).

See, e.g., STEVEN BELENKO, NAT'L CTR. ADDICTION & SUBSTANCE ABUSE, RESEARCH ON DRUG COURTS: A CRITICAL REVIEW, 2001 UPDATE 26 (2001) (reviewing studies reporting lower graduation rates for minorities in drug courts of approximately 30 to 40 percentage points); WIEST ET AL., supra note 38, at 32 (reporting lower graduation rate for non-Caucasians of 25 percentage points); Sechrest & Shicor, supra note 38, at 139 (reporting lower graduation rates of approximately 37 percentage points for African-Americans and 27 percentage points for Hispanics).


See Gennaro F. Vito & Richard A. Tewksbury, The Impact of Treatment: The Jefferson County (Kentucky) Drug Court Program, 62 FED. PROBATION 46, 49, Table 1 (1998) (finding approximately 42% graduation rate for African-American drug-court participants, compared to only 22% for Caucasians with a high school diploma or G.E.D. and 7% for Caucasians without a high school diploma or G.E.D.); Randal Brown, Drug Court Effectiveness: A Matched Cohort Study in the Dane County Drug Treatment Court, 50 J. OFFENDER REHAB. 191, 197 (2011) (finding better outcomes in a drug court for African-Americans and other minorities than for non-minorities); Andrew Fullerson, Drug Treatment Court Versus Probation: An Examination of Comparative Recidivism Rates, 8 SW. J. CRIM. JUST. 30, 35 (2012) (finding greater reductions in recidivism in a drug court for African-Americans than Caucasians); Christine A. Saum et al., Violent Offenders in Drug Court, 31 J. DRUG ISSUES 107, 121 (2001) (finding race had no apparent effect on drug-court graduation); JULIAN M. SOMERS ET AL., MEDIATORS OF DRUG TREATMENT COURT OUTCOMES IN VANCOUVER CANADA (Simon Fraser Univ., 2012) (finding better outcomes for aboriginal natives in a Canadian drug court).


n46  Anne Dannerbeck et al., Understanding and Responding to Racial Differences in Drug Court Outcomes, 5 J. ETHNICITY IN SUBSTANCE ABUSE 1 (2006).

n47  Id. at 11, Table 1.

n48  Id. at 11-13, Table 1.

n49  Id. at 13.

n50  Id. at 14, Table 3.

n51  See Laura S. Cresswell & Elizabeth P. Deschenes, Minority and Non-Minority Perceptions of Drug Court Program Severity and Effectiveness, 31 J. DRUG ISSUES 259, 277 (2001) (concluding minority and non-minority participants viewed drug court as similarly helpful, but minorities were more appreciative of employment assistance, and non-minorities were more appreciative of substance-abuse treatment); John R. Gallagher, Evaluating Drug Court Effectiveness and Exploring Racial Disparities in Drug Court Outcomes: A Mixed Methods Study 94 (2012) (unpublished Ph.D. dissertation, Univ. of Texas at Arlington) (on file with author) (finding African-American drug-court participants preferred employment assistance to treatment interventions); see also Carl Leukefeld et al., Employment and Work Among Drug Court Clients: 12-Month Outcomes, 42 SUBSTANCE USE & MISUSE 1109 (2007) (finding better outcomes in drug court when participants received augmented vocational services).


n53  See generally William B. Lawson & Anthony Lawson, Disparities in Mental Health Diagnosis and Treatment Among African Americans: Implications for the Correctional Systems, in CRIME, HIV & HEALTH: INTERSECTIONS OF CRIMINAL JUSTICE AND PUBLIC HEALTH CONCERNS (B. Sanders et al. eds., forthcoming 2013), available at DOI: 10.1007/978-90-481-8921-2_4 (reviewing disparities in sub-stance-abuse and mental-health diagnoses, treatment access, and treatment outcomes for minorities); Anne Dannerbeck-Janku & Junhui Yan, Exploring Patterns of Court-Ordered Mental Health Services for Juvenile Offenders: Is There Evidence of Systematic Bias?, 36 CRIM. JUST. & BEHAV. 402, 414 (2009) (finding African-American juvenile offenders were less likely than Caucasians to be referred for needed mental-health services); Steven R. Lopez et al., From Documenting to Eliminating Disparities in Mental Health Care for Latinos, 67 AM. PSYCHOLOGIST 511 (2012); Lonnie R. Snowden, Health and Mental Health Policies’ Role in Better Understanding and Closing African American-White American Disparities in Treatment Access and Quality of Care, 67 AM. PSYCHOLOGIST 524 (2012).


n56 Id. at 4 (finding treatment completion in Proposition 36 was lower for Hispanics and African-Americans).

n57 See, e.g., Wolf, supra note 18, at 48 (concluding much of what is known about problem-solving courts and race is "speculative").

n58 Gallagher, supra note 51, at 87, 94.

n59 Id. at 90-91.

n60 Id. at 88.

n61 Cf. Wolf, supra note 18, at 52 (concluding more research needs to be done on race and drug courts).

n62 See generally Cary E. Heck, MRT: Critical Component of a Local Drug Court Program, 17 COGNITIVE BEHAV. TREATMENT REV. 1, 2 (Correctional Counseling 2008) (finding addition of "Moral Reconation Therapy" [MRT] to drug-court curriculum produced better outcomes); Robert A. Kirchner & Ellen Goodman, Effectiveness and Impact of Thurston County, Washington Drug Court Program, 16 COGNITIVE BEHAV. TREATMENT REV. 1, 4 (Correctional Counseling 2007) (finding the completion of each additional step of MRT in a drug court was associated with an 8% further reduction in recidivism); Marinelli-Casey et al., supra note 52 (reporting superior outcomes for drug courts utilizing the MATRIX Model for stimulant dependence); Scott W. Henggeler et al., Juvenile Drug Court: Enhancing Outcomes by Integrating Evidence-Based Treatments, 74 J. CONSULTING & CLINICAL PSYCHOL. 42, 51 (2006) (finding addition of "Multi-Systemic Therapy" [MST] and "contingency management" [CM] improved outcomes in a juvenile drug court).

n64 The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an internet directory of evidence-based treatments called the National Registry of Evidence-Based Programs and Practices (NREPP). The NREPP website may be searched specifically for interventions that have been evaluated among substantial numbers of racial and ethnic minority participants, at http://www.nrepp.samhsa.gov/AdvancedSearch.aspx (last visited Nov. 1, 2012). See also Stanley J. Huey & Antonio J. Polo, Evidence-Based Psychosocial Treatments for Ethnic Minority Youth, 37 J. CLIN. CHILD & ADOLESCENT PSYCHOL. 262 (2008) (reviewing effective treatments for Hispanic and Latino/Latina youths).

n65 See Vito & Tewksbury, supra note 42, at 49 (reporting better outcomes for young, male African-American participants when drug court provided culturally proficient services delivered by an African-American clinician).

n66 See, e.g., NACDL REPORT, supra note 17, at 43 (citing personal observation of one lawyer that Caucasian participants are given more chances before a violation than minorities in a drug court).

n67 Gallagher, supra note 51, at 93 (reporting the perceptions of three African-American drug-court participants that the judge, staff, and/or observers laughed at them or were disrespectful during sanction hearings).

n68 See generally Wendy P. Guastaferro & Leah E. Daigle, Linking Noncompliant Behaviors and Programmatic Responses: The Use of Graduated Sanctions in a Felony-Level Drug Court, 42 J. DRUG ISSUES 396, 410, Table 5 (2012) (finding race was not related to the imposition of sanctions in a felony drug court); Patricia L. Arabia et al., Sanctioning Practices in an Adult Felony Drug Court, 6 DRUG CT. REV. 1 (2008) (finding a felony drug court serving 62% African-American participants and 25% Hispanic participants administered sanctions in a gradually escalating manner consistent with effective principles of behavior modification); Lisa Callahan et al., A Multi-Site Study of the Use of Sanctions and Incentives in Mental Health Courts, LAW & HUMAN BEHAV. 1, 4 (2012), available at DOI: 10.1037/h0093989 (finding no demographic characteristics, including race, predicted the imposition of jail sanctions in several mental-health courts); M. SOMJEN FRAZER, CTR. FOR CT. INNOVATION, THE IMPACT OF THE COMMUNITY COURT MODEL ON DEFENDANT PERCEPTIONS OF FAIRNESS 18, Table 3 (2006) (finding race was not related to participants' perceptions of procedural fairness when sanctions and incentives were imposed in a community court).

n69 See, e.g., O'Hear, supra note 17, at 480 (suggesting failure in drug court may lead to harsher sentences for minorities than not participating in drug court); NACDL REPORT, supra note 17, at 43 (same); JUST. POL'Y INST., supra note 17, at 24.

n70 See supra notes 38-43 and accompanying text for a discussion of graduation rates among minorities and non-minorities in drug courts.

n71 See JUST. POL'Y INST., supra note 17, at 24 (acknowledging very few studies have compared dispositions for participants who failed drug court to those traditionally adjudicated).

n72 See Josh Bowers, Contraindicated Drug Courts, 55 UCLA L. REV. 783, 792 (2008) (concluding sentences for participants who were terminated from drug courts in New York were two to five times longer than for conventionally adjudicated defendants).

n74 See, e.g., *id.* at 163 (noting drug courts must safeguard the due-process rights of participants).

n75 Some readers might recognize these principles as stemming from the precepts of AA and NA. *See* ALCOHOLICS ANONYMOUS WORLD SERVICES, TWELVE STEPS AND TWELVE TRADITIONS 6-8 (1981).
NOTE: BREAKING THE CYCLE AND STEPPING OUT OF THE "REVOLVING DOOR": WHY THE PRE-ADJUDICATION MODEL IS THE WAY FORWARD FOR ILLINOIS MENTAL HEALTH COURTS

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LEXISNEXIS SUMMARY:
... With studies suggesting "that the rate of serious mental illness among the jail population in the United States is at least three to four times higher than the rate of serious mental illness in the general population," it has become clear that individuals with mental illness are greatly overrepresented in prison and jail populations. ... When the first drug courts began, they focused on identifying potential participants early in the process to provide them with an alternative to the normal adjudication process. ... The Illinois Mental Health Court Treatment Act outlines three different adjudication models that courts in Illinois can implement - a "pre-adjudicatory mental health court program," a "post-adjudicatory mental health court program," and a "combination mental health court program" - but does not explicitly say which model courts in the state should use. ... Because solving the underlying causes of a defendant's mental illness is the purported goal of MHCs, a system that may, in fact, make the mental illness worse ultimately fails to uphold the ideals of therapeutic jurisprudence, restorative justice, and preventive law. ... Although one of the major goals of these theories is to treat the defendant's mental illness so that he has a clean slate after his participation in the MHC is complete, by requiring many or all defendants to plead guilty, these courts may ultimately fail to achieve this goal.

HIGHLIGHT:
Traditional courts in the United States are ill-equipped to handle the increasing number of mentally ill defendants entering the criminal justice system. Taking a cue from drug courts, jurisdictions across the country have instituted a new type of problem-solving court: Mental Health Courts (MHCs). MHCs link defendants suffering from mental illness to treatment and supportive services as an alternative to incarceration, in the hopes of lowering recidivism rates and increasing public safety.

This Note examines the three adjudication models commonly employed by MHCs: the pre-adjudication model, the post-adjudication model, and the combination model. In the pre-adjudication model, charges are held in abeyance until the defendant successfully completes treatment. In the post-adjudication model, the defendant is often required to plead guilty before entering treatment. In the combination model, the defendant is often convicted and sentenced to probation that includes treatment. Each of these models has strengths, weaknesses, and different outcomes for clients in those courts.

This Note discusses the three theories that form the founding principles of MHCs: therapeutic jurisprudence, restorative justice, and preventive law. It then examines each of the three MHC adjudication models and analyzes whether each model upholds these theories. The Note concludes that the pre-adjudication model best achieves the goals of the
therapeutic jurisprudence, restorative justice, and preventive law principles and argues that current and new MHCs in Illinois should adopt this model.

TEXT:
[*320]

1. Introduction

Mental health services in communities across the country are becoming overwhelmed by the numbers of people requiring their services. As this is happening, there have been corresponding increases in the number of mentally ill offenders making contact with the criminal justice system. As one commentator stated, the situation has become "a common and tragic story: Mentally ill defendants ... cycle through the criminal justice system repeatedly for petty offenses until they are slapped with lengthy prison sentences as repeat offenders." In the last fifty years, state-run mental health facilities in the United States have steadily closed their doors to patients. Although there were around 559,000 individuals receiving treatment in these hospitals in 1955, "fiscal imperatives, political realignment, philosophical shifts, and medical advances," coupled with the "atrocious conditions at some" resulted in the closure of many. These closures have resulted in a huge reduction in the number of individuals treated, with estimates down to 60,000 to 80,000 individuals being treated in state mental health hospitals by 1999. Closures have also caused concern in the criminal justice system, because as mental health facilities began to close their doors, the number of individuals with mental illness in the system began to increase at an alarming rate. With studies suggesting "that the rate of serious mental illness among the jail population in the United States is at least three to four times higher than the rate of serious mental illness in the general population," it has become clear that individuals with mental illness are greatly overrepresented in prison and jail populations. These numbers cause some scholars to speculate that the criminal justice system is becoming a "surrogate mental health-care provider within North American society" as more and more individuals with mental illness end up in prisons and jails rather than mental health institutions.

With more people entering the system every day, overcrowding, increased costs, and overloaded court dockets are a constant concern for judges, attorneys, and defendants alike. These concerns are exacerbated by the inability of the criminal justice system to adequately treat the defendants' underlying mental disorders, which often results in repeat offenses and further contact with the system. As Northwestern University Professor Linda A. Teplin stated, many mentally ill offenders "may be caught in a revolving door where they are in jail, and back in the community, and in jail and back in the community" unless the underlying causes of their mental disorder are addressed.

To cope with the influx of mentally ill individuals, and to combat a growing problem of repeat offenders, many jurisdictions have adopted the principles of therapeutic jurisprudence, restorative justice, and preventive law in establishing Mental Health Courts (MHCs). An MHC is a court with a docket dedicated to linking defendants suffering from mental illness "to appropriate treatment and supportive services" and diverting them away from incarceration. The purpose of these courts is to use a problem-solving approach to criminal justice that identifies and treats mentally ill offenders in order to lower recidivism rates and increase public safety. Although all MHCs have these two common goals, they often have divergent approaches to reaching them. From eligibility to program requirements, each court's approach is slightly different depending on the community's needs. Although this flexibility has allowed the courts to serve individual defendants' needs, the lack of a single "blueprint" has led to major debates concerning which model is the most effective and most adequately achieves MHC goals.

One area that has been subject to debate concerns the adjudication methods used when admitting clients into MHCs. There are three different adjudication models: the pre-plea/pre-adjudication model (pre-adjudication model), the post-plea/post-adjudication model (post-adjudication model), and the combination model. Most MHCs typically employ only one of these models, depending on where in the criminal prosecution process the defendant enters the MHC, the crime the defendant is accused of committing, or where the alleged crime took place. Although this may appear to be a small detail, the model employed by the MHC can greatly impact the rights of the defendants involved.

Advocates of the pre-adjudication model, where prosecution is deferred and charges are held in abeyance until the defendant successfully completes treatment, often argue that this model makes MHC programs more attractive to defendants and facilitates quicker entry into the programs. The post-adjudication model, on the other hand, requires the defendant to plead guilty before program entrance will be granted. The defendant's sentence usually is not imposed unless the defendant fails to successfully complete the program. While this model lessens the burden on prosecutors, opponents argue that the model puts additional burdens on defendants in terms of obtaining housing or...
employment \textsuperscript{26} and can hamper the defendant's constitutional rights. \textsuperscript{27} In the combination model, the defendant is often convicted and sentenced to probation or a deferred jail sentence, both of which include MHC treatment. \textsuperscript{28} This model, which is employed in a small minority of MHC programs, has also been criticized for the potential burdens it places on participants who are required to plead guilty in order to enter the program. \textsuperscript{29}

This Note explores the three adjudication models typically employed \textsuperscript{[*323]} by MHCs and argues that Illinois courts should adopt a pre-adjudication model because it most successfully achieves the goals of therapeutic jurisprudence, restorative justice, and preventive law. Part II provides an overview of the traditional criminal justice system route defendants take in the absence of an MHC program as well as the various theoretical underpinnings of MHCs, and traces the development of problem-solving courts such as MHCs and their predecessor, drug courts. Next, Part III analyzes the three alternative models in terms of their requirements and the effects they have on defendants' rights. Finally, Part IV recommends that Illinois courts contemplating an MHC employ pre-adjudication principles to strike a balance between the goals of such courts and the rights of those entering, while existing MHCs in other jurisdictions should amend their policies to comply with the pre-adjudication model.

II. Background

MHC programs in the United States are a relatively new innovation. Following the establishment of the first MHC in Broward County, Florida, the idea quickly spread to other jurisdictions, \textsuperscript{a30} and by 2007 there were over 175 courts in jurisdictions across the United States, with dozens more being planned. \textsuperscript{a31} To understand the different MHC adjudication models, it is necessary to understand the development of problem-solving courts and how they differ from the traditional system. Section A provides an overview of the traditional criminal justice system that a defendant would experience in the absence of an MHC option. Section B discusses the tenets of therapeutic jurisprudence, restorative justice, and preventive law theories, which respond to the inability of the traditional system to treat mentally ill defendants and influenced the creation of problem-solving courts. Finally, Section C discusses the rise of the first problem-solving courts - drug courts - and how they led to the creation of MHCs.

A. Non-Mental Health Court Systems

Since U.S. mental health institutions began to close, the number of mentally ill individuals in prisons and jails has risen, and unfortunately these facilities have not been able to meet their needs. \textsuperscript{a32} As one scholar stated, "our prisons were never designed to operate as psychiatric hospitals" \textsuperscript{[*324]} and are "unprepared to adequately meet the needs of mentally ill prisoners." \textsuperscript{a33} To understand why MHCs are beneficial, it is important first to understand what a mentally ill defendant experiences in a jurisdiction without this type of specialized docket. In non-MHC jurisdictions, mentally ill defendants are treated like any other defendant and receive no special treatment. \textsuperscript{a34} While some may view equal treatment as beneficial and appropriate, for defendants suffering from mental illness it can be quite the opposite. \textsuperscript{a35} When a defendant with a mental illness encounters the traditional system, there is no guarantee that mental health services will be available. \textsuperscript{a36} Even when services are available, they may come with long waits, frequent interruptions, or stigmatization, \textsuperscript{a37} or be limited to determinations of competency to stand trial. \textsuperscript{a38}

When court personnel "lack both the tools necessary to perform meaningful assessments and the connections with mental health service providers necessary to know what kinds of treatment options are available," the results can be tragic for defendants. \textsuperscript{a39} In a non-MHC jurisdiction, a defendant will encounter prosecutors, defense counsel, judges, and jail or prison personnel who are usually unfamiliar with mental illness or what would best aid the defendant. \textsuperscript{a40} This unfamiliarity may mean that decisions harm defendants more than help. Judges concerned about public safety, for example, may believe that incarcerating mentally ill defendants is the safest option, even if they are not a serious risk to themselves or the community. \textsuperscript{a41} Similarly, jail personnel who do not understand the needs of mentally ill inmates may unintentionally make their conditions worse through actions that would have little to no effect on defendants without mental illness. \textsuperscript{a42} To complicate matters further for \textsuperscript{[*325]} mentally ill defendants, many jails and prisons lack basic resources, staff, and facilities to address their needs. \textsuperscript{a43}

The inability of prisons and jails to meet the needs of mentally ill defendants also has financial costs. Without a solution to the underlying cause of their crimes, many mentally ill defendants find themselves trapped in a pattern in which they serve their time, are released, and then end up back on the streets without employment or discharge planning. \textsuperscript{a44} The cycle is completed when they eventually end up back before the court and in prison or jail. \textsuperscript{a45} This endless cycle of incarceration, homelessness, and related hospital stays results in very high costs to the state and taxpayers. \textsuperscript{a46} In New York City, for example, the average jail stay for mentally ill persons is 215 days compared to an average of only 42
Without an MHC to help mentally ill defendants, the likelihood that they will commit another offense is high. For example, one study indicated that forty-nine percent of “federal prisoners with mental illness have three or more prior probation, incarcerations or arrests,” but only twenty-eight percent of federal inmates without mental illness fit this description. Another study of participants in an MHC in Bonneville County, Idaho, found that in the first six years of its operation, the recidivism rate of graduates dropped to twenty-four percent and continues to drop each year. These statistics suggest that the traditional adversarial system is not working for mentally ill defendants. Rather than help mentally ill defendants address the underlying causes of their criminal behavior, the traditional system often traps them in a “revolving door” that ends up exacerbating their illness and costing the state and taxpayers more and more money.

[*326]  
B. Therapeutic Jurisprudence, Restorative Justice, and Preventive Law: Theoretical Foundations of Problem-Solving Courts

As it became clear that the traditional criminal justice system was not adequately addressing the underlying causes of defendants’ criminal activity and was increasingly leading to repeat offenses, jurisdictions across the country began instituting problem-solving courts. Many theories are advanced to justify problem-solving courts, but three - therapeutic jurisprudence, restorative justice, and preventive law - have come to the forefront. To understand the objectives of problem-solving courts such as MHCs, it is necessary to first understand these theoretical underpinnings:

It is important for those involved, or those who may be interested in becoming involved with mental health courts … to gain a solid understanding of therapeutic jurisprudence. By acquiring a basic knowledge of this theory, service providers will better appreciate the ultimate goals of the court program and better inform their own participation.

The same can be said for gaining an understanding of restorative justice and preventive law theories, which similarly advocate a non-adversarial approach to effectuate change in the criminal justice system. As such, the following Subsections discuss the development and goals of these theories, beginning with therapeutic jurisprudence and moving through restorative justice and preventive law, focusing on how they provide a “framework in which to implement the formation of specialized mental health courts.”

1. Therapeutic Jurisprudence

The concept of therapeutic jurisprudence is relatively new, having been first introduced in a 1987 paper by Professor David Wexler for a workshop run by the National Institute of Mental Health. Wexler argued that the law, specifically mental health law, should function as a therapeutic agent that considers “the anticipated therapeutic outcomes of [its] rulings,” to avoid causing or contributing to psychological dysfunction in clients. According to Wexler, without taking therapeutic outcomes into account, the law is capable of contributing to psychological dysfunction by: (1) discouraging clients from seeking treatment they need, (2) encouraging clients to receive unnecessary treatment, or (3) “leading persons to regard themselves as dysfunctional or as lacking in control” because of the labels and attributions the law gives them. A system that contributes to psychological dysfunction in these ways is antithetical to the system advocated by therapeutic jurisprudence scholars - a system where the law does not do harm, but remedies it and produces beneficial impacts on those who come into contact with the law. With these considerations in mind, Wexler proposed that certain changes be made in the law that could reduce dysfunction and encourage therapeutic objectives.

Although the initial focus of therapeutic jurisprudence scholarship was mental health law, it has since been applied to other areas and has come to represent a new type of justice. Advocates of problem-solving courts look to and expound upon the theory for support and justification of the establishment and mission of specialty courts. Today, proponents of therapeutic jurisprudence argue that the law should not only seek to punish wrongdoers and protect society, but should also produce “therapeutic” results. To that end, they place an emphasis on each defendant’s emotional and psychological well-being and strive to make the justice system “more humane, therapeutic, beneficial, humanistic, healing, restorative, curative, collaborative, and comprehensive.” By shifting to a therapeutic model, the social and economic costs of criminal activity can be lowered and the lives of the accused can be improved.
In shifting to a therapeutic model, courts must abandon the traditional adversarial approach to criminal justice described above, which can cause or contribute to psychological dysfunction. Instead, courts should strive for a cooperative, non-adversarial approach. One scholar described this aspect of therapeutic jurisprudence as follows:

This theory holds that the law should be administered and applied in a way that incorporates therapeutic goals. It advocates using the criminal justice system in a manner that addresses the underlying factors that may lead an individual to come into contact with the law. It strives to be a vehicle that elicits a more nuanced societal response to proscribed behaviour. Thus, therapeutic jurisprudence focuses on identifying and treating the underlying causes of specific defendants' troubles, which may be drug abuse, mental illness, homelessness, or any number of other issues. Criminal activity itself, they argue, is only a symptom of the underlying disorder plaguing the defendant, and by identifying and treating the disorder, therapeutic jurisprudence can "minimize the offender's future contact with the criminal justice system, hold him accountable for his crimes, and ensure the safety of the public." Diverting individuals away from the criminal justice system and toward treatment programs can also help reduce court and corrections costs by providing an alternative to incarceration. The Thresholds Jail Program in Chicago, Illinois, a program which provides case management for mentally ill clients who have been released from jail, demonstrates how an effective program can reduce incarceration-related costs. Figures indicate that the thirty individuals enrolled in the program spent a combined 2200 fewer days in jail and 2100 fewer days in hospitals during their participation than they had in the year before their participation began. At a cost of about $70 per day for jail and $500 per day for hospital stays, this amounts to savings of around $1.2 million. Information from other jurisdictions - such as King County, Washington, a typical example of MHCs - also indicates that reducing recidivism rates can save money or at least divert precious resources to the areas of greatest need.

Although proponents of therapeutic jurisprudence advocate making what some call "fairly radical" changes to the way defendants and their crimes are viewed, they believe that therapeutic changes should not "trump certain traditional values of justice," and that the traditional goals should remain intact. Despite this stance, critics of the theory argue that therapeutic jurisprudence is incompatible with traditional values of justice and that the restricted focus of therapeutic jurisprudence makes the maintenance of the traditional values extremely difficult. Critics also argue that the personal interest that judges and attorneys must take in individual defendants to implement therapeutic ideals is outside the scope of their positions. By becoming involved in defendants' lives in this way, judges and attorneys risk tainting their impartiality. Another concern is that even though focusing on the underlying cause of criminal activity is admirable, available resources are finite and giving them to individuals charged with crimes is a "catalyst for line-bumping or line-shuffling, preserving scarce services for the 'bad' and taking away services from the 'good.'" A final concern is that a focus on therapeutic ideals leads to coercion. Rather than enter into treatment willingly, many participants are subject to a form of paternalism from the state and are railroaded into entering treatment or therapy programs, critics argue.

Despite these concerns, proponents maintain that therapeutic outcomes are beneficial and that any anti-therapeutic outcomes should be avoided. They also refute claims of coercion by pointing to studies indicating that most participants perceive low levels of coercion. Furthermore, recognizing due process concerns, proponents of therapeutic jurisprudence attempt to apply the law in an even-handed, non-discriminatory way, while still upholding traditional criminal justice system needs such as protecting society, holding defendants accountable for their offenses, and showing "society's repugnance to criminal behaviour." 2. Restorative Justice

The restorative justice theory is very similar to therapeutic jurisprudence in terms of its goals and its emphasis on taking the well-being of each defendant into account; it is sometimes referred to as its sister theory. Like therapeutic jurisprudence, the theory has been thought to advocate radical changes in the legal system. The theory has been described as
an alternative delinquency sanction focused on repairing the harm done, meeting the victim's needs, and holding the offender responsible for his or her actions... Restorative-justice sanctions use a balanced approach, producing the least restrictive disposition while stressing the offender's accountability and providing relief to the victim. The offender may be ordered to make restitution, to perform [*330] community service, or to make amends in some other way that the court orders.  

As this definition states, restorative justice seeks to understand each defendant's needs and provide treatment that will repair the disruptions that mental disorders and criminal behavior caused in his life.  

Although restorative justice and therapeutic jurisprudence have similar goals, there are a few key differences. First, restorative justice's scope is broader than therapeutic jurisprudence's, and it views both the victim and the community as having been harmed by the crime committed.  

Restorative justice also focuses not just on the defendant, but also seeks to put victims and other stakeholders back in "their position prior to or irrespective of the criminality."  It does so by inviting all parties affected by the criminal activity to participate in the process of "determining needs and outcomes." By increasing participation, restorative justice "maximizes opportunities for exchange of information, participation, dialogue, and mutual consent between victim and offender."  

Restorative justice also focuses more on requiring defendants to "pay back" the community for their wrongdoing than therapeutic jurisprudence does.  The defendant can pay back the community by understanding how his behavior caused the victims and the wider community harm, and restorative justice encourages the defendant to take responsibility for that behavior.  

Next, the defendant must satisfy his obligations to the victims or the community by paying restitution, performing community service, or contributing in other ways.  Obligations to the victim take precedence over other imposed sanctions or obligations such as fines payable to the state.  

Another important difference between the two theories is restorative justice's use of "reintegrative shaming." When participants in specialty [*331] courts are noncompliant, judges using a restorative justice model sometimes use public shaming techniques both to encourage compliance with program requirements and to "affirm[] the [defendant's] membership within law-abiding society." For example, in some cases, a court may require the defendant first to register and/or notify the community of his offenses or make public apologies or confessions - the shame - and then to join a support group where treatment and inclusion may begin - the reintegration into society. Shaming techniques, such as those just mentioned, are designed to express disapproval of the defendant's actions and encourage feelings of remorse or shame.  It is thought that by feeling this shame, the defendant's membership in society will be reinforced, and he will want to be reintegrated into the community, a community which has forgiven him. Although these measures are said to punish the actions of the defendant rather than the defendant himself, critics of restorative justice argue that such sanctions are not rehabilitative.  Despite differences in the two theories, it is clear that they both played a role in the development of problem-solving specialty courts.

3. Preventive Law

Like the theories discussed above, theories based on preventive law focus on resolving cases in a nonadversarial manner. Proponents of preventive law in the context of MHCs believe that those involved in the criminal justice system, particularly judges and attorneys, can effectuate societal change by giving defendants the help they need to cure their mental health issues, rather than by following the methods of the traditional legal system. The traditional adversarial legal system, they argue, often results in "litigation that ... upsets the defendant's psyche, depletes financial resources, and prolongs judicial resolution of matters" for those involved. Thus, rather than focus on an adversarial system, proponents of preventive law seek "to help people stay within the bounds of law (i.e. minimize the risk of legal trouble); and take advantage of legal opportunities (i.e. maximize legal benefits)."

By creating specialized dockets such as MHCs, which help mentally ill defendants obtain needed treatment, defendants can lessen the conflict and dispute in their lives and, thus, lessen the "frequency and scope of future legal problems." This, in turn, improves the quality of their "legal health." Proponents of MHCs often look to preventive law for support and state that they are "making an investment in treatment in order to prevent the re-occurrence of crime ... by offenders with mental illness." Many ex-offenders also express a desire for more measures aimed at preventing their return to the criminal justice system, rather than having attorneys who are "more focused on pursuing short-term strategies necessary to close the case." As one defendant stated, "if [defense attorneys] knew more about mental
illness, they would do things differently" and would think about the defendants' best interests and need for long-term treatment to prevent recidivism.\footnote{122}

C. Problem-Solving Courts

As it became clear that the criminal justice system was providing few, if any, real solutions to the issues causing defendants to enter the system in the first place, the first problem-solving courts developed.\footnote{124} Encouraged by therapeutic jurisprudence, restorative justice, and preventive law theories, judges and community leaders began seeking new ways to address the unique circumstances of each defendant who came into their courts.\footnote{115} Rather than let defendants suffering from drug abuse or mental illness go through the regular court system, policymakers began to allow defendants to enter courts on special dockets.\footnote{116} With the guidance of a judge, the programs integrated the judicial process with treatment services to "address the underlying problems of individual litigants, \footnote{333} the structural problems of the justice system, and the social problems of the communities" they are located in.\footnote{117}

By addressing these underlying problems, the courts could "facilitate long-term behavioral and attitudinal change among participants and their communities" in the hopes of improving defendants' quality of life.\footnote{118} This would then lower the recidivism rate, effectively closing the "revolving door" that many participants had been trapped in, and increase public safety.\footnote{119} This approach was thought to be beneficial because it would enable both the court and treatment service providers to tailor programs for each defendant's specific needs in order to respond to them quickly and effectively.\footnote{120} The individual focus also would allow treatment providers to closely monitor each participant's treatment progress.\footnote{121}

Although the first problem-solving courts began in the late 1980s, their number remained relatively low for the next ten years.\footnote{122} In 2000, however, the Conference of Chief Justices and the Conference of State Court Administrators, both policy leaders of the U.S. state court system, passed a resolution encouraging the implementation of more problem-solving courts.\footnote{123} In addition to endorsing the courts generally, the resolution called for "the broad integration ... of the principles and methods employed in the problem-solving courts into the administration of justice to improve court processes and outcomes,"\footnote{124} Further support came in 2001 when the American Bar Association adopted a similar resolution encouraging "law schools, state, local and territorial bar associations, and other organizations to engage in education and training about the principles and methods employed by problem-solving courts."\footnote{125}

Since then, the type and number of problem-solving courts has grown tremendously. Two of the main problem-solving courts, drug courts and mental health courts, are discussed here. Subsection One begins by giving a brief history of drug courts and how they served as a model for the establishment of MHCs. Subsection Two discusses the creation of MHCs. This is particularly relevant to the discussion of adjudication models, as the model employed by a particular court is often influenced \footnote{334} by its goals and characteristics.

1. Drug Courts

In the 1980s and 1990s, the criminal justice system began its so-called "War on Drugs."\footnote{126} At this time, new anti-drug laws and increased enforcement efforts brought a wave of drug case filings into the court system.\footnote{127} To cope with the increase, judges and other policymakers looked to therapeutic jurisprudence, restorative justice, and preventive law for a new way of effecting change.\footnote{128} To these policymakers, justice was not simply about punishing criminal activity with lengthy sentences; rather, it was about improving the community and the lives of those in the system,\footnote{129} and problem-solving courts were a natural solution. In the words of Judge Peggy Fulton Hora,

Justice is fulfilling sentencing goals such as retribution, rehabilitation, restitution, and so forth. And the way it's redefined [in drug courts] is, the whole idea of this approach, is you have people who have a disease called alcoholism and/or addiction. And what is just is getting them well rather than punishing them for their disease.\footnote{130}

In essence, the goal of this "new" justice is to reduce recidivism in offenders with alcohol or substance abuse problems\footnote{131} via a nonadversarial system of treatment and healing, but in a way that takes into account the goals and values of the traditional criminal justice system.\footnote{132} In 1989, these goals began to be realized with the foundation of the first drug court in Miami-Dade County, Florida.\footnote{133} Today, there are over 1600 drug courts operating across the country, and they continue to emphasize therapeutic, restorative, and preventive goals in reshaping the lives of defendants by addressing and treating their addiction rather than only punishing them for it.\footnote{134}
When the first drug courts began, they focused on identifying potential participants early in the process to provide them with an alternative to the normal adjudication process. In the alternative program, participants could expect an intensive program tailored to their specific needs. Generally speaking, the participant was required to sign a contract agreeing to the program's terms. Some common program terms included regular court appearances, increased interaction with the judge, and participation in outside drug treatment. Failure to comply with the contract requirements could mean that the defendant is returned to the regular court to be tried or sentenced. In addition to frequently interacting with the judge, participants would also be expected to interact with a drug court team. The individuals on this team may include the prosecutor, defense attorney, probation officers, and program coordinators or case managers who aid the judge in closely monitoring progress and compliance.

Despite the noble goals of drug courts, critics are quick to point out their deficiencies. According to some, increased court appearances and extra demands placed on defendants by drug court programs are more burdensome than what defendants would face if given regular probation. For example, whereas defendants may have very infrequent court appearances if they abide by the terms of their probation, in drug court programs the defendants may be subject to weekly appearances and/or drug tests. Others are concerned that judges using coercive powers are overstepping their boundaries by becoming so involved in the defendants' lives and that these powers can be abused. A third critique regards participation length. Because programs are tailored to each defendant's needs, program durations may differ and be hard to predict. Although many programs are said to last no more than one year, they may in fact last much longer depending on how quickly the participant can overcome the addiction and satisfy the program requirements. Due to these indeterminate timelines, many participants are required to sign waivers to forgo a speedy trial. Thus, defendants entering the drug court may be signing away certain constitutional rights that they will not be able to get back if they fail in their obligations to the program and the court.

In response to these concerns, proponents concede that drug courts are often more arduous than the normal course. They counter, however, by arguing that "drug addiction is a disease and that intense court supervision provides the incentive for the defendant to stay in the program." Some even highlight the length of participation in terms of the therapeutic benefits it can have in contributing to recovery. In this sense, prolonged treatment is not viewed as a punishment, but as a "restructuring of the defendant's lifestyle." Furthermore, drug courts, like MHCs, are voluntary. Thus, when defendants enter the courts they are choosing to forgo rights in exchange for the opportunity to receive treatment. Whatever the arguments for or against drug courts, their success prompted the creation of other problem-solving courts, such as MHCs, in order to deal with other problems communities across the country face and to ease the burden on court dockets.

2. Mental Health Courts

As previously mentioned, MHCs are a relatively new type of problem-solving court. Their development was the result of decades of frustration with traditional courts' inability to respond to and treat defendants suffering from mental illness. As mental health institutions closed their doors, court dockets began to see a rise in the number of individuals with mental illness. It soon became clear to judges, prosecutors, defenders, and policymakers alike that mental illness was the cause of, or at least contributed to, the offenses these individuals committed. In many cases, individuals suffering from mental illness repeatedly made contact with the criminal justice system after committing minor offenses such as loitering, trespassing on private property, urinating in public, or disturbing the peace. Statistics also indicate that many of these individuals were homeless or unemployed, had alcohol and substance abuse issues, and suffered physical and sexual abuse prior to being arrested and incarcerated.

Proponents of therapeutic jurisprudence, restorative justice, and preventive law were among the first to recognize the problems mentally ill defendants had in the regular system, and they were especially keen for a change. This was in part because they recognized that contact with the traditional system could have especially adverse and anti-therapeutic effects on a defendant's health and well-being. In 1997, these theories helped influence the establishment of the nation's first MHC in Broward County, Florida. Since then the number of these courts has grown tremendously, and there are now specialized mental health dockets across the country. The growth of these courts was encouraged, in part, by the passage of America's Law Enforcement and Mental Health Project Act. This Act authorized the foundation of additional courts based on the success of those already in place. Congress made a number of findings regarding the prevalence of mentally ill offenders in the system and concluded that "16 percent of all inmates in State prisons and local jails suffered from mental illness," and that by some estimates, "25 to 40 percent of America's mentally ill [would] come into contact with the criminal justice system." With the
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funding and support this Act provided, other jurisdictions began to realize that a specialized MHC docket could aid in directing some of these offenders into treatment and integrate them back into the community in a positive way. Like drug courts, MHCs are run by multidisciplinary teams consisting of court personnel, mental health professionals, and other community figures, and are aimed at providing treatment and supervision to defendants [*338] whose mental illness contributed to the commission of their offense. [*167] These teams are driven "by the premise that, but for the accused's mental disorder or condition (and usually attendant socioeconomic decline), she would not likely have become involved in the conduct before the court." [*168] Through diversion, monitoring, and supervision, the MHC hopes to treat the defendant's illness first and foremost and by doing so, increase public safety and reduce recidivism rates. [*169] It is important that the defendants are interacting with a team, rather than numerous individuals with varying experiences or motivations as they would in the regular system. In the traditional system, "defendants often interact with a number of different defenders, prosecutors, and judges all on the same case, which is an approach that often creates barriers that prevent the court from identifying and addressing the unique needs of the mentally ill offender." [*170] By working together, the MHC team hopes to process cases faster, improve access to treatment, improve the defendant's well-being, improve public safety, and reduce recidivism better than under the traditional system. [*171]

Not everyone is a supporter of the MHC model, however. Some worry that although MHCs purport to be completely voluntary, [*172] participants may be "forced" to take medication or are, depending on the adjudication model used, coerced into pleading guilty to enter the court. [*173] Additionally, like critics of drug courts, MHC critics sometimes worry that participation in this court as opposed to the traditional court system may be more burdensome for defendants. [*174] According to some, "one year of mandated treatment and "check in' court dates might be equivalent to three months in jail" and thus, the time the defendant serves may not fit the crime he or she committed. [*175]

There are also many requirements that defendants must abide by as a condition of entering the MHC, and oftentimes defendants are required to sign a contract committing to those conditions. [*176] In the King [*339] County Mental Health Court, for example, defendants have to sign the "Mental Health Court Agreement/Conditions of Treatment" if they are admitted into the court. [*177] Some conditions include meeting with a probation officer twice a month (which can be increased if the defendant does not comply with the treatment plan), attending regular court hearings at least once a month, and not using, possessing, or consuming alcohol, non-prescribed drugs, firearms, or other weapons. [*178]

Failure to comply with a requirement usually will not result in immediate dismissal from the court, however. In most cases, the defendant is given more than one chance to rectify any shortcomings in court performance. For example, in People v. Kimmel, the defendant signed a contract upon entering the MHC stating that if he should "fail to complete the Mental Health Court Program, [he] will return to the Criminal Calendar to be sentenced." [*179] When the defendant did not attend care coordination appointments, lost his job, and failed to perform mandated community service, he was admonished by the court but was allowed to stay in the MHC program. [*180] After he stopped coming to his MHC appearances for over eight months, and only came back after being picked up on a bench warrant, he was, however, removed from the program. [*181]

III. Analysis

As MHCs gain acceptance and support, their numbers continue to grow and several different models and methods of running these courts have emerged. [*182] The model that a court uses depends largely on the needs of the community. [*183] As such, before starting an MHC, community leaders, policymakers, and other stakeholders, such as treatment providers and criminal justice system personnel, must come together to identify the community's needs and what resources are available to meet them. [*184] Without first taking these factors into consideration, the courts will not be able to successfully link participants to appropriate treatment. This, in turn, can result in unsuccessful attempts to treat and rehabilitate the defendant and can jeopardize the court's efforts to improve community safety and reduce recidivism rates. [*185]

In June 2008, the State of Illinois implemented the Illinois Mental Health Court Treatment Act that authorized the creation of specialized [*340] courts that could identify "criminal defendants with mental illnesses." [*186] The Illinois General Assembly passed the Act after finding that a large percentage of criminal defendants in Illinois prisons and jails had a mental illness and that these illnesses were having "a dramatic effect on the criminal justice system in the State of Illinois." [*187] In Illinois, and other jurisdictions where an MHC is available, defendants entering the system will often be given a choice: they can either choose to participate in the MHC, or they may choose to proceed through the traditional system. [*188] If the defendants choose to forgo the traditional adjudication route and enter into the MHC, the disposal of his charges will depend on the adjudication model employed by the court.
The Illinois Mental Health Court Treatment Act outlines three different adjudication models that courts in Illinois can implement - a "pre-adjudicatory mental health court program," a "post-adjudicatory mental health court program," and a "combination mental health court program" - but does not explicitly say which model courts in the state should use. In the first model, the pre-adjudication model, defendants are allowed to enter the MHC before their case is adjudicated. In a post-adjudication model, defendants are required to adjudicate their charges, often by pleading guilty, before being allowed to enter the MHC and treatment. Finally, in a combination model, aspects of both pre-adjudication and post-adjudication models are used and participation in the MHC may often be part of the defendant's probation.

In the following discussion, this Note analyzes the three different adjudication models outlined in the Illinois Mental Health Court Treatment Act as they have been used in Illinois and MHCs across the country.

A. Pre-Adjudication Model

One adjudication model used by some early MHCs is known as the pre-adjudication model. According to the Illinois Mental Health Court Treatment Act, a pre-adjudication court is one in which the defendant can "expedite [his] criminal case before conviction or before filing of a criminal case" by successfully completing an MHC program. If the defendant is successful, then "the court may dismiss the original charges against the defendant or ... otherwise discharge him ... from the program or from any further proceedings" in connection with the original charge. The process in these courts is relatively simple. When the court believes that a defendant is a good MHC candidate, it will offer that person a place in the MHC, so long as the defendant and prosecution agree with admittance.

Typically, a "good candidate" is a person who meets the specific court's mental health diagnosis and charge requirements, whose offense and mental disorder are connected, and who voluntarily makes an informed decision to enter the MHC. Offering defendants a place in the MHC often happens early in the case, sometimes as early as the arraignment or presentment date. If admitted, the defendant's case appears on the MHC docket for treatment progress reports, but the case is not adjudicated. Thus, the defendant is not required to plead guilty or be convicted before entering into treatment.

Although MHCs that use a pre-adjudication approach do not require the defendant to plead guilty, they vary somewhat in precisely what they do with the defendant's charges. In most cases, the prosecutor will hold the charges in abeyance until the defendant successfully completes treatment and other program requirements outside of jail or prison. This way, the court can use the charges as leverage to encourage the defendant to comply with requirements of mental health treatment and other court orders. In other situations, if the defendant agrees to participate in the program then the prosecutor can choose to dismiss the charges immediately, rather than hold them in abeyance if the defendant's charged offense is not serious. Defendants whose charges are dismissed immediately must still complete the program; if the program is not completed their charges can be reinstated and the case will return to its pretrial stance to be adjudicated. Furthermore, some jurisdictions' eligibility requirements state that defendants who previously completed or are discharged from an MHC program within the last three years will not be eligible to enter again, so defendants whose charges are immediately dismissed in these jurisdictions still have an incentive to complete the program because if they fail, they will not be given a second chance at the MHC route. Even if the charges are not initially dismissed, they are often dismissed or reduced after the defendant completes the requirements to the court's satisfaction.

After agreeing to participate in the MHC, the defendant begins court-monitored treatment, which may last one year or more. The exact length of a particular defendant's MHC participation and judicial supervision, however, depends on his individual needs and corresponding level of treatment. Due to the indeterminate length of court participation, defendants may be required to waive their right to a speedy trial before entering the program. Despite the indeterminate participation length, many defendants choose to enter the program because doing so means they will be released from jail immediately and enter treatment as a part of pretrial release.

The strengths and weaknesses of this approach are widely debated. According to some, this approach is best because "the defendant's addiction or other social issues can be addressed immediately." Critics, however, argue that the model is not appropriate because it subjects defendants to harsh treatment if they should fail to meet their program's requirements. The following Subsections discuss these and other strengths and weaknesses of the model by examining how pre-adjudication MHCs are used in jurisdictions across the United States.

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1. Strengths of the Pre-Adjudication Model
One justification for this model put forth by proponents is that it facilitates quick entry into treatment, and thus upholds the ideals of therapeutic jurisprudence, restorative justice, and preventive law. For this reason, some organizations, such as Disability Rights California, a California-based group committed to "advanc[ing] the rights of Californians with disabilities," take the position that MHCs should use pre-adjudication models and not require a conviction or guilty plea to participate. They argue that this model respects both the individual and his civil rights by "focusing on treatment to restore health and reduce criminal activity including: providing better access to treatment, consistent supervision, and support to reconnect with families." The Broward County MHC also chose the pre-adjudication model because it is therapeutic in nature, and stated that the design of its court "was to be as nonthreatening and nonpunitive as possible and would seek to prevent further penetration by the mentally ill offender into the formal adjudication process." Finally, the San Francisco Behavioral Health Court, an MHC that utilizes a pre-adjudication model, feels that it is important to "learn[] about the client first, observe[] how the client responds to treatment, and set[] expectations accordingly." By understanding the defendant's particular needs, therefore, the court can more appropriately match that person to treatment and resolve the underlying causes of the criminal behavior, rather than just watch as he becomes stuck in the "revolving door" of the traditional court system.

Additionally, by focusing on therapeutic, restorative, and preventive ideals and treating the underlying causes of the defendant's criminal behavior rather than requiring him to plead guilty and simply incarcerating him, the pre-adjudication model can lessen the stigma that can come from having a criminal record. In some situations, if a defendant is charged with a felony or misdemeanor and pleads guilty, his ability to find housing and employment may be negatively affected, even if the MHC treatment program is completed successfully. This will only make matters worse for MHC participants, as mentally ill defendants already have a high rate of joblessness and homelessness. By forgoing the requirement of a guilty plea, the defendant can complete treatment to help solve the underlying causes of the criminal behavior and can have a fresh start once he or she graduates from the program. A fresh start, where the defendant is able to continue treatment outside of the court as well as find housing and gainful employment, may be instrumental to ensuring that the defendant does not offend again.

Finally, although some critics of MHCs argue that the court may be more burdensome for the defendant due to the long participation time involved, some prosecutors find this extra involvement preferable. When a defendant is in treatment, prosecutors argue, the strict monitoring that the court imposes on the defendant can be more effective than normal probation. Furthermore, although the MHC requirements are intense, and failing to fulfill them can mean that the defendant will be prosecuted, this may actually serve as an incentive for the defendant to complete treatment. There need to be consequences for failing to complete the court's conditions so that the defendant will not take the MHC program for granted and treat it as a "free pass" through the court system. As one court stated, these courts "operate on the principle that there is both a carrot and a stick. The upside of successfully completing the treatment court program is usually a reduced sentence ... in some cases, a dismissal or reduction of the charge; the downside is the enhanced sentence, i.e., incarceration." Defendants need to understand that they committed a crime and will still be punished for doing so; only the method of punishment will differ - and even then, only slightly - from the traditional system. By helping defendants understand that they committed a crime and holding them accountable for it in a way that limits psychological dysfunction, the court system can help uphold therapeutic, restorative, and preventive ideals and reduce recidivism.

2. Weaknesses of the Pre-Adjudication Model

Although there are several strengths to the pre-adjudication model, it is not flawless. While some prosecutors prefer the model because it allows the court to strictly monitor the defendant during MHC participation, it may cause problems for prosecutors if the defendant ultimately fails to comply with the program requirements. If a long period of time passes between the commission of the crime and when the defendant is removed from the MHC and sent back to the traditional court, for example, the prosecutor may have a difficult time finding witnesses or trying the case. The longer the case remains on the court's docket, the more difficult it may be to preserve evidence and case files to put the defendant on trial. There is also a concern that if the defendant is tried and found guilty, the sentence he will face is ultimately more severe than what he would have dealt with in the traditional system because either he has already been subject to time in treatment and may now be incarcerated on top of it, or because he was given a chance to avoid incarceration and did not take advantage of it, a fact that the judge may not look kindly on.

B. Post-Adjudication Model
Although many early MHCs used a pre-adjudication model, more recently established courts have used a post-adjudication model. In this model, which about half of the MHCs in the United States utilize, the defendant must first plead guilty or be found guilty and then agree to enter the MHC. Some MHCs, such as the King County Mental Health Court in Washington, allow defendants with felony charges to enter supervision and treatment in the MHC in exchange for pleading guilty to a lesser misdemeanor charge. Thus, in either case the defendant will have a guilty plea or conviction to contend with after his treatment concludes, but has an incentive to complete the program successfully to receive a lesser charge.

While participating in the court, the defendant's sentence and incarceration is generally deferred until the program is either successfully completed or until the defendant is terminated from the program for noncompliance. Like pre-adjudication courts, post-adjudication courts vary somewhat in terms of how they dispose of the defendant's charges if he successfully completes the MHC treatment program. Some courts allow defendants to petition the court to expunge the plea or the record, while others may vacate or lessen the charges and the resulting sentence. In some cases, however, the conviction remains on the defendant's record even if the treatment is successfully completed. If the defendant is removed from the program, some courts, such as the Oklahoma County Mental Health Court, immediately sentence the defendant to a number of years in the department of corrections that were agreed to before entering the court. If there was no previous arrangement between the court and defendant, the defendant leaves the MHC and returns to the regular court system where his original charges will be reinstated for sentencing.

Referral to a post-adjudication court varies somewhat from a pre-adjudication court in terms of when the defendant can expect to enter the MHC. Whereas defendants in a pre-adjudication model MHC are referred to the court at a very early stage, defendants in post-adjudication model courts may have to wait much longer to be referred to the court. For example, in post-adjudication courts referral times can range from 0 to 129 days (and generally average 28 days) whereas referral in the pre-adjudication model can happen shortly after initial detention or arrest in most cases - generally within the first 24 to 48 hours of the defendant's arrest. This could mean that defendants who are subject to the post-adjudication model are spending more time in jail before receiving treatment for their mental illness.

Like pre-adjudication courts, the strengths and weaknesses of the post-adjudication model are widely debated among scholars, policymakers, community members, and other stakeholders. For example, for some of these individuals, the post-adjudication model is preferable over other models because it eases the load on the court's docket by disposing of the case. To others, the model is seen as not upholding therapeutic ideals, and for that reason they argue that it should not be utilized. The following Subsections discuss these and other strengths and weaknesses of the post-adjudication model.

1. Strengths of the Post-Adjudication Model

One advantage of the post-adjudication model is that because the defendant's charges have been adjudicated and a sentence has been imposed but deferred, the court can remove the case from the docket. When this happens, the prosecutor no longer needs to worry about preserving evidence, potential witnesses who could provide valuable testimony, or case files, whereas in a pre-adjudication court the case must be kept on the docket until the defendant successfully completes the program. Attempting to preserve these sources of evidence for the widely-varying and often indeterminate amounts of time the defendant may be involved in the MHC and treatment can be very difficult to do, and some prosecutors "worry that their abilities to prosecute a case will be irreparably harmed by a delay due to the defendant's treatment." Disposing of the case in a timely fashion in this way can be important to prosecutors, and may lessen the burden on already packed court dockets. According to some, this model is also preferable because by forcing the defendant to publicly admit guilt and accept treatment, he may begin to accept his mental illness and the effects that it has on his life and the lives of others. While some argue that publicly admitting guilt in this way upholds restorative justice ideals - specifically in terms of the "reintegrative shaming" techniques mentioned in Part II.B.2 - others are concerned that this type of public shaming may not be rehabilitative or in the defendant's best interests.

2. Weaknesses of the Post-Adjudication Model

Critics of the post-adjudication model are quick to point out its shortcomings. One argument critics advance against using this model is that it does not uphold therapeutic ideals. Because the post-adjudication model focuses on trying a case quickly to remove it from the court's docket, it does not do as good a job of quickly connecting defendants to treatment as the pre-adjudication model. In this sense, the post-adjudication model is more like the traditional system described in Part II.A, a model that has repeatedly failed to address the underlying causes of criminal behavior and to
lower recidivism rates. Furthermore, requiring a guilty plea has "no therapeutic value in a court system that places a premium on treatment." \[n252\] Thus, MHCs, courts that focus on connecting mentally ill defendants to treatment, and the post-adjudication model [*348] seem somewhat at odds.

Meanwhile, defense attorneys claim that the post-adjudication model can be more burdensome to their clients than the pre-adjudication model or even the traditional court system. Not only must defendants plead guilty to become eligible for mental health treatment, but they may also be required to forgo many pretrial due process rights including the rights to a speedy trial, jury trial, and a preliminary hearing. \[n253\] In King County, for example, defendants are asked to waive their rights on the merits of the case before entering the MHC. \[n254\] Because participants must give up so many rights and spend an extended amount of time in the MHC, some defense attorneys are wary of the model. \[n255\] What is more, defendants who are unsure whether they can complete the program may be hesitant to enter because doing so will automatically add a conviction to their record, a conviction that may not have occurred if they had entered the traditional criminal court and had taken their chances with a jury. \[n256\] Proponents of a model that reduces psychological dysfunction by focusing on the defendant's well-being argue that a system that discourages some mentally ill defendants from entering the MHC does not uphold the ideals upon which the MHC was founded. \[n257\]

Another criticism of the model stems from the long periods of time defendants must wait between their arrest and referral to the MHC treatment programs. \[n258\] In several courts, even in those that attempt "to expedite the sentencing hearing so that the defendant can be released as soon as possible," \[n259\] potential participants must wait to be convicted and sentenced before they are considered for entrance into the MHC. \[n260\] Because potential MHC candidates are being forced to wait longer before entering treatment in a post-adjudicative court, this could mean that they are spending more time in jail than they would if they were in a court using a pre-adjudicative model. \[n261\] For mentally ill defendants, time spent in jail can be especially destructive to their well-being and can actually make the symptoms of their mental illness worse. \[n262\] If treating the underlying mental illness is a priority for the MHC, then diversion to the MHC program's treatment options and away from incarceration should be swifter than what the post-adjudicative model can offer in many instances.

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C. Combination or Probation-Based Model

Finally, in a combination or probation-based model, the program includes aspects of both pre-adjudication and post-adjudication programs to form a sort of hybrid model. \[n263\] There are very few courts that employ this model. \[n264\] Although the program seems like it would be the best of both worlds, in most instances in which the model is used, it resembles the post-adjudicative model more than the pre-adjudicative model in the sense that convictions are often in place before the defendant may enter treatment. \[n265\] Usually, the defendant must plead guilty or no contest to the charges "in exchange for a plea agreement that the sentence will not involve jail," but will instead involve treatment. \[n266\] After being convicted, the defendant's sentence may or may not be imposed, depending on the court's discretion, \[n267\] and the conviction will usually include probation and perhaps a suspended or deferred jail sentence with completion of a treatment program as a probation requirement. \[n268\] It is important to note that in these programs, like many post-adjudication programs, the defendant's charges cannot be dismissed even if he is able to successfully fulfill the MHC program requirements because the case has already been adjudicated. \[n269\] Although the conviction remains on his record, the defendant may have the remainder of his sentence suspended. \[n270\]

In rare cases, generally those cases in which the defendant has no prior criminal history and the offense committed is very minor, a guilty plea may not be required from the defendant before entering the MHC. \[n271\] In these situations, the defendant enters treatment "via deferred disposition, which involves court-ordered conditional release of the defendant to community treatment prior to adjudication with court monitoring for compliance." \[n272\] At the court's discretion, defendants who successfully complete the program may have their charges dismissed, but again this is no guarantee. \[n273\] Thus, although this route is more similar to the pre-adjudication model, many defendants may not be eligible for this variation of the model, and those who are may still have to deal with their charges once they complete treatment.

One example of a hybrid combination court is the Anchorage Mental Health Court. In this court, which is an MHC that accepts only misdemeanor [*350] charges, the defendant is required to enter a plea of guilty or no contest to the charge in exchange for being offered a place in the MHC. \[n274\] If the plea is accepted, then it is entered and the defendant is scheduled for a sentencing hearing, which usually includes a probationary term. \[n275\] In the traditional court system in Alaska, a misdemeanor probationary term can extend up to ten years; in the MHC program, however, the sentence is
usually between three and five years. In this situation, the reduction in sentence is viewed as an incentive to the defendant to participate in and complete the program.

1. Strengths of the Combination or Probation-Based Model

One strength of the combination model is that it offers the greatest amount of flexibility for the court in terms of who is eligible for the program. For example, in the Anchorage MHC mentioned above, which is predominantly a post-adjudicative court where defendants are required to enter a guilty plea, exceptions are sometimes made for defendants who have no prior criminal record and who have been charged with minor offenses. Thus, the defendant can enter the MHC through a deferred disposition that allows for treatment prior to adjudication of the charges, which, as discussed above, is more akin to the pre-adjudicative model. Although this route allows the defendant to enter into treatment sooner than he would be able to if the model were strictly post-adjudicative, the charges may still be adjudicated at some point, and furthermore, not all defendants will benefit from the quicker entrance into treatment.

2. Weaknesses of the Combination or Probation-Based Model

As this model incorporates many of the same features as the post-adjudicative model in terms of when the defendant may enter the court and what happens to his charges, the potential consequences and weaknesses of the model are very similar to those of the post-adjudicative model. For example, because the defendant is required to plead guilty in many instances, it may be more difficult to obtain housing, employment, and some forms of treatment, even after completing the program successfully. As mentioned above, ensuring access to these necessities may be instrumental in ensuring successful treatment and thus preventing the defendant from offending again.

Furthermore, because treatment is a condition of probation, failure to comply with the treatment can mean that the defendant violated his probation. In this situation, the defendant can be "summarily jailed for curtailing mental health treatment or medication" as part of his sanction. Some defense attorneys feel that when this is the case, their clients are left with a choice of either (1) accepting the court's mental health treatment provider without a way to challenge the treatment the court finds appropriate, even if the chosen treatment does not work for that particular defendant, or (2) forgoing treatment altogether.

Finally, this model presents concerns over the time defendants must spend in custody before they are allowed to enter the MHC. In the Anchorage Mental Health Court, for example, defendants must remain in custody until a treatment plan is approved by the judge. Defendants may be released before a treatment program is agreed to, but only if "a reliable third party who is acceptable to the judge steps forward to take on the responsibility of providing supervision in the community during this interim period." For defendants without family or another person who is willing to take this responsibility, it may mean that they are forced to stay in prison until the court agrees to their treatment plan. As discussed above, many scholars worry that increased time spent in jail can be very harmful for mentally ill defendants. Because solving the underlying causes of a defendant's mental illness is the purported goal of MHCs, a system that may, in fact, make the mental illness worse ultimately fails to uphold the ideals of therapeutic jurisprudence, restorative justice, and preventive law.

IV. Recommendation

MHCs in the United States are no longer experimental. After being in existence for nearly fifteen years with the support of state and federal legislation, MHCs are becoming more abundant. As they do so, the many valuable aspects of these courts are becoming more and more apparent. Courts across the country are realizing that their communities could be benefitted by this type of specialty court and many are taking steps to plan new courts. In Illinois, for example, there are currently thirteen MHCs in operation, and other counties across the state are currently in the process of developing their own. According to the Illinois Mental Health Court Treatment Act, "the Chief Judge of each judicial circuit may establish a mental health court program, including the format under which it operates," Thus, the Chief Judge may choose to use any of the three models listed under the act - a pre-adjudication program, a post-adjudication program, or a combination program.

Although there is no standard blueprint used for the creation or management of MHCs, because the needs of each MHC are dependent on the community it is located in, judges advocating for a new MHC in their community should look to the theories of therapeutic jurisprudence, restorative justice, and preventive law for support. These theories underlie the goals of MHCs and with them stakeholders can strive to implement a uniform pre-adjudication model that will serve the needs of mentally ill defendants who come into contact with the criminal justice system. This Part proposes that new
MHCs developed in the state of Illinois under the Illinois Mental Health Court Treatment Act should employ the pre-adjudication model and that existing courts should begin using the pre-adjudication model if they are not already doing so. Section A begins by explaining why MHCs are beneficial to the state's communities and why they should be implemented in general. Section B demonstrates why the pre-adjudication model is better suited to address defendants' needs than either the post-adjudication or combination models and why the other models fail to adequately uphold the ideals of MHCs. Finally, Section C suggests what new and existing courts must do to implement the pre-adjudication model.

A. MHCs Should Be Adopted in General

Before deciding which adjudication model a particular Illinois community's MHC should employ, the community must necessarily have an established MHC. It has become increasingly clear that a large percentage of people entering the criminal justice system each year are affected by a mental illness, that the traditional court system is failing to find these defendants mental health treatment, and that this failure has contributed to high recidivism rates among this population. As such, establishing a specialty court should be a priority for community stakeholders so that they can begin to develop solutions to the issues presented by dealing with mentally ill defendants.

There are many reasons why a community dealing with mentally ill defendants should strive to establish an MHC. First, MHCs can drastically reduce the costs of incarceration. Indeed, specialty courts as a whole demonstrate this ability and studies show that the costs associated with specialty courts can be far lower than the cost of nonspecialty court treatment. For example, one study found that the cost of drug court treatment was $6.84 per day in the courts sampled, whereas the cost of non-drug court treatment was $19.34 per day. Studies of MHCs across the country reveal similar results. Some prosecutors, such as Will County State's Attorney James Glasgow, advocate for MHCs because they realize that “for every dollar we spend on a prevention program where we deal with the root causes of crime, we save $10 to $20 in remedial costs.” By cutting down on the costs of repeatedly handling the same defendants' cases, an MHC can save incarceration costs and divert these funds towards other areas of need in the community.

Perhaps most importantly, these courts can offer aid to defendants who, in many cases, are desperately in need of treatment and a fresh start in life. As discussed above, in the traditional system many defendants may face incarceration in jails and prisons because judges, prosecutors, and even defense counsel misunderstand their illness and feel that incarceration is the safest option for the defendant and for the community. What these officials should understand, however, is that time spent incarcerated can exacerbate the defendant's mental illness because there may be no opportunity to receive mental health treatment during incarceration. Our criminal justice system should seek not only to hold individuals accountable for their unlawful acts, but should seek to resolve whatever underlying issues may be contributing to this unlawful activity. By using therapeutic jurisprudence, restorative justice, and preventive law theories, communities across Illinois can set up a system that improves access to treatment, improves both the public safety and the defendant's well-being, and can help ensure that mentally ill defendants are able to step out of the criminal justice system's "revolving door."

B. Mental Health Courts Should Employ a Pre-Adjudication Model

Once an MHC is established in the community, those in charge should put into place a pre-adjudication model to handle the defendant's charges. This Section argues that the pre-adjudication model is better suited to achieve the goals of MHCs than either the post-adjudication model or the combination model as outlined in the Illinois Mental Health Court Treatment Act and that Illinois MHCs should use the pre-adjudication model exclusively. The first Subsection shows how the post-adjudication and combination models fall short of achieving the goals of MHCs and how they do not do justice to the theories that MHCs were based on. The second Subsection then addresses potential weaknesses that opponents of the pre-adjudication model have put forth to argue that the model should not be used.

1. The Post-Adjudication and Combination Models Do Not Adequately Achieve the Goals of MHCs

When scholars and stakeholders first considered establishing specialty courts such as MHCs and drug courts, many looked to the theories of therapeutic jurisprudence, restorative justice, and preventive law for guidance. Because MHCs were founded upon these theories and because the goals of MHCs are closely related to them, MHCs should strive to
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uphold them as closely as possible. Unfortunately, the post-adjudication and combination models cannot do this as well as the pre-adjudication model.

Although one of the major goals of these theories is to treat the defendant's mental illness so that he has a clean slate after his participation in the MHC is complete, by requiring many or all defendants to plead guilty, these courts may ultimately fail to achieve this goal. In post-adjudication and combination courts, even a defendant who successfully completes treatment may face many difficulties or stigma upon returning to the community. This is especially true when the defendant attempts to obtain housing or employment. It is no secret that many potential employers require all applicants to disclose on their job applications if they have ever pled guilty to a criminal charge. Any person who is in a post-adjudication court and any defendant in a combination court that does not qualify for the rarely used pre-adjudication model will be required to plead guilty in order to enter into MHC treatment. Potential employers who see this disclosure may be hesitant to give these individuals employment, and if the job requires that the applicant have no criminal background, then the individual would no longer qualify.

[*355] As discussed in Part III.A.1, by requiring defendants to plead guilty and giving few, if any, opportunities to have their charges automatically dismissed or expunged, courts will require defendants to go through life with this mark on their record. This mark, in turn, may serve as a source of stigma. If defendants face this sort of stigma in the community and are unable to obtain employment or housing, they may not be able to maintain what they have achieved in treatment. If they are unable to maintain and keep up with their treatment, these defendants may ultimately end up in a situation where their mental illness returns and contributes to further criminal activity and relegates the defendant back to the "revolving door" of the criminal justice system. Allowing these individuals to return to the "revolving door" means that the court and community have lost sight of the defendant's needs; it can also contribute to the high economic and social costs of criminal activity. Requiring defendants to plead guilty and subjecting them to possible stigma may force them to take responsibility and be accountable for their criminal activities, but it may not represent the least restrictive method of doing so as required by restorative justice.

Rather than aid mentally ill defendants, post-adjudication programs "process [mental health] court participants through the full business-as-usual process including sentencing before program entry." The business-as-usual attitude has failed thus far. Instead of focusing on adjudicating a case as quickly as possible so that prosecutors need not worry about preserving evidence, the court should focus on helping defendants treat their illness and become productive citizens again. It is understandable that prosecutors would want to remove the case from the court's docket to avoid evidentiary problems, but the best way to do this is to ensure that once the defendant completes treatment, he does not make further contact with the criminal justice system. The urgency some prosecutors display to remove the case from the court's docket should instead be focused on helping defendants enter treatment as quickly as possible.

The combination model is similarly unable to adequately prevent mentally ill defendants from returning to the criminal justice system. Although the model seems as though it would present the best of both worlds so to speak, the reality is that very few courts use this model and those that do mainly use the post-adjudication approach. Thus, very few defendants in these courts will benefit from what the pre-adjudication model has to offer. Studies examining the effectiveness of these three models in drug courts indicate that the flexibility offered by this model may not be as effective in reducing recidivism rates as the pre-adjudication model or even the post-adjudication model. For example, one study stated that a possible explanation for the lower success in reducing recidivism observed in the mixed or combination approach is that these programs "tended not to have an established "reward" for program completion, such as dismissal of charges." It also stated that a specialty court that has a clearly defined framework or "set of judicial contingencies can increase the amount of treatment received." In this sense, the pre-adjudication model is superior because it has a more clearly defined route for participating defendants to take - there will be no question as to whether they will be required to plead guilty or as to what will happen to their charges upon successful program completion. By defining the incentive structure the court will use, the pre-adjudication model "may be more effective in communicating these contingencies and their certainty to the offender" which may be an incentive to complete the treatment.

2. The Pre-Adjudication MHC Model Best Addresses the Needs of Mentally Ill Defendants

Of the three adjudication models outlined in the Illinois Mental Health Court Treatment Act, the pre-adjudication model best addresses the needs of defendants who come into contact with the criminal justice system and best upholds the theoretical ideals upon which these courts were founded. First, this model has the potential to save an enormous amount of money for the court system as a whole because "there is little court time spent on the traditional process before... court entry and there is little probation involvement for active... court participants." Additionally, as
discussed in the previous Subsection, defendants in pre-adjudication courts may also experience lower rates of recidivism than defendants in courts using the other models which can also contribute to cost savings.\(^n310\)

Next, although some critics of the model are concerned that it will create evidentiary problems for the prosecutor if the defendant fails to complete treatment, this should not be where courts focus their energy. Because the principles of MHCs are focused on repairing past and preventing future harms by helping the defendant, the level of concern based on evidentiary matters seems to be too high. If anything, this should be a secondary concern. Rather than adjudicate as quickly as \(^n357\) possible to remove the case from the docket, courts and their personnel should aim to treat the defendant with the goal of permanently removing the case from the docket. If the underlying cause of a defendant's criminal activity is a mental illness, then a defendant who successfully overcomes or controls his mental illness will be less likely to recidivate. On the other hand, a defendant who is quickly pushed through the adjudication process and is required to plead guilty - a process that may place negative labels, attributions, or stigmas on even successful defendants - can contribute to dysfunction. Ultimately, this dysfunction is capable of preventing the defendant from getting back on his feet and may prevent him from stepping out of and away from the criminal justice system's "revolving door."\(^n311\)

Aside from this, it is very unlikely that such a significant period of time will pass between the defendant's entrance into the court and any possible failure to complete treatment such that prosecutors would need to worry about preserving evidence or witnesses. Typically, successful participants are involved in the MHC for around two years. If successful participants are only involved for two years, it is unlikely that unsuccessful participants would have involvement that is significantly longer. This is because all MHCs, including pre-adjudication courts, have sanctions for participants who do not comply with treatment provisions. As People v. Kimmel demonstrated, even though participants will be given many opportunities to comply with treatment, eventually they will be asked to leave for repeated transgressions. Because they will be asked to leave, it is difficult to believe that defendants would remain in the court for such a significant period of time that prosecutors will be significantly burdened by having to prosecute the case on a later date. If a situation such as this did occur, it is reasonable to believe it would be in relatively few cases and is not a situation that the majority of prosecutors would have to face.

Finally, although it is true that one purpose of the law is to hold defendants accountable for their criminal behavior, the law should not banish mentally ill defendants to a "revolving door" system. As argued above, the criminal justice system should also seek to help mentally ill defendants; otherwise, the criminal justice system may ultimately be harming both the defendant and the community. By giving the defendant a chance to obtain treatment without automatically stamping his record with a conviction, the pre-adjudication model can help defendants exit and remain free from the "revolving door." The system can also allow defendants to make an informed decision about their future that will limit psychological dysfunction, prevent future crimes, and help them repay the debt owed to the community stemming from the commission of their crime in one of the best ways that they can - by being successful in treatment and not making further contact with the criminal justice system. \(^n358\) The importance of defendants becoming productive citizens is not lost on prosecutors. As Will County State's Attorney James Glasgow stated, both the defendant and the community "benefit[] when those who suffer from mental illnesses learn to manage their conditions so they can function in society by holding down jobs, pursuing educations and paying taxes."\(^n311\)

Furthermore, some mentally ill defendants may not understand the serious nature of their actions and may be unable to do so until they receive treatment. The therapeutic benefit of requiring defendants to plead guilty before receiving treatment may thus be lessened. If MHCs veer away from the principles on which they were founded, they may begin to revert to a more adversarial-focused system in which the needs of the defendant are secondary to punishment. This system has proved unsuccessful in dealing with the unique challenges presented by the various clients that specialty courts work with. The post-adjudication and combination models, by requiring the defendant to plead guilty, are too closely related to the adversarial system that MHCs were meant to depart from. These models do not adequately uphold the principles of therapeutic jurisprudence, restorative justice, and preventive law and as such, should not be used in Illinois MHCs.

C. Going Forward

In the future, MHCs founded in Illinois should use the pre-adjudication model because it best upholds the ideals of therapeutic jurisprudence, restorative justice, and preventive justice. If the Illinois Mental Health Court Treatment Act is going to emphasize that the pre-adjudication model is the model that should be used, then the current Act must be rewritten to reflect that. As mentioned above, the Act currently defines all three models, but does not say which should be used.\(^n312\) Instead, it allows the Chief Judge of each court to decide which would be best.\(^n312\) In order to change this, the current Act needs to be amended to remove the post-adjudication and combination models. This process is likely
complex - an amendatory bill would need to be introduced along with clear and precise instructions detailing the changes to be made, and then the lengthy approval process will commence. Although going this route will be very time consuming and difficult, it is the best way to ensure that judges choose the pre-adjudication model. 

If the Act cannot be rewritten so that the pre-adjudication model is the only option, then each community's MHC planners and stakeholders [*359] must be made aware of what the pre-adjudication model has to offer. They must also be receptive to the three underlying theories and must understand the ways these theories benefit both the defendants and the community. Getting this information out may take time and effort, especially if the attitudes of judges and other court personnel must be changed regarding MHCs and mentally ill offenders. Some judges may not be used to the idea of taking the time to get to know each individual defendant because in the traditional adversarial approach they are encouraged to remain separated to ensure impartiality. In an MHC, the judge must become familiar with the individuals standing before him and "not only talk to them about their treatment and how it's going, but [must] try to get right into their lives." Stakeholders must be educated "about what mental illness really means" today so that they can understand that in many cases it is treatable. 

Changes must also be made to Illinois MHCs that do not use a pre-adjudication model. Some courts, such as the McHenry County and Madison County MHCs, currently use the pre-adjudication model, but other counties, like Cook and Winnebago, employ either a post-adjudication or combination model. In courts that do not currently employ a pre-adjudication model, work will need to be done to change the attitudes of judges, prosecutors, defense counsel, and other stakeholders. Many will likely take a "why fix what is not broken" attitude and question a change. Although the other models may not be "broken" per se, there is evidence that they are not as effective in reducing stigma and recidivism. 

Additionally, some court personnel using the post-adjudication or combination models may be hesitant to change the model once a particular court is open, but changing to the adjudication models is not unheard of. In fact, several courts have done so in the past as attitudes toward the courts and the various models changed and as experience guided them. [*360] One issue that these courts may need to face is how to handle an influx of new clients. Because the pre-adjudication model does not discourage defendants from participating in the same way that the other models may, more individuals may choose to try the program. Although this may present issues of space and funding, it is ultimately better for the community to aid as many defendants as possible because doing so will cause recidivism rates and costs to the community to go down drastically. This, in turn, will lower costs for the court and allow redistributions of funds which can help alleviate some concerns posed by space and funding issues.

A second concern that opponents of change may have is the argument that the pre-adjudication model does not adequately punish defendants for their crimes. Some feel that the defendant has received a "free pass" if he completes the court-mandated treatment program and the charges are dismissed. Although it is true that the defendant will not face incarceration, in this situation by the time participation is complete it is very likely that the he will have spent a considerably longer time in the court than he would have in the traditional system. For example, an MHC defendant charged with a misdemeanor, defined as "any offense for which a sentence to a term of imprisonment in other than a penitentiary for less than one year may be imposed," may be required to spend two or more years in the court, depending on treatment plans. Thus, it seems that critics who argue both that the pre-adjudication model is burdensome due to participation length and that the defendants are getting a free pass want to "have their cake and eat it too." Changing from a post-adjudication or combination model to a pre-adjudication model still holds defendants accountable and does not give "free passes." By requiring longer participation, the pre-adjudication model adequately punishes mentally ill defendants for their criminal behavior, but does so in a way that reduces dysfunction, encourages greater participation, and helps the defendant avoid committing another crime.

V. Conclusion

The time has come for courts in Illinois, and indeed throughout the country, to be realistic about the unique challenges that mentally ill defendants present to courts and the community. Each year, thousands of individuals come into contact with the criminal justice system and studies have repeatedly shown that a disproportionate number of these individuals are affected by mental illness. In many cases, mental illness has contributed to the individual's criminal activity. Rather than follow tradition and use the adversarial system which has proved inadequate to treat [*361] these defendants or reduce recidivism rates, the traditional system should be put aside in favor of MHCs. These courts must be viewed as a serious and viable option, and communities must start acting now to develop them.
An integral component of these courts is their adjudication model. Although the Illinois Mental Health Court Treatment Act outlines three potential models that the courts can use, new and existing courts should either begin with or transition to a pre-adjudication model. This model, which does not require the defendant to plead guilty before he or she is allowed to enter treatment, can help the participant begin treatment as quickly as possible and can ensure that the help he needs is given. The pre-adjudication model upholds the ideals of therapeutic jurisprudence, restorative justice, and preventive law upon which Mental Health Courts were founded. By educating the courts on mental illness and creating another group dedicated to helping these individuals, the stigma and misconceptions surrounding mental illness present in many communities across Illinois, and indeed the country, can be eradicated. Efforts to ensure that this population is not relegated to the "revolving door" of the criminal justice system can best be aided by using a pre-adjudication model.

FOOTNOTES:


n2. Id.


n10. Nolan, supra note 7, at 1541.

n11. See, e.g., District Court Services: Mental Health Court Overview, King County (Wash.), http://www.kingcounty.gov/courts/DistrictCourt/MentalHealthCourt.aspx (last updated May 10, 2012).

n12. Id.


n16. See Donaldson & Johnson, supra note 8, at 25.

n17. Schneider et al., supra note 9, at 60, 191.

n18. Id.


n20. See Schneider et al., supra note 9, at 3.


n22. Griffin et al., supra note 19, at 1286; see generally Steadman & Redlich, supra note 21, at 25-26 (discussing first and second generation MHCs and stating that in a pre-adjudication court, “the prosecutor holds the charges in abeyance and this is what is used as leverage to motivate the participant to comply with mental health treatment and other orders of the court”).


n24. Schneider et al., supra note 9, at 87.

n25. Hora et al., supra note 23, at 515.

Hora et al., supra note 23, at 516 (stating that defendants in post-adjudication courts may risk waiving the right to trial as well as certain defenses by entering the MHC).

Griffin et al., supra note 19, at 1286.

Id.


See supra notes 2-9 and accompanying text.

Cummings, supra note 5, at 306.

Derek Denckla & Greg Berman, Ctr. for Court Innovation, Rethinking the Revolving Door: A Look at Mental Illness in the Courts 6 (2001).

"In fact, many are treated worse, because they are stigmatized by criminal justice officials with little experience dealing with mental illness."

By some estimates, around eighty-three percent of mentally ill prisoners and eighty-nine percent of mentally ill jail inmates do not receive needed mental health treatment while incarcerated. Gregory L. Acquaviva, Comment, Mental Health Courts: No Longer Experimental, 36 Seton Hall L. Rev. 971, 979 (2006) (stating that one-fifth of jails have no access to mental health services); see Denckla & Berman, supra note 34, at 3 (stating that only seventeen percent of state prisoners and eleven percent of jail inmates with mental illnesses receive treatment while incarcerated).

Acquaviva, supra note 36, at 979.

Denckla & Berman, supra note 34, at 6 (stating that courts have not dealt with mental illness well in the past and that courts generally only deal with mental illness when determining that a defendant is "not guilty by reason of insanity," “guilty but mentally ill,” or not competent to stand trial).

Id. at 1.

Acquaviva, supra note 36, at 978-79.

"Incarceration may in fact be the right outcome for some mentally ill offenders who pose a serious threat to individual victims or the public welfare. But for many others, particularly those without violent histories, incarceration makes little sense."
n42. Cummings, supra note 5, at 306 (discussing a study of the New York Corrections system in which officials placed mentally ill inmates into solitary confinement).

n43. Acquaviva, supra note 36, at 978-79 (stating that “one-fifth of jails have absolutely no access to mental health services” and that even some that do grant access to these services often lack properly trained physicians and other mental health professionals).

n44. Denckla & Berman, supra note 34, at 1. For many mentally ill defendants, the next stop after prison or jail is back to a life of living on the street. Id. According to some, homelessness is the “intermediate stop in the journey from hospitals to the criminal justice system.” Cummings, supra note 5, at 285.

n45. Denckla & Berman, supra note 34, at 1.

n46. See Cummings, supra note 5, at 280.

n47. O'Keefe, supra note 30, at 2.

n48. See infra notes 71-72 and accompanying text.

n49. This number was reached by multiplying the rate of $70 per day by 173 - the difference in days between the average prison sentence for inmates with and without mental illness. See infra notes 71-72 and accompanying text; O'Keefe, supra note 30, at 2.

n50. Denckla & Berman, supra note 34, at 4.

n51. Cummings, supra note 5, at 299-300. The study also found that graduates had a ninety-eight percent drop in the number of psychiatric hospitalizations and a ninety percent drop in incarceration. Id.

n52. Schneider et al., supra note 9, at 39.

n53. Kondo, supra note 14, at 380.

n54. Id. at 382-83.


n57. Id. at 20.

n58. See id.

n59. Id. at 23.

n60. See Nolan, supra note 7, at 1546-47 (stating that therapeutic jurisprudence advocates "fairly radical changes in the legal system").

n61. Id. at 1542.

n62. Schneider et al., supra note 9, at 43-44.

n63. Nolan, supra note 7, at 1546 (quoting Susan Daicoff, The Role of Therapeutic Jurisprudence Within the Comprehensive Law Movement, in Practicing Therapeutic Jurisprudence: Law as Helping Profession 465 (Dennis P. Stolle et al. eds., 2000)).

n64. See Schneider et al., supra note 9, at 43.

n65. Id. at 3.

n66. See Kondo, supra note 14, at 390.

n67. Cummings, supra note 5, at 292.


n70. Id.

n71. Id. (stating that these savings may not be realized in reduced budget costs, but do divert money to other areas of need, resulting in "improved use of resources").

n72. See id. ("Over the course of one year, 20 individuals were repeatedly hospitalized, jailed, or admitted to detoxification centers, costing the county approximately $ 1.1 million.").
n73. Nolan, supra note 7, at 1546-47.

n74. Id. at 1547 (internal quotation marks omitted).

n75. Schneider et al., supra note 9, at 61.

n76. Id.

n77. Id.

n78. Id. at 64 (citation omitted).

n79. Id. at 63.

n80. See Kondo, supra note 14, at 379; Nolan, supra note 7, at 1551.

n81. Schneider et al., supra note 9, at 63, 192.

n82. Id. at 61; see also Cummings, supra note 5, at 292 ("Both theories stress that they do not seek to overrule or invalidate traditional notions of justice.").

n83. Tamar M. Meekins, "Specialized Justice": The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense Paradigm, in Rehabilitating Lawyers: Principles of Therapeutic Jurisprudence for Criminal Law Practice 46, 58 (David B. Wexler ed., 2008) (stating that both "theories are well-rooted in concepts of rehabilitation").

n84. Nolan, supra note 7, at 1546-47.


n86. Schneider et al., supra note 9, at 4.

n87. Meekins, supra note 83, at 58.

n89. Meekins, supra note 83, at 58; Nolan, supra note 7, at 1548 (stating that restorative justice places a larger emphasis on "a much wider net of consequences") (quoting John Braithwaite, Restorative Justice and Therapeutic Jurisprudence, 38 Crim. L. Bull. 244, 247 (2002)).

n90. Zehr & Mika, supra note 88.

n91. Id.

n92. See id.

n93. Id.

n94. Meekins, supra note 83, at 68-69.

n95. Zehr & Mika, supra note 88.

n96. Nolan, supra note 7, at 1547.

n97. Meekins, supra note 83, at 61.


n99. Id. at 377-81.

n100. John Braithwaite, Crime, Shame and Reintegration 100 (1989).

n101. McAlinden, supra note 98, at 376 (stating that the reintegrative shaming process ends "with gestures or ceremonies of acceptance or forgiveness").

n102. Meekins, supra note 83, at 61 n.87; see also David B. Wexler, Therapeutic Jurisprudence and Readiness for Rehabilitation, in Rehabilitating Lawyers, supra note 83, at 169, 172 n.25 (explaining that the difference between "reintegrative shaming" and "stigmatization," is that "with reintegrative shaming, "the offender is treated as a good person who has done a bad deed," whereas with stigmatization, "the offender is treated as a bad person." (quoting John Braithwaite, Restorative Justice and Therapeutic Jurisprudence, 38 Crim. L. Bull. 244, 258 (2002)).

n103. Nolan, supra note 7, at 1548 (stating that some scholars of therapeutic jurisprudence are critical of "reintegrative shaming," even going so far as to call the term "unfortunate").
n104. Kondo, supra note 14, at 380.

n105. Id. at 380-81.

n106. Id.


n110. Gruner, supra note 108.

n111. Denckla & Berman, supra note 34, at 20 (quoting Anne Swern of the Brooklyn District Attorney's Office).

n112. Id.

n113. Id.

n114. Schneider et al., supra note 9, at 40.


n116. Nolan, supra note 7, at 1542.

n117. Id. at 1545 (quoting Greg Berman, Introduction to "What Is a Traditional Judge Anyway?" Problem Solving in the State Courts, 84 Judicature 78, 78 (2000)).


n119. See id. at 9, 76.
n120. See Nolan, supra note 7, at 1542.

n121. See id.

n122. See generally Casey & Rottman, supra note 6 (discussing the development and characteristics of various problem-solving courts including community courts, domestic violence courts, drug courts, and mental health courts).

n123. See id. at 1.


n125. Nolan, supra note 7, at 1545.

n126. Casey & Rottman, supra note 6, at 6.

n127. Id.

n128. See Miller & Johnson, supra note 115, at 19.

n129. See Nolan, supra note 7, at 1553 (noting one drug court judge's assertion "that improvement of the community itself constitutes the essence of justice").

n130. Id. (alteration in original).

n131. Casey & Rottman, supra note 6, at 6.

n132. Nolan, supra note 7, at 1553.


n134. Id.
n135. Nolan, supra note 7, at 1542.

n136. Id. at 1543.

n137. See id.

n138. Id. at 1542-43.

n139. See, e.g., People v. Kimmel, 882 N.Y.S.2d 895, 896 (Jamestown City Ct. 2009).

n140. See Casey & Rottman, supra note 6, at 6.

n141. Id.

n142. Hora et al., supra note 23, at 522-23 ("Requirements may prove more onerous than the equivalent traditional court sanctions for the same offense. [Drug treatment courts] generally obligate a defendant to make more frequent court appearances and force the defendant to undertake forms of treatment which place more burdens on the defendant than normal probation.").

n143. See generally Nolan, supra note 7, at 1542 (stating that participants in problem-solving courts may have more regular court appearances and may regularly submit to urinalysis tests).

n144. See, e.g., William D. McColl, Comment, Baltimore City's Drug Treatment Court: Theory and Practice in an Emerging Field, 55 Md. L. Rev. 467, 494-95 (1996) (stating that some critics are concerned that the wide discretion given to judges and other court personnel can be subject to abuse and that the state's power must be checked at times).

n145. Nolan, supra note 7, at 1557.

n146. Id.

n147. McColl, supra note 144, at 481 n.121 ("To be eligible for a stet, the defendant must waive his right to a speedy trial.") (stating that when a prosecutor "stets" a case, the state is declining to prosecute it, but that the state retains the right to reopen the case for any reason within one year); Nolan, supra note 7, at 1559.

n148. Nolan, supra note 7, at 1559.

n149. Id. at 1556.
n150. Hora et al., supra note 23, at 523.

n151. Nolan, supra note 7, at 1555-56. Sanctions may include increased status hearings, modification of treatment or privileges, community service, mandatory drug testing, and in some circumstances, jail time. Id. at 1542-43. Judges may use their discretion in determining if and when to impose such sanctions on a particular individual. See King & Pasquarella, supra note 133, at 4; see also Casey & Rottman, supra note 6, at 6.

n152. Hora et al., supra note 23, at 523.

n153. Id. at 521.


n155. See supra note 30 and accompanying text.

n156. See supra Part II.C.

n157. Osher & Levine, supra note 4, at 3 (stating that some suggest that "transinstitutionalization" or "deinstitutionalization" accounts for the rise in the number of mentally ill individuals in the criminal justice system because those who used to be in mental health institutions before their closure are now being incarcerated).

n158. Council of State Gov'ts, supra note 8, at 8.

n159. Casey & Rottman, supra note 6, at 8.

n160. Schneider et al., supra note 9, at 44-45 ("From being the subject of abuse, experiencing a lack of meaningful treatment, and being subject to higher rates of incarceration, mentally disordered accused typically do not fare well. It is now a generally accepted assertion that the criminal justice system has failed the mentally ill.").

n161. See Nolan, supra note 7, at 1544.


n164. Id. § 2.
n165. Id.

n166. See Casey & Rottman, supra note 6, at 8; see also Schneider et al., supra note 9, at 4 (stating that MHCs also gained inspiration from the successes of drug courts).

n167. Nolan, supra note 7, at 1544.

n168. Schneider et al., supra note 9, at 7.

n169. Casey & Rottman, supra note 6, at 8. The recidivism contemplated here includes both legal and clinical recidivism. Legal recidivism can be defined as repeated criminal activity among mentally ill defendants and clinical recidivism is the repeated psychiatric hospitalization of mentally ill offenders. Id. By reducing these two recidivism rates, MHCs will also relieve the burden placed on the Department of Corrections and reduce the number of mentally ill offenders who are inappropriately incarcerated. Id.

n170. District Court Services, supra note 11.

n171. Id.


n175. McAleer, supra note 173.


n177. Id.

n178. Id.

n179. See, e.g., People v. Kimmel, 882 N.Y.S.2d 895, 896 (Jamestown City Ct. 2009).
n180. Id. at 897.

n181. Id.

n182. See supra notes 122-23 and accompanying text.

n183. See supra notes 17-18 and accompanying text.


n185. See Policy Topics: Survey of Mental Health Courts, supra note 15.


n188. Schneider et al., supra note 9, at 6. For a discussion of the traditional, non-MHC adjudication model, see supra Part II.A.


n190. Steadman & Redlich, supra note 21, at 25.

n191. See id. at 24-25 & tbl.2; Griffin et al., supra note 19, at 1286.

n192. Griffin et al., supra note 19, at 1286.

n193. See, e.g., Almquist & Dodd, supra note 68, at 12 (discussing various studies of first and second generation courts and the distribution of pre-adjudication and post-adjudication models among them).


n195. Id. § 168/35.

n196. Tamar M. Meekins, You Can Teach Old Defenders New Tricks: Sentencing Lessons from Specialty Courts, in Rehabilitating Lawyers, supra note 83, at 144, 148. For a discussion of non-MHC procedures, see supra Part II.A.
The types of eligible diagnoses and charges courts will accept for entrance into the MHC are determined by the individual court. Schneider et al., supra note 9, at 88. For example, some courts accept only Axis I diagnoses (which include depression, schizophrenia, and bipolar disorder), other courts accept Axis I or Axis II diagnoses (which means the addition of developmental and personality disorders), and some accept defendants with co-occurring mental health and substance abuse problems. See Almquist & Dodd, supra note 68, at 10-11. Furthermore, some jurisdictions hear only misdemeanors while others hear broader ranges of offenses, both in terms of their seriousness and their type. Schneider et al., supra note 9, at 88.


Thompson et al., supra note 26, at 5 (stating the MHCs should have a system where "defendants fully understand the program requirements before agreeing to participate ... . They are provided legal counsel to inform this decision and subsequent decisions about program involvement").

Meekins, supra note 196, at 148.

Steadman & Redlich, supra note 21, at 25 (stating that the prosecutor holds the defendant's charges in abeyance and the case is not adjudicated).

Almquist & Dodd, supra note 68, at 12-13.

Steadman & Redlich, supra note 21, at 25.

Id.

Denckla & Berman, supra note 34, at 8.

Hora et al., supra note 23, at 513 (citing Drug Strategies, Cutting Crime: Drug Courts in Action 11 (1997)).

Meekins, supra note 196, at 148.


Griffin et al., supra note 19, at 1286.

Cummings, supra note 5, at 297.

Denckla & Berman, supra note 34, at 8.

n213. Meekins, supra note 196, at 148.

n214. Id.

n215. Id.

n216. See Hora et al., supra note 23, at 513 (stating specifically that the pre-adjudication model "appears more consistent with the therapeutic orientation of the DTC concept").


n219. Id.

n220. Goldkamp & Irons-Guy nn, supra note 154, at viii-ix.

n221. See Donaldson & Johnson, supra note 8, at 25.

n222. See supra notes 11-18 and accompanying text.

n223. Almquist & Dodd, supra note 68, at 13 ("Waiving the requirement of a guilty plea prevents a felony criminal conviction, which could negatively affect the person's chances of finding housing and employment after graduating from the program.").

n224. See Cummings, supra note 5, at 285 (stating that "the intermediate stop in the journey from hospitals to the criminal justice system was, and still is in many cases, homelessness" and discussing the effects of "deinstitutionalization" on the numbers of mentally ill individuals who are homeless).

n225. See supra notes 44-46 and accompanying text.

n226. Hora et al., supra note 23, at 514.

n227. Id.
n228. Id.


n230. Hora et al., supra note 23, at 514. Although critics of the model worry about this gap in time, this scenario is not very likely to happen in the vast majority of cases.

n231. Id. at 514-15.

n232. See Meekins, supra note 196, at 148.

n233. See Almquist & Dodd, supra note 68, at 12. The Mental Health Court in Marion County, Indiana, for example, started with a pre-adjudication model but has started using a deferred disposition/sentence model in which treatment is part of a diversion contract, suggesting they have shifted to a post-adjudication model. Steadman & Redlich, supra note 21, at 29. But see Schneider et al., supra note 9, at 106 (arguing that the observation that a "second generation" of mental health court has emerged is not supported by examination of MHC development).

n234. Schneider et al., supra note 9, at 87.


n236. District Court Services, supra note 11.

n237. Hora et al., supra note 23, at 515.

n238. Schneider et al., supra note 9, at 87.

n239. Cummings, supra note 5, at 298.

n240. Goldkamp & Irons-Guy, supra note 154, at 23.


n242. See, e.g., supra notes 179, 202 and accompanying text.
n243. Steadman & Redlich, supra note 21, at 29.

n244. Id. ("Persons are either not being identified shortly after arrest during initial detention or, if they are identified shortly after arrest, are not enrolled in the MHC until much further into the adjudication process.").

n245. Id. at 30.

n246. Hora et al., supra note 23, at 514-15 ("Evidence for the case may become stale or lost and witnesses or defendants may disappear. All of these occurrences work to hamper the ability of the prosecutor to try the case if the defendant should drop from the treatment program."); see also Almquist & Dodd, supra note 68, at 13.

n247. Meekins, supra note 196, at 149.

n248. Docket size and finite judicial resources are constant concerns for both MHCs and traditional courts. See supra note 7 and accompanying text.

n249. See Meekins, supra note 83, at 61-62. Proponents of post-adjudication drug courts also use this rationale to support the model. They argue that it is therapeutic for defendants to publicly admit to their drug use in order to accept their addiction. See supra notes 102-03 and accompanying text.

n250. See supra notes 98-103 and accompanying text.

n251. See Meekins, supra note 83, at 60 n.75; see also Hora et al., supra note 23, at 516.

n252. Meekins, supra note 196, at 149.

n253. Id.

n254. District Court Services, supra note 11.

n255. See Hora et al., supra note 23, at 516; see also supra note 27 and accompanying text.

n256. See Hora et al., supra note 23, at 516.

n257. See supra notes 56-59 and accompanying text.

n258. See supra note 244 and accompanying text.
n259. Goldkamp & Irons-Guynn, supra note 154, at 40.

n260. See id. at 39-40.

n261. Steadman & Redlich, supra note 21, at 30.

n262. See Denckla & Berman, supra note 34, at 1 (“Prisons and jails are not designed to be therapeutic environments. All too often, the condition of mentally ill individuals seriously deteriorates in custody.”).


n264. See generally Almquist & Dodd, supra note 68, at 12 (stating that in 2002 only three of the eight early MHCs used this model).

n265. Steadman & Redlich, supra note 21, at 25.

n266. Goldkamp & Irons-Guynn, supra note 154, at 39.

n267. Id. at 29.

n268. Griffin et al., supra note 19, at 1286.

n269. Goldkamp & Irons-Guynn, supra note 154, at 40.

n270. Id. at xix.

n271. Id. at 39.

n272. Id.

n273. Id.

n274. Id.
n275. Id. at 39-40.

n276. Id. at 40.

n277. Id. at 39.

n278. Id.

n279. See Thompson et al., supra note 26, at 4 (“Collateral consequences of a criminal conviction may include limited housing options, opportunities for employment, and accessibility to some treatment programs.”).

n280. Id.


n282. Id.

n283. Goldkamp & Irons-Guynn, supra note 154, at 40.

n284. Id.

n285. See supra notes 42-43, 266 and accompanying text.

n286. See supra notes 161-66 and accompanying text.

n287. There are currently MHCs in the following counties: Cook, Champaign, DuPage, Kane, Lake, Lee, Macon, Madison, McHenry, McLean, Rock Island, Winnebago, and Will. Both Grundy and Peoria counties are currently planning for the establishment of MHCs. See Judges to Examine Illinois’ Mental Health Courts, St. J. Reg. (Springfield, IL), Apr. 28, 2010, http://www.sj-r.com/breaking/x1042556417/Judges-to-examine-Illinois-mental-health-courts; see also Mary Schenk, County Ready to Start Mental Health Court, News Gazette (Champaign, IL), Jan. 2, 2011, at B-1.


N289. See supra notes 165, 187 and accompanying text.

n290. See supra notes 11-12 and accompanying text.
n291. See supra notes 46-49, 70-72 and accompanying text.


n293. See, e.g., supra notes 47-49, 70-72 and accompanying text.

n294. Will County Launches Mental Health Court, Morris Daily Herald (IL) (May 1, 2010), http://www.morrisdailyherald.com/2010/04/30/will-county-launches-mental-health-court/ar9ouih/ (quoting Will County State's Attorney James Glasgow).

n295. See supra note 72 and accompanying text.

n296. See supra notes 40-43 and accompanying text.

n297. See supra notes 36-38 and accompanying text.


n299. See supra notes 44-46, 119 and accompanying text.

n300. See supra note 85 and accompanying text.

n301. Finigan et al., supra note 292, at 44.

n302. See supra notes 50-52 and accompanying text.

n303. See Finigan et al., supra note 292, at 44.


n305. Id.

n306. Id. at 480.
n307. Id.

n308. Finigan et al., supra note 292, at 44 (discussing this model as it pertains to drug courts).

n309. See supra note 304 and accompanying text.

n310. See supra notes 179-81 and accompanying text.

n311. Will County Launches Mental Health Court, supra note 294.


n313. Id. § 168/15.

n314. For a discussion on the approval processes and procedures for amendatory bills in Illinois, see The Legislative Reference Bureau, Illinois Bill Drafting Manual 84-118 (2010).

n315. See Nolan, supra note 7, at 1543 ("Prosecutors and defense counsel ... play much reduced roles. In fact, lawyers are frequently not even present during regular drug court sessions. Instead, the main courtroom drama is between the judge and client, both of whom speak openly and freely in the drug court setting.").


n317. Id.


n319. See supra notes 304-307 and accompanying text.

n320. Some of these changes can also be attributed to changes in the needs of the community. See, e.g., Finigan et al., supra note 292, at I (discussing how the Multnomah County Drug Court was originally designed as a pre-plea court but over time changed into a combination and finally a post-plea program).

n321. See supra note 256 and accompanying text.
n322. See supra notes 228-29 and accompanying text.