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THE IMPACT OF THERAPEUTIC JURISPRUDENCE ON MENTAL HEALTH COURT OUTCOMES

By

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ABSTRACT

Therapeutic jurisprudence is the hypothesis that the law itself can have therapeutic and/or anti-therapeutic consequences. Therapeutic jurisprudence is an important element in mental health courts because these specialty courts operate on the assumption that the principles of therapeutic jurisprudence reduce recidivism rates. Previous research has shown that mental health courts have been successful in reducing the rates of recidivism among mentally ill offenders. However, none of these studies, to date, have examined exactly what aspect of the court reduces these rates of recidivism and what makes them successful. The current study utilized a sample of 291 mentally ill criminal offenders participating in a mental health court to examine whether those participants who had the targeted therapeutic jurisprudence variable of communication with the judge had a reduction in recidivism rates, technical violations, and severity of new charges in comparison to those who did not. Analyses did not provide support for any of the hypotheses. However, females were shown to be have more communications with the judge, take longer in days to reoffend, and were more likely to be present in the courtroom than males. Implications and suggestions for future research examining therapeutic jurisprudence are discussed.

INTRODUCTION

More than half of all incarcerated inmates in the jails and prisons of the United States have a mental illness (U.S. Department of Justice, 2006). For some mentally ill criminal offenders, the criminal justice system appears to serve as "an asylum of last resort" (Belcher, 1988, p.193). This is a problem that is getting increasingly worse; the Los Angeles County jail houses more people suffering from mental illness than any mental health hospital in the country (Council of State Governments, 2002). Many mentally ill defendants are arrested as a direct result of their mental illness (Bernstein & Seltzer, 2003; Council of State Governments, 2002). Research indicates that police often arrest mentally ill individuals because they believe it may lead to reduced homelessness and better access to treatment (Seltzer, 2005; Thompson et al., 2003). Contrary to this belief, Ditton (1999) found that nearly 40% of mentally ill prisoners did not receive mental health treatment of any type while incarcerated. Once convicted, mentally ill inmates serve sentences, on average, between 12 and 15 months longer than other inmates without mental illnesses (Ditton, 1999; Stefan & Winick, 2005). Furthermore, research indicates higher rates of recidivism among mentally ill offenders than criminal offenders without a mental illness (Belcher, 1988; Ditton, 1999). In 1997, specialty courts, called mental health courts, were developed to try to reduce these inflated recidivism rates by matching the needs of mentally ill offenders with treatment services (Steadman, Davidson, & Brown, 2001; Stefan & Winick, 2005).

It has been hypothesized that mental health courts, employing the principles of therapeutic jurisprudence can break of the cycle of mentally ill criminal offenders being arrested and rearrested and provide mental health treatment (Bernstein & Seltzer, 2003; Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003; Stefan & Winick, 2005). Therapeutic jurisprudence is the hypothesis that the law itself can have therapeutic and/or anti-therapeutic consequences (Wexler, 1990). An example of a therapeutic consequence is the ability for a defendant to have direct interactions with the judge as opposed to going through the attorney to communicate with the judge. Therapeutic jurisprudence is especially important in mental health court, because the primary purpose of these courts is to reduce rates of recidivism, which is significantly different from the traditional adversarial roles of the criminal justice system.

Characteristics of Mental Health Courts

The primary goal of mental health court is to divert the mentally ill offender out of the legal system and into treatment, in the hopes that this will reduce recidivism rates among this population. This treatment focus is different from the adversarial nature of most traditional court proceedings in that the primary goal is not to prosecute offenders but to provide them with mental health services and make them accountable for their compliance with treatment (Bernstein & Seltzer, 2003; Cosden, et al., 2003; Stefan & Winick, 2005). "Mental health court is an alternative to the criminal justice system that many with mental illness may find more desirable than typical criminal processing of their minor (or even more serious) offenses" (Stefan & Winick, 2005, p. 511). This alternative is also beneficial for the courts themselves as defendants with mental illnesses often require more of the judge's time than can be offered in traditional court proceedings (Thompson, Reuland, & Souweine, 2003).

Despite the fact that there is no single model for mental health courts, there are several similarities that often exist among these courts. These include having one docket for mental health court with a single judge presiding, often the judge, prosecutor, and defense attorneys have received training in mental health issues, and the courts will only take defendants with a documented mental illness or developmental disability (Bernstein & Seltzer, 2003; Thompson et al., 2001). Mental health courts order participants to engage actively in community mental health treatment (Redlich et al., 2006). Many mental health courts require a guilty or *nolo contendere* plea as a term of participation in the court (Bernstein & Seltzer, 2003). Individuals have the right to opt-out of mental health court and be transferred to the regular trial division where they can have a jury trial. Individuals in mental health court often have adjudication withheld and at the conclusion of their time in mental health court, many defendants may have their charges dropped or their sentences deferred if they have fully complied with the treatments recommended by the judge (Watson et al., 2001).

One way that mental health courts differ from traditional courts is that there are no jury trials. Instead, an individual in mental health court will have numerous hearings spanning over the course of their participation in mental health court. These hearings are used to determine the best treatment options for the defendant, to check on the defendant's competency, and to ensure progress is being made and maintained. Some courts employ the use of sanctions for defendants

who have a difficult time complying with the court's terms. Sanctions include jail time, house-arrests, or fines.

Voluntary Nature of the Court

Another tenet of mental health court is that it must be voluntary. If it is not voluntary, it would violate the equal protection guarantee of the 14th Amendment, the 6th Amendment right to a trial by jury, and could also be violating the Americans with Disability Act (Bernstein & Seltzer, 2003). As noted earlier, mental health courts do not employ jury trials, but rather mandate that participants take a plea. In addition to the voluntary nature of entering the court, the defendant should also have the right to withdraw from mental health court and be allowed to enter the general trial division at any time (Bernstein & Seltzer, 2003). Seltzer (2005) noted that no court, to date, gives a defendant credit for completing or meeting court imposed mandates while in mental health court before transferring to the general trial division. Perceived legal coercion is not therapeutic, and it is the role of the judge to explain the voluntary nature and to understand how to deal with feelings of coercion. While Poythress and his colleagues (2002) discovered that up to 32% of their sample was not aware that participation in mental health court was voluntary, they found that it was not perceived as being coercive.

Mental Health Courts and Recidivism

Mental health courts have been shown to reduce the number of new crimes committed, reduce psychological and legal distress, and improve quality of life (Cosden et al., 2003; Herinckx, Swart, Ama, Dolezal, & King, 2005; McNiel & Binder, 2007). In addition to helping the offender, mental health courts have the potential to provide protection for the community by treating mentally ill offenders (Bernstein & Seltzer, 2003). One study also reported that in addition to reducing new arrests, mental health courts also decrease the severity of new arrests of those participating in the court (Moore & Hiday, 2006; Steadman, Redlich, Griffin, Petrila, & Monahan, 2005).

Mentally ill criminal offenders who go through mental health court have reported improvements in their drug problems, life satisfaction, independent functioning, and psychological distress; more so than a treatment as usual comparison group (Cosden et al, 2003). The average number of arrests of those who complete mental health court are substantially lowered and there is a reduction in the number of probation violations committed

(Herinckx et al., 2005). Mental health courts have also been found to reduce the crime rates for mentally ill offenders by 400% (Herinckx, et al., 2005).

As compared to a treatment as usual group, defendants in mental health court have been shown to be less likely to be convicted of a new crime but more likely to receive sanctions for probation violations (Cosden et al., 2003). Cosden and her colleagues (2003) explained that this finding could be due to the increased scrutiny of defendants in mental health court and the use of jail time as a therapeutic sanction. McNiel and Binder (2007) found that those defendants who participated in mental health court went a longer time without incurring new charges than those defendants who did not participate. Additionally, survival analysis indicated that these results became more robust as more time passed. Other studies have shown that while defendants who went through mental health court were arrested more often for technical probation violations, those who were eligible but did not go through mental health court were likely to be arrested for more serious crimes (Steadman et al., 2005). This finding may be explained again by the increased amount of scrutiny in mental health court. That is, defendants in mental health court are seen much more frequently than those in traditional court proceedings and are continuously monitored by members of their treatment team. In addition to reducing recidivism, participants of mental health court experience a decrease in the number of days spent on inpatient treatment units and fewer hours of crisis management (Herinckx et al., 2005). Having regular contact with mental health professionals could reduce the need for crisis stabilization inpatient treatment.

Concerns regarding Mental Health Courts

While most studies demonstrate the efficacy of mental health courts in reducing recidivism rates in comparison to traditional courts, not all researchers are convinced they are effective. Seltzer (2005) argues that due to the fact that most of the mental health courts require defendants to take a guilty plea, this may later impede their ability to obtain the services they need or to attain employment. Others (Stefan & Winick, 2005) have cited that some mental health courts are thought to be coercive, violate due process, and unsuccessful when the wrong treatments are recommended and may contribute to the stigma associated with mental illness. One explanation for the perceived reduction in recidivism rates for individuals who go through mental health courts could be that many mental health courts chose to only take misdemeanor cases. Only 10% to 20% of mentally ill offenders are being served by mental health courts (Wolf, 2002). These rates suggest that 90% of mentally ill individuals who have committed a

criminal offense are placed in traditional court proceedings. Thus, severity of crime may be a confounding factor in the reduction in recidivism rates in mental health courts.

Some mental health courts use remote videoconferencing with the defendant attending their hearing remotely via the local jail. Issues such as whether the use of videoconferencing could interfere with the defendant's rights and their ability to communicate with their attorney have been raised (Wiggins, 2003-2004). Unfortunately, to our knowledge, these concerns have not been empirically studied. It is unknown whether defendants who appear via remote video for their hearing have the same benefits of therapeutic jurisprudence than those who are physically present in the courtroom at the time of their hearing. Specifically, one important aspect of therapeutic jurisprudence is direct contact with the judge; it is unknown if defendants who appear via remote video have as much direct communication with the judge as those who are present in the courtroom during their hearings.

Therapeutic Jurisprudence

Mental health courts generally demonstrate the desire to treat defendants with mental disorders with respect and dignity, something that was perhaps missing from traditional court proceedings (Stefan & Winick, 2005). Specifically, there are elements of mental health courts that are believed to act as therapeutic agents in their own right. These elements are referred to as therapeutic jurisprudence. The term therapeutic jurisprudence was coined by law and psychology professor, David Wexler, in 1990. Wexler (1990) defined therapeutic jurisprudence as "the study of the use of the law to achieve therapeutic objectives," (p.4). Therapeutic jurisprudence principles include the belief the law can impact an individual's psychological well-being (Wexler, 2000). Winick (1997) stated that the term was purposely defined broadly so that it could include any aspect of the law that impacts the physical or psychological well-being of an individual.

Wolf (2002) cautions that the therapeutic nature of mental health courts may be successful due, in part, to the selection criteria used for extending participation opportunities to mentally ill offenders. Because mostly misdemeanor cases are selected for participation, and because community treatment facilities often prefer to take only those motivated for treatment, Wolf (2002) reports that these routines may be inflating the findings that mental health courts are actually therapeutic (Casey & Rottman, 2000; Stefan & Winick, 2005). Additionally, nothing

is known about differences in how these therapeutic jurisprudence principles are applied between genders and races/ethnicities.

The Relationship between the Specialty Courts and Therapeutic Jurisprudence

The implementation of therapeutic jurisprudence in specialty courts may be a natural process due to the nature of the specialty courts. For example, courts which handle similar cases on one docket may become more adept at applying the principles than one with a docket with general cases (Casey & Rottman, 2000). Specialty courts are generally more flexible in procedures and practice. Because of the similarity of cases on the docket, skill development in applying therapeutic jurisprudence may advance faster than those with a general docket. Specialty courts have more access to mental health professionals than general courts. The judge in a specialty court has generally more knowledge about the specialty issue than a judge in a general court (Bernstein & Seltzer, 2003).

The principles of therapeutic jurisprudence can explain how the procedures and guidelines of mental health court affect the defendants who go through a mental health court program (Senjo & Leip, 2001). This collaborative aspect of the specialty courts are thought to promote psychological well-being of defendants, which is the foundation of therapeutic jurisprudence (Senjo & Leip, 2001). Casey and Rottman (2000) reported the following as examples of therapeutic jurisprudence in action in mental health courts; "expedited case processing to address the individual's treatment needs quickly; judicial training in mental illness and timely access to mental health assessments for determining treatment options; participation of client and client's family members in determining treatment, subject to consideration of public safety; and cooperation among the court, other components of the criminal justice system, and community service providers," (p.450). Knowing that their counsel is advocating for them can improve the defendant's chance for success in mental health court and also increase their understanding of the court procedures (Seltzer, 2005). The principles of therapeutic jurisprudence can be applied to all interactions within the court setting.

Therapeutic jurisprudence is not a principle unique to mental health courts; it began in drug courts. Drug courts provide supervision and close interactions with the judge. Senjo and Leip (2001) examined the role of therapeutic jurisprudence in drug courts by comparing the ratio of the number of supportive, indifferent, and adversarial comments to the total number of comments received by the defendant in court and determining the influence these comments had

on the defendant's behavior change. Behavior change was measured by the use of urinalysis (Senjo & Leip, 2001). This study reported that more supportive comments lead to positive increases in behavior change, while more adversarial comments lead to negative offender behavior change (Senjo & Leip, 2001). It is possible, as an alternative explanation, that defendants who were doing the best in the program received the most positive comments. The findings on the effect of race and gender are mixed. For example, some studies reported that neither gender nor race was associated with the success of completion of drug courts (Butzin, Saum, & Scarpitti, 2002; GAO, 2005); however, another study reported that women and Caucasian participants were most likely to complete drug court (Gray & Saum, 2005).

The Judge's Role in Therapeutic Jurisprudence

Therapeutic jurisprudence practices are related to the potentially therapeutic behaviors of key actors in the proceedings, such as judges and attorneys (Wexler, 1992; Wexler, 2010). One component of the theoretical model of therapeutic jurisprudence is the action of the judge speaking directly to the defendant, and in turn, the ability for the defendant to speak directly to the judge (Wexler, 2010). This is different from traditional court proceedings, where a defendant is often discouraged from speaking during a hearing, especially directly to the judge (Bernstein & Seltzer, 2003). Boothroyd and his colleagues (2003) observed that in a mental health court, 47% of the comments made during the hearings were attributed to the judge while 33% were made by the defendant. Wexler (1996) claims that if the judge does not directly involve the defendant in his or her hearing, this could contribute to the cognitive distortions about the law and the case on behalf of the defendant. It has been reported that if a judge can directly involve the defendant in the process of establishing an accurate foundation for the plea, the court may actually assist in correcting negative thinking patterns which could be psychologically valuable (Wexler, 1996; Wexler, 2010). Winick & Wexler (2001) also recommend that "judges should always strive to treat offenders with dignity and respect, to inspire their trust and confidence that the judge has their best interests at heart, and to provide them a full opportunity to participate, and to listen attentively to what they have to say," (p.483).

Winick & Wexler (2001) claim that specialty court judges can have a therapeutic jurisprudence function because they are often specially trained and view themselves as a therapeutic agent. Because of this role, judges should be trained to express empathy, how to understand denial, and should be able to employ psychological principles to motivate defendants

(Winick & Wexler, 2001). Belenko (1998) noted the proactive role that a judge employs in specialty courts and reported that the judge can reinforce positive behavior in the defendant. A study which examined the interactions between a judge and a drug court defendant indicated that 50% of the defendants found the experience of discussing their progress and problems with the judge extremely important, 27% found it somewhat important, and 12% did not find this interaction to be important (Cooper & Bartlett, 1996). It has been documented that defendants who feel respected by his or her judge and believes the judge is an impartial authority are more likely to be compliant in the court than those who do not feel respected (Simon, 1996). It is unknown, at this time, if there are differences in direct interactions with the judge between genders and races/ethnicities.

The Current Study

The current study aimed to examine the effects of the targeted therapeutic jurisprudence variable on reducing recidivism rates in a mental health court in a southeastern city. The targeted therapeutic jurisprudence variable which was examined in this study included whether or not the judge ever spoke directly to the defendant and whether or not there was verbal interaction between defendant and judge. These were operationalized into two groups, Judge Talk (JT), in which the judge spoke directly to the defendant but the defendant never spoke directly to the judge and Judge/Defendant Interaction (JDI), in which they spoke to each other.

The court studied was established in 2008. At the time of its inception, this mental health court did not accept defendants with violent charges and only served those with misdemeanor and felony charges which were deemed to be appropriate for the court. These decisions were made on a case to case basis by the presiding judge. Currently, the court accepts defendants with violent charges and most felonies. The mental health court has sanctions in place for some defendants who do not comply with court requirements depending on the particular defendant and the number of times the noncompliance occurs. In addition to the legal team, representatives from the local crisis stabilization unit, inpatient/outpatient mental health facility, or the Veteran Affairs (VA) office are often present in court. The present study was part of an ongoing, longitudinal study which began a few months after the inception of the court in 2008. Primary Hypotheses was:

1.) It was predicted that those defendants who had hearings with JT or JDI would be less likely to incur new criminal charges in the 12 months following their first court

appearance than those who did not have communication with the judge. This was done by examining those defendants who entered the mental health court from June 2008 to July 2009 and were followed for12 months to determine if they reoffended. Diagnosis, gender, race, number of charges the defendants had in their first hearing in mental health court, and if the defendant was present in the courtroom or appeared for his/her hearing via remote video from the jail (presence) were covariates in this analysis.

2.) It was predicted that of those defendants who did reoffend, those who had JT or JDI would take longer to reoffend than those who did not have communication with the judge. Diagnosis, gender, race, number of charges the defendants had in their first hearing in mental health court, and presence were covariates in this analysis.

3.) Additionally, it was predicted that of those defendants who reoffended, those who had JT or JDI would incur less severe charges than defendants who did not have communications with the judge. Severity of crime was a dichotomous variable (misdemeanor/felony). Diagnosis, gender, race, severity of charges the defendants had in their first hearing in mental health court, and presence were covariates in this analysis.

4.) Finally, it was predicted that those defendants who had JT or JDI would be less likely to incur technical violations (i.e. fail to meet one of the court's requirements) than those who did not have communication with the judge. Diagnosis, gender, race, number of charges the defendants had in their first hearing in mental health court, and presence were covariates in this analysis.

METHODS

Participants

Data for the present study were drawn from a larger study examining overall recidivism rates in a mental health court in a southeastern city. The current study examined individuals who entered the mental health court between June 2008 and July 2009. A total of 291 participants were examined. The sample was predominately male (70.4%) and African American (59.8%), which was representative of the local jail population. The participants' mean number of charges for first appearance at mental court was 2.27 (SD=2.36). The demographic data for the sample is summarized in Table 1.

Measures

Court observation forms, dockets, and information from the Justice Information System (JIS) were used to obtain all study data. The court observation forms included a variety of information about the defendant, defense attorney, prosecutor, and judge. A box was checked on the observation form if the defendant ever spoke directly to the judge and another box was checked if the judge ever spoke directly to the defendant. Additionally, a box was selected on the observation form to show if defendant was present in the courtroom, present via remote video, or not present at the time of their hearing.

The court docket contained the defendant's name, race, gender, number of charges, specific name of charges, severity of charges, where the defendant was at the time of their hearing (in jail or in court) and the defendant's present location. Typical locations included the local jail, the state hospital, or the clerk's office. The Justice Information System (JIS) is a court database accessed by attorneys, court personnel, and mental health professionals which contains online information about defendant's legal status, mental illnesses, and pending charges. For the purpose of this study, JIS was used for obtaining the defendant's diagnosis, number of new charges incurred after his/her first court appearance, and severity of new charges incurred.

It was initially planned that the participants would be divided into three groups based on whether or not there was verbal communication with the judge (Judge Talk, JT; Judge/Defendant Interaction, JDI; and none) in their initial mental health court appearance. However, because the JT group was not large enough to use for meaningful comparisons (JT group, N=9), chi-square analysis using the Likelihood Ratio value was used to determine whether the JT and JDI groups differed on each of the variables of interest. There were no differences between JT and JDI on

gender ($\chi^2(1)=0.544$, p=0.48), race ($\chi^2(1)=1.22$, p=0.27), presence during the hearing ($\chi^2(1)=0.945$, p=0.33), diagnosis ($\chi^2(1)=0.390$, p=0.53), or severity of crime ($\chi^2(1)=0.372$, p=0.54). Regression analysis revealed that the two groups did not differ on number of charges (*b*=.001, *t*(201) =.158, *p*=.874). Because no major differences emerged between the JT and JDI groups, these groups were combined into one therapeutic jurisprudence group. Individuals who were in this merged therapeutic jurisprudence group were all spoken to by the judge.

Procedure

The study protocol was approved the university's Institutional Review Board (IRB). All participants were treated in accordance with the IRB. Observations of the mental health court began in June 2008. At each hearing, two research assistants went to court completed court observation forms. Between June 2008 and July 2009, 22 hearings (91.6%) out of 24 held that year, were attended by research assistants. The participants' names and docket numbers were entered into a password protected spreadsheet. Each participant was assigned a randomly-generated number using a random number table. This participant number became the only identifying piece of information for the participant. This participant number was entered into a separate database and all information obtained from the docket, court observation form, and JIS were coded and entered into this database. All information was entered for both raters in order to assess the interrater reliability. Correlations were examined to ensure interrater reliability between observer one and observer two on presence in court (*r*=.97), JT (*r*=.93), and JDI (*r*=.96). Power analyses determined that with the current sample, there was adequate power (>80%) to detect a medium effect size between the predictors and the dependent variables (Cohen, Cohen, West, & Aiken, 2003).

RESULTS

Table 3 displays the correlations for each variable of interest.

Differences between Groups

Gender. Chi-square analyses were conducted to determine if the defendants differed by gender on any target variables. Gender ($\chi^2(1)=1.20$, p=0.55) was not related to having a psychotic spectrum or bipolar disorder. There was a significant difference between the sexes and the presence variable; nearly 37% of males were present in court while 63.4% were on video compared to 53.5% of females present while 46.5% were on video ($\chi^2(1)=7.13$, p=.008). Females (80%) were more likely to be spoken to by the judge than males (65.4%) ($\chi^2(1)=6.09$, p=.014). There were no differences between the genders on the severity of the original charges ($\chi^2(1)=.140$, p=.708). Females took longer, in days, than males to reoffend (*b*=39.15, *t*(116)=2.00, *p*=.048).

Race. African American participants (68%) were more likely than Caucasian participants (54%) to be diagnosed with a psychotic or bipolar disorder ($\chi^2(1)=5.01$, p=.025). There were no differences between the races in the judge talk variable ($\chi^2(1)=.220$, p=.639), presence variable ($\chi^2(1)=.413$, p=.520), or severity of original charges ($\chi^2(1)=1.63$, p=.202). No difference was observed between the races on number of days to reoffend (*b*=5.27, *t*(116)=.267, *p*=.790).

Other group differences. Of those mentally ill criminal offenders present in the courtroom at the time of their hearing, 83.3% were spoken to by the judge while 16.6% were not spoken to by the judge. Of those offenders who appeared via remote video for their hearing, 60% were spoken to by the judge, while 40% were not spoken to by the judge ($\chi^2(1)=18.12$, p<.001). Of those offenders present in the courtroom at the time of their hearing, 31.4% had felony charges and 68.6% had misdemeanor charges. Of those offenders who appeared for their hearing via remote video, 59.2% had felony charges and 40.8% had misdemeanor charges ($\chi^2(1)=21.78$, p<.001). There were no differences observed between those with psychotic/bipolar disorders and the likelihood of being spoken to by the judge ($\chi^2(1)=.380$, p=.538) or the presence variable ($\chi^2(1)=.690$, p=.406).

Hypothesis One- Recidivism

Hypothesis one predicted that those defendants who had hearings with the targeted therapeutic jurisprudence variable would be less likely to incur new criminal charges in the 12 months following their first court appearance than those who did not. Logistic regression was used with diagnosis, gender, race, severity and number of charges the defendants had in their first hearing in mental health court, and presence entered as covariates. Hypothesis one was not supported. There were no differences in the 12 months following a mental health court appearance between the two groups (B= -.004, SE= .01, Wald = .109, p =.741). However, severity of the charges the defendant had in their first mental health court hearing was associated with incurring new criminal charges in the 12 months following their first court appearance. Individuals with misdemeanor charges were more likely to incur new criminal charges with felony charges (B= -.949, SE= .29, Wald = 10.77, p =.001). Refer to table 2 for descriptives of covariates.

Hypothesis Two- Time to Incur New Charges

Hypothesis two predicted that of those defendants who reoffended, those who had hearings with the targeted therapeutic jurisprudence variable would take longer to reoffend than those who did not. An ANCOVA was used and diagnosis, gender, race, severity and number of charges the defendants had in their first hearing in mental health court, and presence were covariates in this analysis. Hypothesis two was not supported. There were no differences in the time to incur new criminal charges between the two groups (F(1, 92) = .058, p =.811, d =0.12). Refer to table 2 for descriptives of covariates.

Hypothesis Three-Severity of New Charges

Hypothesis three predicted that of the defendants who reoffended, those had hearings with the targeted therapeutic jurisprudence variable would incur less severe charges than those who did not. A logistic regression was used with severity of crime being a dichotomous variable (misdemeanor/felony). Diagnosis, gender, race, number of charges the defendants had in their first hearing in mental health court, and presence were held constant. Hypothesis three was not supported. There were no differences in the severity of the new charges between the groups (B= -.455, SE= .516, Wald = .778, p =.378). Refer to table 2 for descriptives of covariates.

Hypothesis Four-Violations of Probation

Hypothesis four predicted that those defendants who had hearings with the targeted therapeutic jurisprudence variable would be less likely to incur probation violations (i.e. fail to meet one of the court's requirements) than those who did not. Logistic regression was used and diagnosis, gender, race, severity and number of charges the defendants had in their first hearing in mental health court, and presence were covariates in this analysis. This hypothesis was not supported. There were no differences in the number of probation violations between the groups (B= .264, SE= .924, Wald = .081, p =.775). Refer to table 2 for descriptives of covariates.

DISSCUSSION

The present study examined the role of therapeutic jurisprudence on recidivism rates in mental health court defendants. Therapeutic jurisprudence was operationalized in this study as direct communications from the judge to the defendant because this relationship has been described as a key component of the theory of therapeutic jurisprudence (Wexler, 1992; Wexler, 2010). Despite claims of the importance of this relationship appearing consistently in law literature (Belenko, 1998; Boothroyd et al., 2003; Simon, 1996; Wexler, 1992; Wexler, 1996; Wexler, 2010; Winick & Wexler, 2001), to date and to our knowledge, it had not been tested empirically.

The primary hypotheses were not supported. Despite having adequate power, communication between the judge and the defendant in mental health court hearings was unrelated to recidivism, length of time to reoffend, severity of new charges, and probation violations in the present study. Although this study did not provide empirical support for the theory of therapeutic jurisprudence, several interesting results were found between groups.

Defendants present in the courtroom at the time of their hearing were more likely to be spoken to by the judge than those appearing for their hearing via remote video. Those present were more likely to have misdemeanor charges than felony charges. This is of concern because, in general, those defendants with felony charges were less likely to be transported from the jail to the courthouse for their hearing. In an effort to save money and resources, courts are using telecommunication more often. Although the current study did not provide empirical support for the idea that communication with the judge has an effect on recidivism rates, the impact of having defendants appear via remote video for hearings needs to be further examined as it may be impacting other variable than the ones studied here (sentencing, for example).

Gender may also be an important variable to study. Females were more often present in the courtroom than males, who appeared more often via remote video, and the females were more likely to be spoken to by the judge than the males. However, there were no differences between the genders in severity of crime. This suggests that despite the fact that females did not differ from males in rates of felonies and misdemeanors; they were more often brought to the court for their hearing than males and were spoken to more often. This could suggest that female felons were either more likely to be transported from the jail or were less likely to be incarcerated at the time of their hearing. There are other factors which could contribute to this

finding. For example, inmates who act out in jail may not be transported to court from the jail and men may act out in jail more often than females. Additionally, there may be a confound of gender of judge by gender of defendant, as all of the judges in the mental health court studied were male. There is research that supports the notion of chivalry in the criminal justice system in that females are less likely to be incarcerated and are given shorter sentences than males (Blackwell, Holleran, & Finn, 2008). Given the findings, this is an important variable to examine in future studies as the current findings suggest that female defendants are treated differently in what might be describe as "chivalrous" manner.

Females took longer, in days, to reoffend than males. This suggests that being present in the courtroom at the time of one's hearing and having communication with the judge may have an effect on the length of time to recidivate in females. Because our sample size of women was small (N=89) and most were spoken to by the judge (80%), there would not have been enough power to detect an impact of communication with the judge on rates of recidivism. Based on the results of the present study, future research should focus more heavily on gender differences, including the variables of crime severity and therapeutic jurisprudence. Additionally, the content, length, and valence of the interactions between the judge and the defendant should be examined.

The primary hypotheses were not supported. There are several possible several explanations for these results. First, the findings may imply that therapeutic jurisprudence has no impact in reducing rates of recidivism. Perhaps having a judge speak directly to a defendant is not enough to reduce recidivism rates in this population. Alternatively, these findings could reflect that examination of whether or not the judge spoke to the defendant is not sufficient in defining therapeutic jurisprudence. In the present study, the specific content and length of the interaction between the defendant and the judge was not examined. Future research should examine the content and the length of the interactions by obtaining and coding transcripts from mental court hearings. Senjo and Leip (2001) reported that more supportive comments by the judge in a drug court lead to positive increases in behavior change, as measured by urinalysis, while more adversarial comments lead to negative offender behavior change. Future research should examine the valence of the judges' comments to the defendants in a mental health court and examine the effect this has on recidivism rates. Unfortunately, in many courts, a large number of defendants on court dockets leaves little time for lengthy interactions between the

judge and the defendants. Thus, another variable that needs to be examined, especially in crowded mental health courts, is the length of time each defendant has in front of the judge.

The present study has several strengths. It had high interrater reliability on all observational data. Additionally, the present study had adequate power to detect relationships between the variables. The demographics of the present study were representative of the local jail population. The current study also highlighted differences between the genders and a gender difference in judge and defendant interaction was found. This study was the first of its kind, to our knowledge, to empirically test the theory of therapeutic jurisprudence.

There were several limitations of the current study. The primary limitation was that the targeted therapeutic jurisprudence variable was dichotomized into a judge talk/judge did not talk to the defendant variable. As described above, the content, valence, and length of the communications were not assessed within the longitudinal parent study. Another limitation of the current study was that the mental health court examined may not have been representative of the majority of mental health courts. Each mental health court is different because there are no standards, only recommendations, in place for mental health courts. The court studied may have handled a more severe population in that it took violent felons whereas many mental health courts only handle misdemeanor offenses (Wolf, 2002). Additionally, this court handled up to 60 defendants in a two hour hearing, leaving little time for judge defendant interactions.

The literature of the effectiveness of mental health courts is, for the most part, generally positive but only when examining a narrow segment of the courts that have specific qualities (i.e. courts which only accepted misdemeanor charges, had a limited number of defendants, and included voluntary-only defendants). It is important to continue to examine what components of the courts are the "active" ingredients that make them successful. As the results of this study demonstrated, the popular belief that having a judge talk directly to defendants in mental health court is an important part of the court was not supported, but gender, a variable generally ignored in the mental health court research, has proved to be an important variable. Research focusing on defendant characteristics may prove to be as valuable as the court-wide variables which are generally studied. Although research on other types of therapeutic courts may help provide directions, the structure of an individual court may profoundly impact the relevance of variables such as therapeutic jurisprudence.

TABLES

Table 1. Demographics of study participants

	N	Range	Mean (SD)
Age (N=291)	277	18-71	36.43 (11.82)
Race (N=291)	**N**	**Percentage**	
African American	174	59.8%	
Caucasian	117	40.2%	
Gender (N=291)			
Male	205	70.4%	
Female	86	29.6%	
Diagnosis (N=291)			
Psychotic/Bipolar	156	53.6%	
Not psychotic/not bipolar	94	32.3%	
No diagnosis reported	41	14.1%	

Table 2. Descriptives of Covariates

	N	Range	Mean (SD)
Number of charges in initial MHC hearing	291	1-16	2.27 (2.36)
Number of MHC hearings in 1 yr.	291	1-12	3.59 (2.39)
New charges in 1 yr.	291	0-10	1.11(1.79)
Days to reoffend in 1 yr.	120	7-353	138.6(101.3)
Severity of Charges at initial MHC hearing (N=291)	**N**	**Percentage**	
Felony	138	47.4%	
Misdemeanor	152	52.2%	
Both	1	0.3%	
Presence (N=291)			
Present	121	41.6%	
Remote Video	170	58.4%	
Therapeutic Jurisprudence (N=291)			
Judge Talk (JT)	9	3.1%	
Judge/Defendant Interaction (JDI)	193	66.3%	
JDI/JT combined	202	69.4%	
None	88	30.2%	
New Charges after initial MHC hearing			
New Charges within 1 yr.	120	41.2%	
No new charges	171	58.8%	
New felony charges	59	49.6%	
New misdemeanor charges	61	50.4%	

Table 2 continued

Violations of probation ONLY (VOP)	16	5.5%
Treatment Provider (N=291)		
Community Mental Health	64	22.0%
State Hospital	13	4.5%
Jail/Prison	90	30.9%
None Reported	124	42.6%

Table 3. Correlations

	Race	Gender	Diagnosis	Judge Talk	Presence	# of charges	Severity of Charges	New Charges?	Severity of new charges
Race	1	-.026	.128*	-.072	-.042	-.078	.085	.071	.006
Gender	-.026	1	.069	.092	-.156*	.051	.037	.054	-.006
Diagnosis	.128*	.069	1	.049	.053	-.090	-.083	.025	-.051
Judge Talk	-.072	.092	.049	1	-.072	.067	-.058	-.048	.025
Presence	-.042	-.156*	.053	-.072	1	.179*	-.261*	.027	.058
# of charges	-.078	.051	-.090	.067	.179*	1	-.266*	-.063	-.134
Severity of charges	.085	.037	-.083	-.058	-.261*	-.266*	1	.200*	.288*
New charges?	.071	.054	.025	-.048	.027	-.063	.200*	1	-
Severity of new charges	.006	-.006	-.051	.025	.058	-.134	.288*	-	1

APPENDIX A

"INSTITUTIONAL REVIEW BOARD APPROVAL"

Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8673 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 4/10/2009

To: Joyce Carbonell

Address: MC4301
Dept.: PSYCHOLOGY DEPARTMENT

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
Evaluation of Mental Health Court

The application that you submitted to this office in regard to the use of human subjects in the research proposal referenced above has been reviewed by the Human Subjects Committee at its meeting on 04/08/2009. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If you submitted a proposed consent form with your application, the approved stamped consent form is attached to this approval notice. Only the stamped version of the consent form may be used in recruiting research subjects.

If the project has not been completed by 4/7/2010 you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the Committee.

You are advised that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report, in writing any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the Chair of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects

involving human subjects in the department, and should review protocols as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Human Research Protection. The Assurance Number is IRB00000446.

Cc: Janet Kistner, Chair
HSC No. 2009.1860

APPENDIX B

"INSTITUTIONAL REVIEW BOARD APPROVAL"

RE-APPROVAL MEMORANDUM

Date: 4/14/2011

To: Joyce Carbonell

From: Thomas L. Jacobson

Re: Re-approval of Use of Human subjects in Research

Evaluation of Mental Health Court

Your request to continue the research project listed above involving human subjects has been approved by the Human Subjects Committee. If your project has not been completed by 4/11/2012, you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the committee.

If you submitted a proposed consent form with your renewal request, the approved stamped consent form is attached to this re-approval notice. Only the stamped version of the consent form may be used in recruiting of research subjects. You are reminded that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report in writing, any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the Chair of your department and/or your major professor are reminded of their responsibility for being informed concerning research projects involving human subjects in their department. They are advised to review the protocols as often as necessary to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

Cc: Janet Kistner, Chair

HSC No. 2011.6103

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BIOGRAPHICAL SKETCH

Emily Gottfried attended San Diego State University, where she graduated with a Bachelor of Arts degree in Psychology in 2006. She attended Teachers College of Columbia University, where she graduated with a Master of Arts degree in Psychology in 2008. She is currently a graduate student in the Clinical Psychology doctoral program at Florida State University.

Emily's research interests involve the intersection of mental illness and the criminal justice system. Specifically, her research focuses on mentally ill criminal defendants, personality and gender differences in offending populations, and factors which impact rates of recidivism.