

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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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.

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1. INTRODUCTION

Mental health services in communities across the country are becoming overwhelmed by the numbers of people requiring their services.¹ As this is happening, there have been corresponding increases in the number of mentally ill offenders making contact with the criminal justice system.² 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.”³ 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,”⁴ coupled with the “atrocious conditions at some”⁵ 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 1999.⁶ 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.⁷ 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.⁸ These numbers cause some scholars to speculate that the criminal justice system is becoming a “‘surrogate’ men-

1. Gary Hearn, *Foreword* to KITCHENER HUMAN SERVS. & JUSTICE COORDINATING COMM., *MENTAL HEALTH, THE JUSTICE SYSTEM, AND YOU: UNDERSTANDING THE PROCESS, AND THE PEOPLE THAT CAN HELP* 4, 4 (2010).

2. *Id.*

3. Jeff Gerritt, *Salvaging Lives, Saving Money: Eight Pilot Courts That Divert Mentally Ill Offenders from Prison*, DETROIT FREE PRESS (Mar. 4, 2012), <http://www.freep.com/article/20120304/OPINION02/203040478>.

4. FRED C. OSHER & IRENE S. LEVINE, COUNCIL OF STATE GOV'TS, *NAVIGATING THE MENTAL HEALTH MAZE: A GUIDE FOR COURT PRACTITIONERS* 1, 1 (2005).

5. John E. Cummings, Comment, *The Cost of Crazy: How Therapeutic Jurisprudence and Mental Health Courts Lower Incarceration Costs, Reduce Recidivism, and Improve Public Safety*, 56 LOY. L. REV. 279, 283 (2010).

6. PAMELA M. CASEY & DAVID B. ROTTMAN, *PROBLEM-SOLVING COURTS: MODELS AND TRENDS* 8 (2003); OSHER & LEVINE, *supra* note 4, at 1.

7. James L. Nolan, Jr., *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 40 AM. CRIM. L. REV. 1541, 1541 (2003).

8. Herbert Donaldson & Jennifer Johnson, *San Francisco's Behavioral Health Court: On the Cutting Edge*, S.F. MED., OCT. 2005, at 24, 24; *see also* COUNCIL OF STATE GOV'TS, *CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT* 4 (2002) (noting that approximately five percent of the U.S. population suffers from a serious mental illness whereas the rate of mental illness in prison and jail populations in 1999 was closer to sixteen percent).

tal 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.⁹

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.¹⁰ These concerns are exacerbated by the inability of the criminal justice system to adequately treat the defendants’ underlying mental disorders,¹¹ which often results in repeat offenses and further contact with the system.¹² 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.¹³

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).¹⁴ 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.¹⁵ 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.¹⁶ 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.¹⁷ 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.¹⁸

One area that has been subject to debate concerns the adjudication methods used when admitting clients into MHCs. There are three differ-

9. RICHARD D. SCHNEIDER ET AL., *MENTAL HEALTH COURTS: DECRIMINALIZING THE MENTALLY ILL* 42 (2007).

10. Nolan, *supra* note 7, at 1541.

11. 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).

12. *Id.*

13. Jeff Coen, *Mental Health Court Opens: Plan Offers Drugs and Counseling*, CHI. TRIB., May 13, 2004, § 2, at 1.

14. LeRoy L. Kondo, *Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 24 SEATTLE U. L. REV. 373, 379–81 (2000); see also Nolan, *supra* note 7, at 1545–48.

15. *Policy Topics: Survey of Mental Health Courts*, NAT’L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Mental_Health_Courts_Survey.htm (last visited Nov. 19, 2012).

16. See Donaldson & Johnson, *supra* note 8, at 25.

17. SCHNEIDER ET AL., *supra* note 9, at 60, 191.

18. *Id.*

ent adjudication models: the pre-plea/pre-adjudication model (pre-adjudication model), the post-plea/post-adjudication model (post-adjudication model), and the combination model.¹⁹ Most MHCs typically employ only one of these models, depending on where in the criminal prosecution process the defendant enters the MHC,²⁰ the crime the defendant is accused of committing, or where the alleged crime took place.²¹ 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,²² often argue that this model makes MHC programs more attractive to defendants and facilitates quicker entry into the programs.²³ The post-adjudication model, on the other hand, requires the defendant to plead guilty before program entrance will be granted.²⁴ The defendant's sentence usually is not imposed unless the defendant fails to successfully complete the program.²⁵ While this model lessens the burden on prosecutors, opponents argue that the model puts additional burdens on defendants in terms of obtaining housing or employment²⁶ and can hamper the defendant's constitutional rights.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.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.²⁹

This Note explores the three adjudication models typically em-

19. Patricia A. Griffin et al., *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVICES 1285, 1285 (2002).

20. See SCHNEIDER ET AL., *supra* note 9, at 3.

21. See HENRY J. STEADMAN & ALLISON D. REDLICH, POLICY RESEARCH ASSOCS., INC., AN EVALUATION OF THE BUREAU OF JUSTICE ASSISTANCE MENTAL HEALTH COURT INITIATIVE 24–25 tbl.2 (2005) (unpublished report), available at <https://www.ncjrs.gov/pdffiles1/nij/grants/213136.pdf>.

22. 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”).

23. Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 513–14 (1999) (discussing the adjudication models used in drug courts, a predecessor and model for MHCs).

24. SCHNEIDER ET AL., *supra* note 9, at 87.

25. Hora et al., *supra* note 23, at 515.

26. See MICHAEL THOMPSON ET AL., COUNCIL OF STATE GOV'TS JUSTICE CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT 4 (2007).

27. 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).

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

29. *Id.*

ployed 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,³⁰ and by 2007 there were over 175 courts in jurisdictions across the United States, with dozens more being planned.³¹ 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.³² As one scholar stated, “our prisons were never designed to operate as psychiatric hospi-

30. See KELLY O'KEEFE, CTR. FOR COURT INNOVATION, THE BROOKLYN MENTAL HEALTH COURT EVALUATION: PLANNING, IMPLEMENTATION, COURTROOM DYNAMICS, AND PARTICIPANT OUTCOMES 2 (2006), available at http://www.courtinnovation.org/_uploads/documents/BMHC_evaluation.pdf.

31. Nolan, *supra* note 7, at 1544; COUNCIL OF STATE GOV'TS JUSTICE CTR., MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS 1 (2008).

32. See *supra* notes 2–9 and accompanying text.

tals” and are “unprepared to adequately meet the needs of mentally ill prisoners.”³³ 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.³⁴ While some may view equal treatment as beneficial and appropriate, for defendants suffering from mental illness it can be quite the opposite.³⁵ When a defendant with a mental illness encounters the traditional system, there is no guarantee that mental health services will be available.³⁶ Even when services are available, they may come with long waits, frequent interruptions, or stigmatization,³⁷ or be limited to determinations of competency to stand trial.³⁸

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.³⁹ 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.⁴⁰ 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.⁴¹ 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.⁴² To complicate matters further for

33. Cummings, *supra* note 5, at 306.

34. DEREK DENCKLA & GREG BERMAN, CTR. FOR COURT INNOVATION, *RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS* 6 (2001).

35. *Id.* at 6–7 (“In fact, many are treated worse, because they are stigmatized by criminal justice officials with little experience dealing with mental illness.”).

36. 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).

37. Acquaviva, *supra* note 36, at 979.

38. 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).

39. *Id.* at 1.

40. Acquaviva, *supra* note 36, at 978–79.

41. DENCKLA & BERMAN, *supra* note 34, at 1 (“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.”).

42. 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).

mentally ill defendants, many jails and prisons lack basic resources, staff, and facilities to address their needs.⁴³

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.⁴⁴ The cycle is completed when they eventually end up back before the court and in prison or jail.⁴⁵ This endless cycle of incarceration, homelessness, and related hospital stays results in very high costs to the state and taxpayers.⁴⁶ In New York City, for example, the average jail stay for mentally ill persons is 215 days compared to an average of only 42 days for all inmates.⁴⁷ Assuming that the average cost of a day in jail is \$70,⁴⁸ then the cost to jail mentally ill defendants is around \$12,110 more than an average inmate.⁴⁹

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 probations, incarcerations or arrests,” but only twenty-eight percent of federal inmates without mental illness fit this description.⁵⁰ 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.⁵¹ 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.

43. 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).

44. 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.

45. DENCKLA & BERMAN, *supra* note 34, at 1.

46. See Cummings, *supra* note 5, at 280.

47. O’KEEFE, *supra* note 30, at 2.

48. See *infra* notes 71–72 and accompanying text.

49. 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.

50. DENCKLA & BERMAN, *supra* note 34, at 4.

51. 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.*

*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.⁵²

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.⁵³ 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.”⁵⁴

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.⁵⁵ 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.⁵⁶ 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

52. SCHNEIDER ET AL., *supra* note 9, at 39.

53. Kondo, *supra* note 14, at 380.

54. *Id.* at 382–83.

55. See David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, in *ESSAYS IN THERAPEUTIC JURISPRUDENCE* 3, 9 (David B. Wexler & Bruce J. Winick eds., 1991).

56. David B. Wexler, *An Introduction to Therapeutic Jurisprudence*, in *ESSAYS IN THERAPEUTIC JURISPRUDENCE*, *supra* note 55, at 17, 17.

may need, (2) encouraging clients to receive unnecessary treatment, or (3) “lead[ing] persons to regard themselves as dysfunctional or as lacking in control” because of the labels and attributions the law gives them.⁵⁷ 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.⁵⁸ With these considerations in mind, Wexler proposed that certain changes be made in the law that could reduce dysfunction and encourage therapeutic objectives.⁵⁹

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.⁶⁰ Advocates of problem-solving courts look to and expound upon the theory for support and justification of the establishment and mission of specialty courts.⁶¹ 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.⁶² 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.”⁶³ 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.⁶⁴

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.⁶⁵

Thus, therapeutic jurisprudence focuses on identifying and treating the

57. *Id.* at 20.

58. *See id.*

59. *Id.* at 23.

60. *See* Nolan, *supra* note 7, at 1546–47 (stating that therapeutic jurisprudence advocates “fairly radical changes in the legal system”).

61. *Id.* at 1542.

62. SCHNEIDER ET AL., *supra* note 9, at 43–44.

63. 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)).

64. *See* SCHNEIDER ET AL., *supra* note 9, at 43.

65. *Id.* at 3.

underlying causes of specific defendants' troubles, which may be drug abuse, mental illness, homelessness, or any number of other issues.⁶⁶ 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."⁶⁷

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.⁶⁸ 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.⁶⁹ 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.⁷⁰ 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.⁷¹ 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.⁷²

Although proponents of therapeutic jurisprudence advocate making what some call "fairly radical"⁷³ 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.⁷⁴ 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.⁷⁵ 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.⁷⁶ By becoming involved in defend-

66. See Kondo, *supra* note 14, at 390.

67. Cummings, *supra* note 5, at 292.

68. LAUREN ALMOUIST & ELIZABETH DODD, COUNCIL OF STATE GOV'TS JUSTICE CTR., MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE, at vi (2009).

69. COUNCIL OF STATE GOV'TS, *supra* note 8, at 13.

70. *Id.*

71. *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").

72. See *id.* ("[O]ver the course of one year, 20 individuals were repeatedly hospitalized, jailed, or admitted to detoxification centers, costing the county approximately \$1.1 million.").

73. Nolan, *supra* note 7, at 1546–47.

74. *Id.* at 1547 (internal quotation marks omitted).

75. SCHNEIDER ET AL., *supra* note 9, at 61.

76. *Id.*

ants' lives in this way, judges and attorneys risk tainting their impartiality.⁷⁷ 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.'" ⁷⁸ 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.⁷⁹

Despite these concerns, proponents maintain that therapeutic outcomes are beneficial and that any anti-therapeutic outcomes should be avoided.⁸⁰ They also refute claims of coercion by pointing to studies indicating that most participants perceive low levels of coercion.⁸¹ 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."⁸²

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.⁸³ Like therapeutic jurisprudence, the theory has been thought to advocate radical changes in the legal system.⁸⁴ The theory has been described as

[a]n 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 per-

77. *Id.*

78. *Id.* at 64 (citation omitted).

79. *Id.* at 63.

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

81. SCHNEIDER ET AL., *supra* note 9, at 63, 192.

82. *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.")

83. 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").

84. Nolan, *supra* note 7, at 1546-47.

form community service, or to make amends in some other way that the court orders.⁸⁵

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.⁸⁶ In a way, this theory seeks to blend the law with social work to correct what its proponents view as failures in social services provided by the government and the community.⁸⁷

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.⁸⁸ As such, restorative justice 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."⁸⁹ It does so by inviting all parties affected by the criminal activity to participate in the process of "determining needs and outcomes."⁹⁰ By increasing participation, restorative justice "maximizes opportunities for exchange of information, participation, dialogue, and mutual consent between victim and offender."⁹¹

Restorative justice also focuses more on requiring defendants to "pay back" the community for their wrongdoing than therapeutic jurisprudence does.⁹² 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.⁹³ Next, the defendant must satisfy his obligations to the victims or the community by paying restitution, performing community service, or contributing in other ways.⁹⁴ Obligations to the victim take precedence over other imposed sanctions or obligations such as fines payable to the state.⁹⁵

Another important difference between the two theories is restorative justice's use of "reintegrative shaming."⁹⁶ When participants in spe-

85. BLACK'S LAW DICTIONARY 1428 (9th ed. 2009).

86. SCHNEIDER ET AL., *supra* note 9, at 4.

87. Meekins, *supra* note 83, at 58.

88. Howard Zehr & Harry Mika, *Fundamental Concepts of Restorative Justice*, NAT'L INST. OF JUSTICE (Dec. 3, 2007), <http://nij.gov/nij/topics/courts/restorative-justice/fundamental-concepts.htm>.

89. 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)).

90. Zehr & Mika, *supra* note 88.

91. *Id.*

92. *See id.*

93. *Id.*

94. Meekins, *supra* note 83, at 68–69.

95. Zehr & Mika, *supra* note 88.

96. Nolan, *supra* note 7, at 1547.

cialty courts are noncompliant, judges using a restorative justice model sometimes use public shaming techniques both to encourage compliance with program requirements⁹⁷ and to “affirm[] the [defendant’s] membership within law-abiding society.”⁹⁸ 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.⁹⁹ Shaming techniques, such as those just mentioned, are designed to express disapproval of the defendant’s actions and encourage feelings of remorse or shame.¹⁰⁰ 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.¹⁰¹ Although these measures are said to punish the actions of the defendant rather than the defendant himself,¹⁰² critics of restorative justice argue that such sanctions are not rehabilitative.¹⁰³ 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.¹⁰⁴ 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.¹⁰⁵ 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.¹⁰⁶ Thus, rather than focus on an adversarial system,

97. Meekins, *supra* note 83, at 61.

98. Anne-Marie McAlinden, *The Use of ‘Shame’ with Sexual Offenders*, 45 BRIT. J. CRIMINOLOGY 373, 373 (2005).

99. *Id.* at 377–81.

100. JOHN BRAITHWAITE, CRIME, SHAME AND REINTEGRATION 100 (1989).

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

102. 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 “[w]ith 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))).

103. 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”).

104. Kondo, *supra* note 14, at 380.

105. *Id.* at 380–81.

106. *Id.*

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).”¹⁰⁷

By creating specialized dockets such as MHCs, which help mentally ill defendants obtain needed treatment, defendants can lessen the conflict and dispute in their lives¹⁰⁸ and, thus, lessen the “frequency and scope of future legal problems.”¹⁰⁹ This, in turn, improves the quality of their “legal health.”¹¹⁰ 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.”¹¹¹ 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.”¹¹² As one defendant stated, “[i]f [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.¹¹³

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.¹¹⁴ 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.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.¹¹⁶ With the guidance of a judge, the programs integrated the judicial process with treatment services to “address the underlying problems of individual liti-

107. Louis M. Brown, *The Other Side of the Law* (1995), reprinted in *What Is Preventive Law?*, CYBERINSTITUTE ONLINE, <http://www.cyberinstitute.com/preventivelaw/week1.htm> (last modified July 8, 1998).

108. RICHARD S. GRUNER, *What Is Preventive Law?*, CYBERINSTITUTE ONLINE, <http://www.cyberinstitute.com/preventivelaw/week1.htm> (last modified July 8, 1998).

109. *Nat'l Center for Preventive Law: Louis M. Brown Program in Preventive Law*, CAL. W. SCH. L., http://www.preventivelawyer.org/main/default.asp?pid=brown_program.htm (last visited Nov. 19, 2012).

110. GRUNER, *supra* note 108.

111. DENCKLA & BERMAN, *supra* note 34, at 20 (quoting Anne Swern of the Brooklyn District Attorney's Office).

112. *Id.*

113. *Id.*

114. SCHNEIDER ET AL., *supra* note 9, at 40.

115. See JOANN MILLER & DONALD C. JOHNSON, PROBLEM SOLVING COURTS: NEW APPROACHES TO CRIMINAL JUSTICE 9, 19 (2009).

116. Nolan, *supra* note 7, at 1542.

gants, the structural problems of the justice system, and the social problems of the communities” they are located in.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.¹¹⁸ This would then lower the recidivism rate, effectively closing the “revolving door” that many participants had been trapped in, and increase public safety.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.¹²⁰ The individual focus also would allow treatment providers to closely monitor each participant’s treatment progress.¹²¹

Although the first problem-solving courts began in the late 1980s, their number remained relatively low for the next ten years.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.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.”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.”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 in-

117. *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)).

118. MILLER & JOHNSON, *supra* note 115, at 9.

119. *See id.* at 9, 76.

120. *See* Nolan, *supra* note 7, at 1542.

121. *See id.*

122. *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).

123. *See id.* at 1.

124. Task Force on Therapeutic Justice of the Conference of Chief Justices, *Resolution In Support of Problem-Solving Courts*, CONF. OF ST. CT. ADMINS. (Aug. 3, 2000), <http://cosca.ncsc.dni.us/Resolutions/CourtAdmin/resolutionproblemsolvingcts.html>.

125. Nolan, *supra* note 7, at 1545.

fluenced by its goals and characteristics.

1. *Drug Courts*

In the 1980s and 1990s, the criminal justice system began its so-called “War on Drugs.”¹²⁶ At this time, new anti-drug laws and increased enforcement efforts brought a wave of drug case filings into the court system.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.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,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.¹³⁰

In essence, the goal of this “new” justice is to reduce recidivism in offenders with alcohol or substance abuse problems¹³¹ 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.¹³² In 1989, these goals began to be realized with the foundation of the first drug court in Miami-Dade County, Florida.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.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.¹³⁵ In the alternative program, participants could expect an intensive program tailored to their specific

126. CASEY & ROTTMAN, *supra* note 6, at 6.

127. *Id.*

128. See MILLER & JOHNSON, *supra* note 115, at 19.

129. 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”).

130. *Id.* (alteration in original).

131. CASEY & ROTTMAN, *supra* note 6, at 6.

132. Nolan, *supra* note 7, at 1553.

133. RYAN S. KING & JILL PASQUARELLA, THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 1 (2009), available at http://www.sentencingproject.org/doc/dp_drug_courts.pdf.

134. *Id.*

135. Nolan, *supra* note 7, at 1542.

needs.¹³⁶ Generally speaking, the participant was required to sign a contract agreeing to the program's terms.¹³⁷ Some common program terms included regular court appearances, increased interaction with the judge, and participation in outside drug treatment.¹³⁸ Failure to comply with the contract requirements could mean that the defendant is returned to the regular court to be tried or sentenced.¹³⁹ In addition to frequently interacting with the judge, participants would also be expected to interact with a drug court team.¹⁴⁰ 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.¹⁴¹

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.¹⁴² 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.¹⁴³ 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.¹⁴⁴ A third critique regards participation length. Because programs are tailored to each defendant's needs, program durations may differ and be hard to predict.¹⁴⁵ 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.¹⁴⁶ Due to these indeterminate timelines, many participants are required to sign waivers to forgo a speedy trial.¹⁴⁷ Thus, defendants entering the drug

136. *Id.* at 1543.

137. *See id.*

138. *Id.* at 1542–43.

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

140. *See* CASEY & ROTTMAN, *supra* note 6, at 6.

141. *Id.*

142. Hora et al., *supra* note 23, at 522–23 (“[R]equirements 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.”).

143. *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).

144. *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).

145. Nolan, *supra* note 7, at 1557.

146. *Id.*

147. 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,

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.¹⁴⁸

In response to these concerns, proponents concede that drug courts are often more arduous than the normal course.¹⁴⁹ 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.”¹⁵⁰ Some even highlight the length of participation in terms of the therapeutic benefits it can have in contributing to recovery.¹⁵¹ In this sense, prolonged treatment is not viewed as a punishment, but as a “restructuring of the defendant’s lifestyle.”¹⁵² Furthermore, drug courts, like MHCs, are voluntary.¹⁵³ 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.¹⁵⁴

2. *Mental Health Courts*

As previously mentioned, MHCs are a relatively new type of problem-solving court.¹⁵⁵ Their development was the result of decades of frustration with traditional courts’ inability to respond to and treat defendants suffering from mental illness.¹⁵⁶ As mental health institutions closed their doors, court dockets began to see a rise in the number of individuals with mental illness.¹⁵⁷ 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

supra note 7, at 1559.

148. Nolan, *supra* note 7, at 1559.

149. *Id.* at 1556.

150. Hora et al., *supra* note 23, at 523.

151. 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.

152. Hora et al., *supra* note 23, at 523.

153. *Id.* at 521.

154. See JOHN S. GOLDKAMP & CHERYL IRONS-GUYN, CRIME AND JUSTICE RESEARCH INST., EMERGING JUDICIAL STRATEGIES FOR THE MENTALLY ILL IN THE CRIMINAL CASELOAD: MENTAL HEALTH COURTS IN FORT LAUDERDALE, SEATTLE, SAN BERNARDINO, AND ANCHORAGE, at vii (2000).

155. See *supra* note 30 and accompanying text.

156. See *supra* Part II.C.

157. 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).

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.¹⁵⁸ 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.¹⁵⁹

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.¹⁶⁰ In 1997, these theories helped influence the establishment of the nation's first MHC in Broward County, Florida.¹⁶¹ Since then the number of these courts has grown tremendously, and there are now specialized mental health dockets across the country.¹⁶²

The growth of these courts was encouraged, in part, by the passage of America's Law Enforcement and Mental Health Project Act.¹⁶³ This Act authorized the foundation of additional courts based on the success of those already in place.¹⁶⁴ 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 suffer[ed] 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."¹⁶⁵ With the 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.¹⁶⁶

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 defend-

158. COUNCIL OF STATE GOV'TS, *supra* note 8, at 8.

159. CASEY & ROTTMAN, *supra* note 6, at 8.

160. 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.")

161. See Nolan, *supra* note 7, at 1544.

162. See, e.g., *Criminal Justice/Mental Health Learning Sites*, COUNCIL OF STATE GOV'TS JUSTICE CENTER, <http://consensusproject.org/learningsites> (last visited Nov. 19, 2012).

163. See generally America's Law Enforcement and Mental Health Project Act, Pub. L. No. 106-515, 114 Stat. 2399 (2000).

164. *Id.* § 2.

165. *Id.*

166. 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).

ants 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

167. Nolan, *supra* note 7, at 1544.

168. SCHNEIDER ET AL., *supra* note 9, at 7.

169. 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.*

170. *District Court Services*, *supra* note 11.

171. *Id.*

172. *Policy Topics: Survey of Mental Health Courts*, *supra* note 15.

173. Kelly McAleer, *Mental Health Court: The Drawbacks*, PSYCHCENTRAL (Apr. 12, 2010), <http://blogs.psychcentral.com/forensic-focus/2010/04/mental-health-court-the-drawbacks/>.

174. Nolan, *supra* note 7, at 1555–56.

175. McAleer, *supra* note 173.

176. See, e.g., KING CNTY. DIST. COURT, MENTAL HEALTH COURT AGREEMENT/CONDITIONS OF TREATMENT, available at [http://www.kingcounty.gov/courts/DistrictCourt/~media/courts/DistrictCourt/MHC/KCDC_RMHC_Agreement_Conditions_of_Treatment.ashx](http://www.kingcounty.gov/courts/DistrictCourt/~/media/courts/DistrictCourt/MHC/KCDC_RMHC_Agreement_Conditions_of_Treatment.ashx).

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

177. *Id.*

178. *Id.*

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

180. *Id.* at 897.

181. *Id.*

182. *See supra* notes 122–23 and accompanying text.

183. *See supra* notes 17–18 and accompanying text.

184. *See* Michelle Rock, NAMI Presentation on Mental Health Courts in Illinois 17 (Oct. 16, 2009) (slides on file with author).

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

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 “[p]re-adjudicatory mental health court program,” a “[p]ost-adjudicatory mental health court program,” and a “[c]ombination mental health court program”—but does not explicitly say which model courts in the state should use.¹⁸⁹ In the first model, the pre-adjudication model, defendants are allowed to enter the MHC before their case is adjudicated.¹⁹⁰ 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.¹⁹¹ 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.¹⁹² 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.¹⁹³ 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.¹⁹⁴ If the defendant is successful, then “the court may dismiss the original charges

186. See 730 ILL. COMP. STAT. 168/5 (2010); Rock, *supra* note 186, at 4.

187. 730 ILL. COMP. STAT. 168/5.

188. SCHNEIDER ET AL., *supra* note 9, at 6. For a discussion of the traditional, non-MHC adjudication model, see *supra* Part II.A.

189. 730 ILL. COMP. STAT. 168/10.

190. STEADMAN & REDLICH, *supra* note 21, at 25.

191. See *id.* at 24–25 & tbl.2; Griffin et al., *supra* note 19, at 1286.

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

193. 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).

194. 730 ILL. COMP. STAT. 168/10.

against the defendant or . . . otherwise discharge him . . . from the program or from any further proceedings” in connection with the original charge.¹⁹⁵ 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.¹⁹⁶ Typically, a “good candidate” is a person who meets the specific court’s mental health diagnosis and charge requirements,¹⁹⁷ whose offense and mental disorder are connected,¹⁹⁸ and who voluntarily makes an informed decision to enter the MHC.¹⁹⁹ Offering defendants a place in the MHC often happens early in the case, sometimes as early as the arraignment or presentment date.²⁰⁰ If admitted, the defendant’s case appears on the MHC docket for treatment progress reports, but the case is not adjudicated.²⁰¹ Thus, the defendant is not required to plead guilty or be convicted before entering into treatment.²⁰²

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.²⁰³ 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.²⁰⁴ 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.²⁰⁵ Defendants whose charges are

195. *Id.* § 168/35.

196. 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.

197. 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.

198. See KITCHENER HUMAN SERVS. & JUSTICE COORDINATING COMM., *supra* note 1, at 30.

199. THOMPSON ET AL., *supra* note 26, at 5 (stating the MHCs should have a system where “[d]efendants fully understand the program requirements before agreeing to participate They are provided legal counsel to inform this decision and subsequent decisions about program involvement”).

200. Meekins, *supra* note 196, at 148.

201. STEADMAN & REDLICH, *supra* note 21, at 25 (stating that the prosecutor holds the defendant’s charges in abeyance and the case is not adjudicated).

202. ALMQUIST & DODD, *supra* note 68, at 12–13.

203. STEADMAN & REDLICH, *supra* note 21, at 25.

204. *Id.*

205. DENCKLA & BERMAN, *supra* note 34, at 8.

dismissed immediately must still complete the program; if the program is not completed their charges can be reinstated²⁰⁶ and the case will return to its pretrial stance to be adjudicated.²⁰⁷ 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,²⁰⁸ 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.²⁰⁹

After agreeing to participate in the MHC, the defendant begins court-monitored treatment, which may last one year or more.²¹⁰ The exact length of a particular defendant's MHC participation and judicial supervision, however, depends on his individual needs and corresponding level of treatment.²¹¹ Due to the indeterminate length of court participation, defendants may be required to waive their right to a speedy trial before entering the program.²¹² 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.²¹³

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."²¹⁴ 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.²¹⁵ 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.

206. Hora et al., *supra* note 23, at 513 (citing DRUG STRATEGIES, CUTTING CRIME: DRUG COURTS IN ACTION 11 (1997)).

207. Meekins, *supra* note 196, at 148.

208. See, e.g., 730 ILL. COMP. STAT. 168/20 (2010).

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

210. Cummings, *supra* note 5, at 297.

211. DENCKLA & BERMAN, *supra* note 34, at 8.

212. Hora et al., *supra* note 23, at 513 (citing DRUG STRATEGIES, CUTTING CRIME: DRUG COURTS IN ACTION 11(1997)).

213. Meekins, *supra* note 196, at 148.

214. *Id.*

215. *Id.*

I. 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.²¹⁶ For this reason, some organizations, such as Disability Rights California, a California-based group committed to “[a]dvanc[ing] the rights of Californians with disabilities,”²¹⁷ take the position that MHCs should use pre-adjudication models and not require a conviction or guilty plea to participate.²¹⁸ They argue that this model respects both the individual and his civil rights by “focus[ing] on treatment to restore health and reduce criminal activity including: providing better access to treatment, consistent supervision, and support to reconnect with families.”²¹⁹ 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 non-threatening and nonpenal as possible and would seek to prevent further penetration by the mentally ill offender into the formal adjudication process.”²²⁰ 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.”²²¹ 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.²²²

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.²²³ This will only

216. 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”).

217. *Vision and Mission*, DISABILITY RTS. CAL., <http://www.disabilityrightsca.org/about/vision.htm> (last updated July 1, 2011).

218. *Mental Health Court Principles*, DISABILITY RTS. CAL. (Feb. 26, 2011), <http://www.disabilityrightsca.org/legislature/Principles/103101.htm>.

219. *Id.*

220. GOLDKAMP & IRONS-GUYNN, *supra* note 154, at viii–ix.

221. See Donaldson & Johnson, *supra* note 8, at 25.

222. See *supra* notes 11–18 and accompanying text.

223. ALMQUIST & DODD, *supra* note 68, at 13 (“[W]aiving 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.”).

make matters worse for MHC participants, as mentally ill defendants already have a high rate of joblessness and homelessness.²²⁴ 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.²²⁵

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.²²⁶ 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.²²⁷ 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.²²⁸ 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."²²⁹ 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

224. 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).

225. See *supra* notes 44–46 and accompanying text.

226. Hora et al., *supra* note 23, at 514.

227. *Id.*

228. *Id.*

229. People v. Kimmel, 882 N.Y.S.2d 895, 901 (Jamestown City Ct. 2009).

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.²³⁰ 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.²³¹ 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.²³²

B. Post-Adjudication Model

Although many early MHCs used a pre-adjudication model, more recently established courts have used a post-adjudication model.²³³ In this model, which about half of the MHCs in the United States utilize,²³⁴ the defendant must first plead guilty or be found guilty and then agree to enter the MHC.²³⁵ 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.²³⁶ 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.²³⁷ 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,²³⁸

230. 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.

231. *Id.* at 514-15.

232. See Meekins, *supra* note 196, at 148.

233. 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).

234. SCHNEIDER ET AL., *supra* note 9, at 87.

235. See, e.g., 730 ILL. COMP. STAT. 168/10 (2010).

236. *District Court Services*, *supra* note 11.

237. Hora et al., *supra* note 23, at 515.

238. SCHNEIDER ET AL., *supra* note 9, at 87.

while others may vacate or lessen the charges and the resulting sentence.²³⁹ In some cases, however, the conviction remains on the defendant's record even if the treatment is successfully completed.²⁴⁰ 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.²⁴¹ 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.²⁴²

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.²⁴³ 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.²⁴⁴ 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.²⁴⁵

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.

239. Cummings, *supra* note 5, at 298.

240. GOLDKAMP & IRONS-GUINN, *supra* note 154, at 23.

241. Edward M. Blau, *Mental Health Courts*, 78 OKLA. B.J. 2823, 2824 (2007).

242. See, e.g., *supra* notes 179, 202 and accompanying text.

243. STEADMAN & REDLICH, *supra* note 21, at 29.

244. *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.")

245. *Id.* at 30.

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.²⁴⁶ 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.”²⁴⁷ 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.²⁴⁸ 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.²⁴⁹ 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.²⁵⁰

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.²⁵¹ 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.”²⁵² Thus, MHCs, courts that focus on connecting mentally ill defendants to treatment, and the post-adjudication model

246. 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.

247. Meekins, *supra* note 196, at 149.

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

249. *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.

250. *See supra* notes 98–103 and accompanying text.

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

252. Meekins, *supra* note 196, at 149.

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.²⁵³ In King County, for example, defendants are asked to waive their rights on the merits of the case before entering the MHC.²⁵⁴ 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.²⁵⁵ 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.²⁵⁶ 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.²⁵⁷

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.²⁵⁸ In several courts, even in those that attempt "to expedite the sentencing hearing so that the defendant can be released as soon as possible,"²⁵⁹ potential participants must wait to be convicted and sentenced before they are considered for entrance into the MHC.²⁶⁰ 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.²⁶¹ 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.²⁶² 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.

253. *Id.*

254. *District Court Services*, *supra* note 11.

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

256. See Hora et al., *supra* note 23, at 516.

257. See *supra* notes 56–59 and accompanying text.

258. See *supra* note 244 and accompanying text.

259. GOLDKAMP & IRONS-GUINN, *supra* note 154, at 40.

260. See *id.* at 39–40.

261. STEADMAN & REDLICH, *supra* note 21, at 30.

262. See DENCKLA & BERMAN, *supra* note 34, at 1 ("[P]risons and jails are not designed to be therapeutic environments. All too often, the condition of mentally ill individuals seriously deteriorates in custody.").

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.²⁶³ There are very few courts that employ this model.²⁶⁴ 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-adjudication model in the sense that convictions are often in place before the defendant may enter treatment.²⁶⁵ 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.²⁶⁶ After being convicted, the defendant’s sentence may or may not be imposed, depending on the court’s discretion,²⁶⁷ 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.²⁶⁸ 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.²⁶⁹ Although the conviction remains on his record, the defendant may have the remainder of his sentence suspended.²⁷⁰

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.²⁷¹ 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.”²⁷² At the court’s discretion, defendants who successfully complete the program may have their charges dismissed, but again this is no guarantee.²⁷³ 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 mis-

263. See, e.g., 730 ILL. COMP. STAT. 168/10 (2010).

264. See generally ALMQUIST & DODD, *supra* note 68, at 12 (stating that in 2002 only three of the eight early MHCs used this model).

265. STEADMAN & REDLICH, *supra* note 21, at 25.

266. GOLDKAMP & IRONS-GUYNN, *supra* note 154, at 39.

267. *Id.* at 29.

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

269. GOLDKAMP & IRONS-GUYNN, *supra* note 154, at 40.

270. *Id.* at xix.

271. *Id.* at 39.

272. *Id.*

273. *Id.*

demeanor 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.²⁷⁴ If the plea is accepted, then it is entered and the defendant is scheduled for a sentencing hearing, which usually includes a probationary term.²⁷⁵ 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.²⁷⁶ 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.²⁷⁷ 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-adjudication model.²⁷⁸ 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 consequences²⁷⁹ and weaknesses of the model are very similar to those of the post-adjudication 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.²⁸⁰ As mentioned above, ensuring access to these

274. *Id.*

275. *Id.* at 39–40.

276. *Id.* at 40.

277. *Id.* at 39.

278. *Id.*

279. 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.”).

280. *Id.*

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.²⁸¹ 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.²⁸²

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.²⁸³ 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.”²⁸⁴ 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.²⁸⁵ 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.²⁸⁶ 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 current-

281. Meekins, *supra* note 83, at 67.

282. *Id.*

283. GOLDKAMP & IRONS-GUINN, *supra* note 154, at 40.

284. *Id.*

285. *See supra* notes 42–43, 266 and accompanying text.

286. *See supra* notes 161–66 and accompanying text.

ly in the process of developing their own.²⁸⁷ According to the Illinois Mental Health Court Treatment Act, “[t]he Chief Judge of each judicial circuit may establish a mental health court program, including the format under which it operates.”²⁸⁸ 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,²⁸⁹ 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.²⁹⁰ As such, establishing a specialty court should be a priority for community stakeholders so that they can begin to develop solutions to the issues present-

287. 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.

288. 730 ILL. COMP. STAT. 168/15 (2010).

289. *See supra* notes 165, 187 and accompanying text.

290. *See supra* notes 11–12 and accompanying text.

ed 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.²⁹¹ 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.²⁹² Studies of MHCs across the country reveal similar results.²⁹³ Some prosecutors, such as Will County State's Attorney James Glasgow, advocate for MHCs because they realize that "[f]or 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."²⁹⁴ 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.²⁹⁵

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.²⁹⁶ 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.²⁹⁷ 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."

291. See *supra* notes 46–49, 70–72 and accompanying text.

292. MICHAEL W. FINIGAN ET AL., NPC RESEARCH, THE IMPACT OF A MATURE DRUG COURT OVER 10 YEARS OF OPERATION: RECIDIVISM AND COSTS 42 tbl.14 (2007).

293. See, e.g., *supra* notes 47–49, 70–72 and accompanying text.

294. *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).

295. See *supra* note 72 and accompanying text.

296. See *supra* notes 40–43 and accompanying text.

297. See *supra* notes 36–38 and accompanying text.

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 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.²⁹⁸ 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.

²⁹⁸ Max Deitchler, Comment, *You Can't Manage What You Don't Measure: An Evaluation of Arkansas's Drug Courts*, 64 ARK. L. REV. 715, 741 (2011).

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.²⁹⁹ 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.³⁰⁰

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.”³⁰¹ 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,³⁰² 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.³⁰³

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

299. See *supra* notes 44–46, 119 and accompanying text.

300. See *supra* note 85 and accompanying text.

301. FINIGAN ET AL., *supra* note 292, at 44.

302. See *supra* notes 50–52 and accompanying text.

303. See FINIGAN ET AL., *supra* note 292, at 44.

may not be as effective in reducing recidivism rates as the pre-adjudication model or even the post-adjudication model.³⁰⁴ 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.”³⁰⁵ 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.”³⁰⁶ 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.³⁰⁷

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.”³⁰⁸ 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.³⁰⁹

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

304. David B. Wilson et al., *A Systematic Review of Drug Court Effects on Recidivism*, 2 J. EXPERIMENTAL CRIMINOLOGY 459, 475 (2006).

305. *Id.*

306. *Id.* at 480.

307. *Id.*

308. FINIGAN ET AL., *supra* note 292, at 44 (discussing this model as it pertains to drug courts).

309. *See supra* note 304 and accompanying text.

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."

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,³¹⁰ 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 sys-

310. See *supra* notes 179–81 and accompanying text.

tem. 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."³¹¹

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.³¹² Instead, it allows the Chief Judge of each court to decide which would be best.³¹³ 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.³¹⁴ 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

311. *Will County Launches Mental Health Court*, *supra* note 294.

312. 730 ILL. COMP. STAT. 168/10 (2010).

313. *Id.* § 168/15.

314. 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).

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.³¹⁵ 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.”³¹⁶ Stakeholders must be educated “about what mental illness really means” today so that they can understand that in many cases it is treatable.³¹⁷

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.³¹⁸ 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.³¹⁹

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.³²⁰

315. 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.”).

316. Christopher J. Hughes, *Changing Attitudes on Mental Health*, GOLACKAWANNA, Oct. 9, 2011, at 3, available at <http://www.scribd.com/doc/68050722/Go-Lackawanna-10-09-2011> (quoting Lackawanna County Judge Robert Mazzoni).

317. *Id.*

318. See, e.g., MCHENRY COUNTY MENTAL HEALTH COURT, 22ND JUDICIAL MENTAL HEALTH COURT PROGRAM: PARTICIPANT MANUAL (2012), available at <http://www.co.mchenry.il.us/departments/courtadmin/Pages/MHealthCourtHome.aspx>; *JMHCP Spotlight: Winnebago County, Illinois*, COUNCIL ST. GOV’TS. JUST. CENTER, <http://consensusproject.org/features/jmhcpIL> (last visited Nov. 19, 2012).

319. See *supra* notes 304–307 and accompanying text.

320. 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).

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,³²¹ 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.³²² 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 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,”³²³ 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

321. See *supra* note 256 and accompanying text.

322. See *supra* notes 228–29 and accompanying text.

323. 730 ILL. COMP. STAT. 5/5-1-14 (2010).

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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.

