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Diversion of Offenders with Mental Disorders: Mental Health Courts

Sarah Ryan, LLB, LLM

sarah.ryan@ireland.com

Dr Darius Whelan,

Lecturer in Law, Faculty of Law, University College Cork, Ireland.
d.whelan@ucc.ie

Summary

At present, if people with mental disorders appear before the criminal courts in Ireland, unless they are unfit for trial or not guilty by reason of insanity, the system governing their case will be the general one which applies to all criminal cases. In recent decades, a number of other common law jurisdictions have begun to set up mental health courts as a means of diverting some people with mental disorders from the criminal justice system and into more appropriate treatment. This article begins with a review of the background to mental health courts, focusing on the concept of diversion from the criminal justice system and the role of Therapeutic Jurisprudence theory as an inspiration for the establishment of mental health courts. The main features of mental health courts are identified and the features of those in existence in the United States are contrasted with those in Canada and England and Wales. Some of the main arguments against the use of these courts will be discussed, including the contentions that defendants' participation may not be truly voluntary and that their due process rights are not adequately protected.. The question of whether a mental health court should be established in Ireland is considered.

Contents

Background: Diversion and Therapeutic Jurisprudence
- Diversion from the Criminal Justice System
- Therapeutic Jurisprudence

Features of Mental Health Courts
- United States: Ten Essential Elements
- Canada: Pre-Adjudication Model
- England and Wales

Critical Analysis of Mental Health Courts and Implications for Ireland
- The Merits of Mental Health Courts

Criticisms of Mental Health Courts
Implications for Ireland
Conclusion
Bibliography

Background: Diversion and Therapeutic Jurisprudence

Diversion from the Criminal Justice System

The aim of diversion as a concept is to identify persons with mental disorders who come into contact with the criminal justice system[1] and, where appropriate, ensure that they are treated in a psychiatric setting, whether residential or non-residential, rather than continuing through the standard criminal justice process. As a matter of policy, the question of whether to divert or not is a difficult one and "[e]ach such individual represents, in microcosm, the dilemma of policy: treatment or punishment?" (Bartlett and Sandland 2007, p 202). On a medicalised view of mental disorder, the tendency would be towards treatment, but on a criminalised model, the tendency would be towards punishment. Matters are complicated by the difficulty of balancing the offender's need for treatment and right to liberty against society's need for protection from the risk of harm (even though people with mental disorder are only responsible for a small proportion of all violence in society).[2]

Diversion may occur at any stage of the criminal justice process. A police officer might decide to have a person who has been arrested for a minor offence assessed by a psychiatrist and, on receiving the assessment, decide not to proceed with charges. An officer who has exercised a power of detention under civil mental health legislation in a situation where criminal charges might be brought might make a similar decision.[3] If a file were sent to a public prosecution service, charges might also be dropped at that stage. Once the person appears in court, the judge might facilitate diversion in some way as well, e.g. by remanding the person on bail (see Whelan 2009, pp 500-503). Even if the person is convicted of a crime, a non-custodial sentence may operate as *de facto* diversion.[4] Alternatively, once they have begun to serve their sentence, the person might be transferred from prison to a mental treatment centre.

The World Health Organisation's *Resource Book on Mental Health, Human Rights and Legislation* recommends that legislation should allow for diversion from the criminal justice system to the mental health system at all stages - from the time a person is first arrested and detained by the police, throughout the course of the criminal investigations and proceedings, and even after the person has begun serving a sentence for a criminal offence (Freeman and Pathare 2005, p 75).

The *Vision for Change* report in 2006 recommended that every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why

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[1] Later in this article, persons with mental disorders who come into contact with the criminal justice system will be referred to in abbreviated fashion as "offenders with mental disorders". This categorisation will apply, whether the person has been convicted of an offence or not. For discussion of the issues of definition involved, see Bradley 2009, p 17.

[2] Definitive statements on the relationship (if any) between mental illness and violence are difficult to make. For a summary of this field see Stuart 2003.

[3] In Ireland, a Garda may detain a person under s.12 of the Mental Health Act 2001. See Whelan 2009, pp 123-129.

[4] The Irish courts do not presently have the power to send a convicted person to a psychiatric centre, even thought this was recommended in Department of Health 1995, Chapter 7. Compare the availability of "hospital orders" in England and Wales – see Whelan 2009, pp 528-529.

this should not be done (Expert Group on Mental Health Policy 2006, p 137). It proposed that the forensic mental health services should be expanded and reconfigured so as to provide court diversion services, and that legislation should be devised to allow this to take place (Expert Group on Mental Health Policy 2006, p 140).

At present, there is a Prison Inreach and Court Liaison Service (PICLS) in operation at Cloverhill Prison in Dublin, which helps identify prisoners with severe mental illness, assists the courts in diverting them towards appropriate treatment options, and offers treatment services to remand prisoners with less severe forms of mental illness (see McInerney and O'Neill 2008, O'Neill 2006, O'Neill et al 2008). During 2009, 103 patients were diverted to more appropriate community settings, 62 to a community mental health facility and 41 to general psychiatric hospitals (Irish Prison Service 2009, p 43).

In a 2006 discussion paper on forensic mental health services, the Mental Health Commission stated that legislation must provide for options whereby mentally disordered persons who present before the courts can be detained for assessment or treatment and that this should include mechanisms for facilitating treatment in the community (Mental Health Commission 2006, p 50). The Commission outlined the potential scope of court diversion schemes and stated that the development of court diversion schemes would require further legislative change (Mental Health Commission 2006, pp 28-39, p 50). The Commission reiterated these recommendations in its recent Position paper (Mental Health Commission 2011).
A formalised court diversion scheme frequently includes the establishment of a mental health court, and the potential features of such a court will be discussed below. The Irish Penal Reform Trust recommended that the government consider the idea of establishment of a mental health court in 2001 (Irish Penal Reform Trust 2001). It was noted however, that a "mere court system will never be sufficient if this court system is not an inherent part of a well-planned, co-ordinated monitoring and service provider programme" (Irish Penal Reform Trust 2011, p 4). The National Crime Council has proposed the establishment of community courts, which would be able to refer persons to mental health services where appropriate (National Crime Council 2007). A Working Group of the Mental Health Commission and an Garda Síochána recommended in 2009 that the introduction of a mental health court be examined. The Group proposed that a mental health court or community court be introduced on a pilot basis initially, while noting that mental health courts are not a panacea, a comprehensive strategy is required, and mental health courts are just one element of the overall strategy (Mental Health Commission and an Garda Síochána 2009, p 21). The Inspector of Prisons, Judge Michael Reilly, has supported the call for the establishment of a community court system, including a mental health court (see Reilly 2010).

Mental health courts are speciality criminal courts which endeavour "to decrease the repeated cycling of offenders with mental illness through the system and to increase access to and engagement with mental health and substance use services" (Redlich et al 2010b, p 272). They are problem-solving courts based on the concept of therapeutic jurisprudence which recognises that the traditional criminal justice system is ineffective in dealing with offenders with mental disorders.

Ireland is not unfamiliar with the concept of problem-solving courts. The Irish Drug Treatment Court (see Working Group on a Courts Commission 1998, Farrell Grant Sparks 2002) has been in operation since 2001, on a permanent basis since 2006, with its main objective being the reduction of crime through rehabilitation. While in 2009 there was speculation that the operation of the court was to cease due to the small numbers of participants and low success rates (Holland 2009, McCárthaigh 2009), following a review it was announced in 2010 that it was to be expanded and allowed to continue for a further two year period (Department of Justice, Equality and Law Reform 2010). The review found that the court had had a positive effect on offenders' recidivism rates and provided for an improved quality of life for them and their families (Department of Justice, Equality and Law Reform 2010, p 29). It was observed that 18 months after participation in the drug court programme had commenced, there was a 78 per cent reduction in offending behaviour (Department of Justice, Equality and Law Reform 2010, p 35). An expansion of the catchment area for offenders

and an extension of the scheme to suitable candidates in the Circuit Court were proposed (Department of Justice, Equality and Law Reform 2010, p 31).

Therapeutic Jurisprudence

Therapeutic Jurisprudence (TJ) is a theory which emerged in the late 1980s and has been the foundation stone for numerous problem-solving courts, including mental health courts, drug courts, and domestic violence courts. [5] Therapeutic Jurisprudence promotes the employment of a "problem-solving, pro-active and results oriented posture that is responsive to the current emotional and social problems of legal consumers" (Lurigio and Snowden 2009, p 199). Therapeutic Jurisprudence acknowledges the fact that any contact with the justice system will have an impact on an individual, and for an offender with mental disorder, this impact can be profound. It "shuns the idea that criminal accused proceed through the criminal justice system wearing a superman cape that deflects all experiences without exception" (Lurigio and Snowden 2009, p 199). It does not, however, favour Therapeutic Jurisprudence values above all else and endeavours to enhance the therapeutic effect of the court, without diminishing due process or other rights of the accused (Winick 2008, p 26). Inspired by the Therapeutic Jurisprudence movement, mental health courts strive to reduce the anti-therapeutic effects of the criminal justice system on the mentally ill, and enhance any potential therapeutic effects (Brookbanks 2006, p 2). The creation of mental health courts also resonates with the principles of the restorative justice movement (see National Commission on Restorative Justice 2009).

Therapeutic Jurisprudence recognises the role of judges and lawyers as therapeutic agents. In a sense, the judge in a mental health court is functioning as a social worker (Winick in Stefan and Winick 2005, p 522). But the judge is part of an interdisciplinary team which helps the individual deal with his or her mental disorder by developing a treatment plan and providing the ongoing services of a case manager (Miller and Perelman 2009, p 121). In applying the principles of TJ, the judge and the defendant's lawyer must treat the defendant with dignity and respect and accord the defendant a sense of voice and validation (Winick in Stefan and Winick 2005, p.524). TJ supports problem-solving courts as they are designed to respond more effectively and holistically to cases in which complex, often overlapping, social and personal issues are involved (Bakht 2005, p 225).

The concept of Therapeutic Jurisprudence is not without its critics. It has been contended that justice and therapy are incompatible mandates, judges should not be cast in the role of service broker, and that their building of a rapport with the participant taints their impartiality (Schneider et al 2007, p 61). Treatment under the supervision of a mental health court could be perceived as paternalistic and coercive, with the powerful criminal justice system forcing persons into treatment which they would not otherwise have sought (Schneider et al 2007, p 63). Finally, given that social services are a finite resource, it is argued that therapeutic jurisprudence results in an unfair distribution of these services, allowing a certain group of people to skip the queue ahead of no less deserving clients (Schneider et al 2007, p 64).

In general terms, the legal system would benefit from adoption of the main principles of TJ, while being vigilant to ensure that values of due process and the rule of law are not watered down through a paternalistic application of TJ principles.[6] It is important that TJ not be used as a cloak or mask for courts or tribunals to legitimise unjustified exercise of medical authority (Freckelton 2008, pp 585-6). Freckelton has provided a helpful list of 20 reflections on TJ which could possibly adorn the noticeboard of all mental health courts. For example, he states that TJ is not an end in itself, is not an excuse for woolly thinking, it does not justify simply acting in what someone considers a person's best interests, it does not qualify the principles of natural justice or procedural fairness and

[5] Therapeutic Jurisprudence theory was originally propounded by Professors David Wexler and Bruce Winick. See for example Wexler 2000 and Winick 2006.

[6] See also the analogous debate about the interpretation of "best interests" in the Mental Health Act 2001 as discussed in Whelan 2011.

it does not legitimise paternalism or coercion, in fact, the opposite (Freckelton 2008, p 595). Assuming that Therapeutic Jurisprudence is used in a robust manner, without diluting due process rights, it provides a helpful set of principles which can underpin the establishment of a mental health court.

Features of Mental Health Courts

The mental health court model was first pioneered in the United States and Broward County, Florida was the site of the first mental health court, established in 1997 (Slate 2003, p 25, n 8). In the intervening 14 years, over 250 such problem solving courts have been founded (Schneider 2010, p 201).

The issues that faced the United States in the 1990s are similar to those facing the Irish criminal justice system today, i.e. overcrowding in the prison system (Committee for the Prevention of Torture 2011, p 15), the inappropriate detention of people with mental disorders in prisons (Committee for the Prevention of Torture 2011, p 47) and an inadequate civil mental health service (Independent Monitoring Group for a Vision for Change 2010). Canada and England have followed the example of the USA and mental health courts are now well established in Canada and running on a pilot basis in parts of England since 2009.

There is no single model of a mental health court. They vary from county to county in the United States and those established in Canada and England differ greatly from their U.S. counterparts. All mental health courts, however, are founded on the basis of Therapeutic Jurisprudence and they all adopt a less adversarial approach to an accused person with mental disorder, in a criminal court, with a special docket which deals exclusively with this type of case. [7] They aim to divert the accused person from the traditional justice system to mental health treatment programmes, which will be of benefit to both the accused and society by reducing recidivism rates. Our discussion of the main features of such courts will begin with the mental health courts as they operate in the United States, and then turn to consider in turn the mental health courts in Canada and England.

United States: Ten Essential Elements

In 2007, the US Bureau of Justice Assistance published what it called "The Essential Elements of a Mental Health Court", which we will refer to as the *Essential Elements* (Thompson et al 2007). These elements are outlined below and provide a useful framework for any discussion of the features of mental health courts.

1. Planning and Administration

Firstly, the *Essential Elements* stipulate that when designing a mental health court, a multidisciplinary committee should be established to facilitate its design. The logic behind this is that the "mental health courts are situated at the intersection of the criminal justice, mental health and substance abuse treatment and other social services systems" (Thompson et al 2007, p 1) and so collaboration and cooperation are vital.

2. Target Population

[7] Mental health courts adopt a more co-operative and less adversarial approach than traditional courts as in a mental health court the parties and the judge have the same interest in getting the accused out of the criminal justice system and into the civil mental health-care system - see Schneider et al 2007, pp 92-3. However, it is important that due process continue to be observed – see further discussion later in this article.

As the court can only serve a portion of accused persons with mental disorders, this portion should be appropriately identified and it should only include defendants whose crime is committed as a consequence of their mental disorder (Thompson et al 2007, p 2).

The target population of individual mental health courts varies greatly. Traditionally, the majority of mental health courts would only accept those who had committed minor or misdemeanour offences, for example public order offences. However, a second generation of mental health courts is emerging which appear to be accepting a wider range of offences (Redlich et al 2005). Of the seven second generation mental health courts studied by Redlich et al, all were found to accept felonies and were more relaxed about accepting violent offenders, though public safety remained a real concern (Redlich et al 2005, p 534). The basis for this lies firstly in the fact that a person charged with a serious offence, who is facing significant jail time, and for whom the stakes are higher, is more likely to comply with treatment in the face of such strong motivating factors (Fisler 2005, p 590). Moreover, Fisler notes that "it takes time to engage in treatment" (Fisler 2005, p 590). As the treatment mandated for felonies is substantially longer than it would be in the case of a minor offence, it facilitates a better outcome for the participant (Fisler 2005, p 590).

3. Timely Participant Identification and Linkage to Services

One of the primary goals of a mental health court is to provide safe and effective treatment in the community (Thompson et al 2007, p 3). The early identification of an eligible participant is imperative in order to minimise the effects of the criminal justice system on the individual and return him or her to the community (Thompson et al 2007, p 3). It is suggested that referrals should be taken from the police, judges, jail staff and pre-trial staff, all of whom should be educated on the mental health courts and eligibility criteria (Thompson et al 2007, p 3).

4. Terms of Participation

The *Essential Elements* assert that "[m]ental health courts need general program parameters for plea agreements, program duration, conditions and the impact of program completion" (Thompson et al 2007, p 4). They also stipulate that the length of participation required in a mental health court programme should not exceed the maximum period of probation or incarceration which an individual would have expected to receive, had they followed the traditional criminal justice process (Thompson et al 2007, p 4). Again, considerable differences can be observed among the various mental health courts in this regard.

Many mental health courts, particularly the second generation of such courts, operate under a post-plea adjudication model. This means that the defendant is required to plead guilty in order to be entitled to participate in the programme. Earlier courts, such as Broward County Mental Health Court, operate on a pre-adjudication basis and in certain instances, charges may be immediately dismissed. For others, they will be held in abeyance and upon completion of the program will be either dismissed or reduced (Berg 2005, p 19). As a second generation court, however, Brooklyn's Felony Mental Health Court demands that an accused plead guilty prior to admittance to the programme. Arguably, the requirement of a guilty plea is antithetical to the aims of therapeutic jurisprudence and this issue will be returned to in our critical analysis below.

All mental health courts will provide supervision of an individual's treatment programme and at each status hearing, praise will be offered for compliance with programme conditions. The purpose of such hearing is to "keep the person on track" (Redlich et al 2010b, p 273). However, sanctions will be used in the event of non-compliance and the individual mental health court will determine what form these sanctions will take. As mental health courts are a form of diversion from the justice system, the use of jail as a sanction should be limited. Yet, Redlich et al have remarked that the newer mental health courts "seem to be comfortable using jail as a sanction" (Redlich et al 2005, p 535).

5. Informed Choice

Participation in the mental health court is voluntary and a defendant may opt to continue with his or her case in the traditional criminal court at any point. The *Essential Elements* highlight the importance of conveying the programme requirements and terms of participation to any potential participant (Thompson et al 2007, p 4). It should be stressed that the decision to enter into the mental health court programme is theirs and that they are not obliged to participate simply because they meet the eligibility criteria. Competency to make this choice is a contentious issue which will be examined further in our critical analysis section below, but legal representation is an important starting point in ensuring a defendant is given the opportunity to make an informed choice.

6. Treatment Supports and Services

Mental health courts should have available to them an array of services and supports in order to adequately address the needs of their participants (Thompson et al 2007, p 6). These include medications, counselling and, due to the large number of participants who will have co-occurring substance abuse problems, linkages with abuse treatment centres are of utmost importance. The providers of the treatment should advise the court where they feel that the treatment being mandated should be altered to better suit the needs of the individual. The scarcity of community mental health services available is an issue and mental health court outcomes are heavily dependent on treatment availability (Erickson et al 2006, p 341). If the underlying services are inadequate or non-existent then funding must be improved, and sufficient services created to facilitate the proper functioning of the mental health court (Heerema 2005, pp 276-277).

7. Confidentiality

The *Essential Elements* specify that "health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and their constitutional rights as defendants" (Thompson et al 2007, p 7). The sharing of information is imperative in order to ensure that the participant obtains the treatment which they need, however, the court staff should only be given access to the minimum amount of information required in decision-making (Miller and Perelman 2009, p 116).

8. Court Team

The "nuts and bolts" of individual mental health courts may differ but "integral to the functioning of a mental health court is a multidisciplinary team approach" (Schneider 2008, p 510). The *Essential Elements* mandate that a special court team, comprised of criminal justice and mental health staff, should receive special and ongoing training to facilitate the correct treatment of participants (Thompson et al 2007, p 8). While the exact composition of the team will vary, typically it will consist of a judicial officer, a treatment provider or alternatively a case manager, a defence lawyer and possibly a probation officer.

The judge's role is central (Thompson et al 2007, p 8). He or she "holds a pivotal position in bringing about reduced recidivism by pursuing a procedural regimen that conveys legitimacy to participants and invites internalisation of the law's norms" (Wales et al 2010, p 265). However, this role for the judge has been criticised on the basis that he or she should be more concerned about a person's rights as opposed to their best interests (Stefan in Stefan and Winick 2005, p 522).

9. Monitoring and Adherence to Court Requirements

Criminal justice and mental health staff should collaborate in the monitoring of participants' adherence to court conditions (Thompson et al 2007, p 9). Previously, participants were generally monitored by the community healthcare providers, mental health court staff or a combination of these with probation officers (Redlich et al 2005, p 536). The newer courts however, appear to rely on staff directly linked to the court to monitor their participants (Redlich et al 2005, p 536).

10. Sustainability

The collection of data on the operation of the mental health court is fundamental in order to sustain the court on a long term basis. Its performance should be assessed so that any shortcomings may be identified and addressed. Further, efforts should be made to cultivate support for the mental health court in the community, given that any potential participants will be returned there for treatment.

Canada: Pre-Adjudication Model

Most Canadian mental health courts operate a pre-adjudication model, and a plea of guilty is not a necessary precondition for entry to the court. At the outset, the primary focus is assessing the fitness of a person to stand trial (Schneider 2008, p 510). People brought before the traditional court, about whom there are concerns surrounding their fitness to stand trial, are transferred to the mental health court to be assessed. Consequently, at this juncture, participation in the Canadian mental health court is not voluntary. Once fitness is established, an accused may be traversed back into his or her own court, or elect to remain within the jurisdiction of the mental health court. Thus, participation then becomes voluntary and the court is operated in a similar way to those in the United States. Sentences given by this court tend to be more focused on rehabilitation than punishment and a person for whom diversion is not appropriate can plead guilty and remain in the mental health court for this reason.

As regards the types of offences accepted, the Canadian Criminal Code divides offences into three categories, presumptively divertible, discretionary and not divertible. Violent offences are not automatically excluded but a prerequisite is that there is a nexus between the crime and the illness (Schneider et al 2007, p 88). If the Crown determines that the individual has successfully completed the programme, a stay will be put on the charges against the participant by the mental health court at their request and there will be no conviction or admission of responsibility (Schneider et al 2007, p 89).

Like the mental health courts in the United States, sanctions will be used in the event of non-compliance with participation conditions and confidentiality remains a paramount concern. Unlike the mental health courts of the United States, however, most Canadian courts avoid the use of jail as a sanction, preferring to employ other methods such as increased frequency of status hearings or changes to the treatment plan (Slinger and Roesch 2010, p 261).

Established in 1998, Toronto Mental Health Court is the only full-time mental health court in operation in Canada (Schneider et al 2007, p 97). It was established in an effort to address two primary issues, i.e. to deal with pre-trial concerns about fitness to stand trial and to tackle recidivism amongst the mentally ill. As a full-time operating court, forensic psychiatrists are available five days a week, thus, a person may be referred to the mental health court and be assessed for fitness within one day (Bakht 2005, p 246). Equally, legal representatives are readily available to provide information and support to the mentally ill defendant in order to facilitate the expeditious handling of the matter (Bakht 2005, p 247).

England and Wales

There are around 100 diversion and liaison schemes in operation in England and Wales.[8] The Bradley Report noted in 2009 that the Government was planning to pilot mental health courts.[9] The

[8] See James 1999 and James 2010. The number of schemes has declined from around 150 in 1999 to around 100 in 2009.

[9] Bradley 2009, pp 77-78. Lord Bradley discussed his visit to the mental health court in the Bronx, New York, and raised some concerns that should perhaps be explored before importing the idea as it stands. He questioned the value of

Justice Secretary launched a multi-disciplinary mental health court pilot project at Brighton and Stratford Magistrates' Courts later in 2009. As mental health courts are in their infancy in England, there is a dearth of information available on their functioning.

The pilot schemes adopt a problem-solving approach to offenders with mental disorders while operating in the regular magistrates' court (see Rutherford 2010). In Stratford, a dedicated mental health court operates one day a week while in Brighton cases are heard among the normal court lists (Winstone and Pakes 2010, p 2).

The stated aims of the mental health court pilot project are to develop a model for identifying offenders with mental disorders and ensuring that they receive the appropriate treatment and to determine the potential costs of operating such a court (Winstone and Pakes 2010, p 1). They also seek to reduce recidivism amongst the mentally ill, to halt the revolving-door syndrome which persists and to improve access to treatment for offenders (Winstone and Pakes 2010, p 1). All defendants are screened at the charge stage, resulting in a combined 4000 screenings during 2009-2010, with 547 deemed to require further assessment (Winstone and Pakes 2010, p 10). Referrals were most often made by the police but can also be made by defence solicitors, the court, probation officers and custody officers. Self referrals and referrals by friends and family are also permitted (Winstone and Pakes 2010, p 15).
Unlike their US and Canadian counterparts, persons with a dual diagnosis of mental health and substance abuse problems are not permitted to participate in the court unless the primary need is of a mental health nature. This issue was identified as an area of concern in an evaluation report and the report suggested that the criteria should be extended to include offenders with a dual diagnosis (Winstone and Pakes 2010, p 31).

The initial findings of the evaluation report are promising and it has identified the core requirements for a nationwide mental health court scheme (Winstone and Pakes 2010, p 31) yet it remains to be seen whether the funding will be forthcoming for the expansion of the project. James has suggested that the mental health court model is unlikely to find a place in the UK, as UK mental health law and diversion mechanisms enable more directly interventionist solutions to be adopted (James 2010, p 246).

Critical Analysis of Mental Health Courts and Implications for Ireland

The Merits of Mental Health Courts

The most obvious advantage of mental health courts is that they aim to divert a group of people, for whom prison is an entirely inappropriate place, away from the criminal justice system and into mental health treatment programmes. The inadequacy of prison for those with mental disorders has been well documented, and it is evident that the negative effects of incarceration on the mentally ill may be profound (See Byrne and Irwin 2010, Committee for the Prevention of Torture 2011). In prison, these vulnerable people are prone to victimisation and stigmatisation, and the experience may lead to a deterioration in their already fragile mental state (Brookbanks 2006, p 13). Coupled with this is the fact that prison officers are ill-equipped to deal with the complex needs of these prisoners and mental health treatment programmes and resources are severely lacking behind prison walls. European states must be conscious that the European Court of Human Rights has stated in *Aerts v Belgium* [1998] ECHR 64; (2000) 29 EHRR 50 that in certain circumstances a detention of a person with mental disorder by a criminal court must be to an appropriate clinical setting (see Bartlett et al 2006, pp 39-41). Mental health courts, then, may offer a pragmatic solution to these problems.

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such courts if the role of liaison and diversion services is to be developed as recommended. Of the list of key features of such courts, the majority could be met by effective liaison and diversion services which would eventually be available to all courts, rather than just a small proportion.

The mental health court seeks to include the offender in the court process and offers them an opportunity to be heard and to have a voice in the courtroom. In mandating treatment as opposed to incarceration, mental health courts seek to provide better outcomes for offenders with mental disorders, affording them the treatment and support that they need to function in the community. There are indications that mental health courts can reduce recidivism. A study comparing San Francisco Mental Health Court to the traditional criminal court discovered that the likelihood of mental health court participants being charged with a new crime 18 months after enrolment was 26 per cent lower than that of individuals who had been dealt with by the traditional court (McNiel and Binder 2007, p 1401).This figure increased to 55 per cent in respect of violent crimes (McNiel and Binder 2007, p 1401). Similarly, in Pittsburgh Mental Health Court only ten per cent of its 223 graduates between 2001 and 2008 were rearrested (Schwartz 2008). This compares with a 68 per cent United States national average of re-arrest rates amongst all offenders (Schwartz 2008). In a recent meta-analysis of literature on the effectiveness of mental health courts in the USA, it was found that mental health courts reduced recidivism by an overall effect size of -0.54 (Sarteschi et al 2011). [10]

A further notable merit of mental health courts is that they can potentially reduce costs. Reports from the United States have found that while in the first year that a person was under the auspices of the mental health court, the costs were roughly the same, these costs fell considerably in the second year as the individual required less supervision (Kuehn 2007, p 1642). The Allegheny County Mental Health Court in Pennsylvania estimated that it saved approximately $18,000 per person during the two years of mental health court participation, amounting to a saving of $3.5million of taxpayer's money over that period (Keuhn 2007, Kaplan 2007). These savings are significant given the fact that the average annual cost of keeping a prisoner in Ireland in 2009 was €77,222 (Irish Prison Service 2010, p 9). By establishing a mental health court in Ireland, perhaps the burden would be eased somewhat on the already over-extended prison system by diverting offenders with mental disorders from prison to community treatment services.

Criticisms of Mental Health Courts

Stefan has asserted that "[t]he creation of mental health courts to solve the problems represented by people with psychiatric disabilities in the criminal justice system is similar to an unhappy teenager deciding to have a child to solve her problems" (Stefan and Winick 2005, p 501). Mental health courts could never be a cure-all for the problems faced by the criminal justice system, and they can be criticised on a number of grounds. For each criticism, there are counter-arguments which may refute the criticism. In our view, a well-designed and appropriately-resourced mental health court could be introduced in Ireland and none of the criticisms is so strong as to undermine the intrinsic merit of adoption of a mental health court system.

1. Voluntariness

All mental health courts claim to be voluntary in nature, though there is little evidence to verify that they actually are (Redlich et al 2010a, p 92). A defendant can opt to have their case heard in a mental health court, or to continue down the criminal justice route. However, the extent of the voluntariness of this decision has been queried and "[t]he fear of coercion or lack of voluntariness is an aspect of the mental health court movement that remains a significant concern" (Heerema 2005, p 270). In addition, in opting to participate in the specialised court, participants will frequently have to enter a plea of guilty as a pre-condition to acceptance into the programme.
Stefan contends that persons entering the mental health courts do not have the requisite understanding of the benefits and drawbacks of being involved (Stefan and Winick 2005, p 516).

[10] In Sarteschi et al 2011, "effect size" is calculated using a method known as *Hedge's adjusted g*. Using Cohen's effect size guidelines, the -0.54 result suggests that mental health courts may be moderately effective treatments for reducing recidivism.

Further, everyone involved in the court has a vested interest in the individual's enrolment and even the public defenders in the United States appear to consider themselves part of the mental health court team (Stefan and Winick 2005, p 516). Consequently, it is suggested that "[t]his is not an atmosphere that is conducive to knowing and intelligent decision-making" (Stefan and Winick 2005, p 516). As all involved perceive participation in the mental health court to be in the best interests of the defendant, this paternalistic standpoint can create a coercive atmosphere (Miller and Perelman 2009, p 119). As discussed earlier, it is important that Therapeutic Jurisprudence not be used to cloak a paternalistic interpretation of the person's best interests.

The issue of competence also arises and it is a matter which is rarely addressed unless the offender is refusing treatment (Schneider et al 2007, p 95). When a defendant is deciding whether to enter the mental health court, he or she is likely to be under considerable stress and the situation may have exacerbated his or her mental illness symptoms (Seltzer 2005, p 574). At the same time, there is limited information on whether, at the time of making the decision, the participant was "stable" or competent to make it (Redlich 2005, p 609). It is a fundamental element of the right to fair trial that the defendant must be fit to stand trial, or to plead to the charge. In the literature on U.S. courts, it has been found that some defendants who enter mental health courts do not appear to be competent to plead guilty. Redlich et al (2010a, p 99) found, for example, that 27 per cent of clients of Brooklyn Mental Health Court demonstrated clinically significant impairment of understanding. A further issue of concern is that, if a defendant is referred for a competence evaluation, he or she may "fall through the cracks" and not receive the benefits of any diversion scheme. Stafford and Wygant (2005) have recommended that issues of competence be considered in the design of mental health courts, to ensure that defendants who are too disturbed for mental health court are also diverted from the criminal justice system. Competency is not so much an issue in Canadian courts given that the primary objective of the court is to determine a person's fitness to stand trial, though at this juncture participation is not voluntary.

Supporters of mental health courts have refuted accusations of coercion, stating that, as such, "facing hard choices...does not amount to coercion in a legal sense" (Winick in Stefan and Winick 2005, p 516). Moreover, the fact that the defendant has the option to participate in a mental health court at all is a benefit which would not otherwise be available in jurisdictions where no such courts exist. Studies have found that, subjectively, participants do not feel coerced into mental health courts (O'Keefe 2006, Poythress et al 2002). In a study of Brooklyn Mental Health Court it was reported that "participants were not concerned with coercion and were often confused as to why the questions were being asked" (O'Keefe 2006, p 39). Similarly, Broward County Mental Health Court clients did not find their experience in the court to be coercive (Poythress et al 2002, p 529). While these indications are positive, arguably increased efforts should be made to ensure that there exists as little coercion as possible, that it is made abundantly clear to participants that participation is voluntary, that defendants must be competent to choose to enter the court and that defence lawyers do not identify themselves more as part of the court team than as counsel for their client.

2. Due Process Rights

The decision of an individual to participate in the specialised court can result in a waiver of important due process rights inherent in the traditional criminal courts. One of the most significant waivers is that of the right to litigate and avoid criminal conviction due to the requirement of many courts of a guilty plea prior to enrolment. Some argue that the relinquishing of this right scarcely seems fair, given it is such an important right of a "normal" accused (Schneider et al 2007, p 87).

Offenders themselves seem to prefer the less adversarial nature of the court, as evidenced by the high levels of satisfaction with the procedural justice aspect of the Brooklyn Mental Health Court (O'Keefe 2006, p 39). Yet the necessarily informal nature of the court can lead to a lack of procedural safeguards for the defendant when compared to the traditional criminal court (Miller and Perelman 2009, p 119). Ultimately, the judge must play a very significant role in ensuring that the

principles of therapeutic jurisprudence are applied, but at the same time the defendant's due process rights are respected.

Treatment programmes can last for a period longer than what the offender could have expected to spend in prison upon conviction, thereby infringing on a person's liberty as they are under the auspices of the court for a much longer time. Few courts, in fact, expressly limit the length of supervision to the maximum expected prison sentence (Seltzer 2005, p 578). Slate warns against an overemphasis on this aspect given that such programmes are "aimed at thwarting the cycle of release and re-arrest and so, in the long run, reduce the offender's time under the control of the criminal justice system" (Slate 2003, p 19).

The matter of confidentiality of the individual's personal information also arises. While the multidisciplinary approach of the mental health court is usually hailed as an innovative and positive development, it does give rise to privacy concerns. Should a mental health court be established in Ireland, special consideration would have to be given to the matter of privacy, as one of the fundamental human rights under the Irish Constitution and the European Convention on Human Rights, and clear procedures would need to be established to ensure compliance.

3. Stigmatisation and Segregation of the Mentally Ill

As a group within society, people with mental disorders have been criminalised in recent times (Schneider et al 2007, pp 21-29). Fuelled by sensationalist media reporting, people with mental disorders are often portrayed as dangerous and violent. While mental health courts seek to address the problem by providing mental health treatment to offenders with mental disorders, the majority of whom are not violent and do not present a significant risk to society (Stuart 2003), some critics have argued that the specialised courts have, in fact, the opposite effect, i.e. that the processing of cases involving the mentally ill in a separate court actually further stigmatises this group of people and implies that they are different from "normal" offenders (Wolff 2002, p 433). Indeed, in England it has been recommended that should the mental health court pilot project be extended, the name "mental health court" should be dropped as it carries the potential for stigmatisation (Winstone and Pakes 2010, p 29).

Stefan argues that mental health courts are a form of segregation, created on the basis of what those in power wanted and not as a result of a demand from the group of defendants which it is intended to serve (Stefan and Winick 2005, p 512). In support of her argument, Stefan cites the unfairness experienced by African Americans in the criminal justice system in the southern states (Stefan and Winick 2005, p 512). In spite of the inequalities which existed "no one would consider a separate courts system just for black defendants, with white judges providing social services, as anything but patronising and discriminatory" (Stefan and Winick 2005, p 513). A better response to the problem would be to fix the criminal justice system itself as, arguably, an inaccessible court room is preferable to a segregated system (Stefan and Winick 2005, p 512). Stefan's viewpoint may now be bolstered by the adoption of the UN Convention on the Rights of Persons with Disabilities 2006 which emphasises equality and non-discrimination regarding people with disabilities, including mental disorders (see Flynn 2009, McSherry and Weller 2010).

Counter-arguments to these criticisms include the fact that the court is voluntary and, in addition, the mental health court is an improvement in the treatment of offenders with mental disorders. Schneider, Bloom and Heerema argue that given the "procedural, evidentiary, legal and logistical peculiarities" of cases involving the mentally ill, they are better dealt with by a speciality court (Schneider et al 2007, p 14). As regards the Convention on the Rights of Persons with Disabilities, a strong argument may be made by states that, in accordance with Article 5(3) of the Convention, mental health courts are a form of reasonable accommodation for people with disabilities.

4. Diversion of Resources

One of the root causes of the criminalisation of the mentally ill has been identified as the failure of the civil mental health services. Scarce resources lead to untreated mental disorders in the community, which in turn contributes to the substantial numbers of mentally ill being arrested. The establishment of mental health courts potentially results in a shifting of already limited resources to a priority group of people and away from those who are just as deserving of treatment. The question arises, are mental health courts simply moving a particular group of people to the front of the queue? (Steadman et al 2001, p 458). If so, this is a "disturbing form of rationing" (Haimowitz 2002, p 1227) and there is something inherently wrong in a system where, in order to get the required treatment, a person needs to first be arrested (Stefan and Winick 2005, p 508). The criminal justice system is hardly an appropriate front door through which to access mental health services (Seltzer 2005, p 583). Before considering the establishment of a mental health court, adequate and sufficient services need to be in place so that this unintended consequence may be avoided.

5. Lack of Empirical Data

Given that mental health courts are a relatively new phenomenon, there is a lack of concrete evidence to support the claim that they are effective in meeting their aims. The mental health court model was embraced "with absolutely nothing other than intuition to suggest that they were of any use whatsoever" (Schneider 2010, p 201). Most studies have been site-specific and focussed on individual mental health courts rather than any general assessment of all courts. Multi-court or multi-jurisdictional studies are scarce (Schneider et al 2007, p 184) The most significant recent multi-court study is Sarteschi et al 2011. The reports which have indicated positive results may be skewed by the fact that these courts "engage in what is referred to in the insurance literature as 'preferred selection' or 'cream skimming'" (Wolff 2002, p 431), i.e. they select the participants who are most likely to succeed in the court, for example by selecting those who have committed minor offences and are open to treatment rather than those charged with violent felonies that are resisting treatment. Such "cherry-picking" of participants limits the court's ability to have any real effect on the numbers of mentally ill in prisons and results in the remainder of mentally ill defendants being left within the traditional court system (Wolff 2002, p 431). Studies are also hampered by the lack of consensus as to how "success" of mental health courts should be defined (Schneider at al 2007, pp 195-197).

Notwithstanding these concerns, there is a good deal of evidence in the literature that mental health courts have been effective, using various measures of effectiveness. The fact that more evidence needs to be gathered is an argument for additional research rather than a reason to discontinue the mental health court initiatives.

Implications for Ireland

The structure of the current system for dealing with offenders with mental disorders, and resources available for such, are inadequate. Part of the problem lies in the lack of legal powers for Irish judges to sentence a convicted person to a mental health treatment centre (see footnote 4 above).

With a large prison population, steps need to be taken to cease the unnecessary incarceration of the mentally ill. Mental health courts are not intended to be a panacea, but could potentially offer a partial solution to the problem.

In the event of mental health courts being established in Ireland, it would be advisable to study the various existing courts and to select the best elements from them. The principles of therapeutic jurisprudence would need to be applied in a careful manner, to avoid paternalistic interference with defendants; constitutional rights. For example, at the first indication that the offender could be eligible to participate in the mental health court, a solicitor should be appointed. This would ensure that the defendant was fully informed and sufficiently equipped to make the decision whether to partake in the court or not. A guilty plea should not be a pre-condition to admission to the

programme. Moreover, as is the case in the Irish Drug Treatment Court, a stay should be put on the charges upon admission to the court and these should be dropped upon graduation. Issues of voluntariness and competence should be considered in designing the mental health court, to ensure that only those defendants who are genuinely competent to decide to enter the court will be accepted into the court. A continuation of treatment and support following completion of the court programme is vital as a mental health court "should not lead to a dead end but hopefully represents a bridge to the recipient of essential services on an ongoing basis" (Schneider 2008, p 513).

Legislation would possibly be needed to establish the mental health court and to give the courts more powers in other forms of diversion. For example, Irish courts should have the specific legislative power to remand a person on bail to a mental treatment centre and to sentence a person to a mental health centre in appropriate cases. The court would not operate alone in diverting the mentally ill but should work in parallel to schemes such as the Prison Inreach and Court Liaison Service scheme at Cloverhill Prison (O'Neill et al 2008, p 11). These schemes would need to be expanded so that they would apply to the entire country (see Committee for the Prevention of Torture 2011, p 47).

Critically, the issue of resources could pose a barrier to the establishment of a mental health court in Ireland. Mental healthcare resources are at present scarce and prior to even contemplating the establishment of a mental health court, substantial funding would need to be allocated to the development of community mental health treatment facilities. Without the requisite facilities, a mental health court would be futile. Inadequate resources have hindered the success of the Irish Drug Treatment Court, and the numbers of successful graduates have remained low in comparison to similar courts in other jurisdictions on account of the absence of residential facilities (Department of Justice, Equality and Law Reform 2010, p 29).

Conclusion

In an ideal world, mental health courts would not be required (Slate 2003, p 24). With a properly functioning mental health service, the needs of a mental ill person would be addressed at first instance, obviating the need, in a great many cases, for intervention by the criminal justice system at a later stage. However, we do not live in a perfect world and untreated mental disorder in the community is resulting in large numbers of people with mental disorders being arrested and sentenced to prison. Mental health courts, premised on the theory of therapeutic jurisprudence, have the capacity to alter this situation to the benefit of both the offender and society in general. The therapeutic jurisprudence principles provide a refreshing framework of principles which enable courts to provide a more appropriate service to people with mental disorders. In helping defendants to address their mental health problems, the courts may facilitate a major improvement in the lives of certain individuals.

There is no standard model of a mental health court as each one differs from the next. All strive to provide better outcomes for the individual involved by employing a multi-disciplinary court team approach. Participation is voluntary and all provide for mandated treatment in mental health centres coupled with supervision for the duration of the programme. Preliminary evaluations of mental health courts are positive and it is maintained that these courts reduce recidivism and consequently the costs involved in incarcerating these offenders.

However, there is a lack of empirical data on mental health courts. It is difficult therefore to determine if mental health courts are as beneficial as their proponents suggest. Part of the problem lies in the fact that the vast majority of available reports are site-specific and do not offer an evaluation of mental health courts as a whole. While all claim to be voluntary, this contention has been called into question and the existence of coercion has been noted as a real concern. While mental health courts have as a stated aim the reduction in the criminalisation and stigmatisation of people with mental disorders, they could be perceived as being more stigmatising with a specialised

court resulting in a form of segregation of the mentally ill from "normal" offenders. The need for mental health courts will always be symptomatic of another problem, that is, an inefficient and ailing civil mental health service. Without reforms and increased funding in this area, mental health courts will be founded purely in an effort "to patch a broken system" (Schneider 2008, p 513).

From an Irish perspective, mental health courts cannot be the only answer to the problems faced by the criminal justice system, but could represent an important component in ending the inappropriate criminalisation of the mentally ill. Drawing on the experiences of the United States, Canada and England and Wales, establishing a mental health court which incorporates the best aspects of the courts in each of these jurisdictions is a form of action to which serious consideration should be given. Ideally, an Irish mental health court should not insist on a guilty plea as a pre-requisite to participation. This is arguably antithetical to the goal of decriminalising the mentally ill. As is the case in the Irish Drug Treatment Court, charges should be dropped upon successful completion of the programme. Moreover, the court should not use jail as a sanction for non-compliance with mandated treatment. Since jail is a toxic and inappropriate place for those with mentally illness, employing it as a sanction is inappropriate. Clear procedures should be put in place to ensure that a person makes a voluntary choice to participate, free from coercion and fully informed.

With an over-crowded prison system in crisis, mental health courts, in conjunction with a comprehensive national diversion scheme, could substantially enhance prospects for people with mental disorders currently caught up in the criminal justice system. Such a change would require political will and close cooperation between the judiciary, the Courts Service, the Department of Justice and Equality, the Prison Service, the Health Service Executive and the Probation Service, amongst other agencies. An action plan would need to be formulated and studies would need to be undertaken to assess the feasibility of establishing a mental health court in Ireland. Certainly, funding would need to be put in place to ensure that the requisite resources are available to any such court. We believe that a mental health court would add value to the Irish justice system, and note that the National Crime Council and Inspector of Prisons favour community courts which would deal with offenders with mental disorders. The manner in which offenders with mental disorders are currently dealt with is unacceptable. It is time that serious consideration is given to the establishment of mental health courts as at least a partial solution to this issue.

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