Mindful
Continuing Education

Processing and Treating Mentally Ill Criminal Offenders: Current Practices

Executive Summary

Mentally ill offenders possess a unique set of circumstances and needs. However, all too often, they cycle through the criminal justice system without appropriate care to address their mental health. According to the Bureau of Justice Statistics, individuals with mental health needs make up a large proportion of the US correctional population. An estimated 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates have a mental health problem. These individuals often receive inadequate care, with only one in three state prisoners and one in six jail inmates having received mental health treatment since their admission (James and Glaze 2006). Offenders with severe mental illness place even more strain on the criminal justice system as a whole, in terms of their unique case-processing requirements and treatment needs and their increased risk of recidivism (Baillargeon et al. 2009; Cloyes et al. 2010; Feder 1991). Housing mentally ill offenders in the criminal justice system is costly. In addition to high health care costs, mentally ill inmates tend to have higher rates of prison misconduct and recidivism (Fellner 2006; Toch and Adams 2002).

Despite the evidence that mental illness in the criminal justice system is a pressing concern, our comprehensive effort to identify cost-effective, evidence-based programs and policies for managing and treating mentally ill persons in the criminal justice system brought to light how limited current knowledge is on this topic. There have been only a few rigorous evaluations of criminal justice programs and policies targeted at mentally ill offenders. This limitation, in and of itself, is a notable finding, as it shows what more needs to be done to better understand how to effectively alleviate the costs and challenges of treating and processing offenders with mental illness in the criminal justice system. Given these challenges and their financial consequences for society and governments, it is important to understand how to identify and provide early intervention for those who suffer from mental illness in the criminal justice system.

This report focuses on the societal and economic costs of holding mentally ill offenders in jails and prisons. It also presents a detailed discussion of how mentally ill offenders are processed in the criminal justice system, highlighting the diversity of protocols and practices outlined in state statutes to address these challenges. Further, it discusses several promising criminal justice interventions and policies for mentally ill offenders, including the following:

- Diversionary mechanisms, such as mental health courts, that route mentally ill offenders to community-based mental health treatment programs instead of prison or jail

- Community-based reentry programs providing coordinated services and case management for mentally ill offenders transitioning into the community
- Policies that provide mentally ill offenders with increased access to medical and mental health care

After reviewing these promising interventions, the background analysis finishes with suggestions for future research and a discussion of the implications of our findings.

I. Introduction

Individuals with mental illness are overrepresented in the US criminal justice system. Severe mental illness afflicts nearly one-quarter of the US correctional population, including individuals in prisons, in jails, and on probation (Ditton 1999; Lurigio and Fallon 2007). Epidemiological studies place between 15 and 24 percent of prison inmates in this category (Baillargeon et al. 2009; Diamond et al. 2001; Ditton 1999), and the most recent report from the Bureau of Justice Statistics (BJS) on the mental health of prison and jail populations in the United States indicates that more than 700,000 inmates reported symptoms or a history of a mental health disorder at midyear 2005 (James and Glaze 2006). These numbers represent a substantial need for mental health treatment in the criminal justice system. However, given that many prisons and jails are not equipped to handle this growing population with special needs, these numbers raise concerns about the well-being of mentally ill individuals involved in the criminal justice system, as well as the safety in correctional facilities and communities in general.

At the request of Janssen Pharmaceuticals Inc., this background analysis examines how individuals with mental illness are processed and treated in the criminal justice system and discusses the implications of insufficient or inadequate care for these individuals. In particular, the main objectives of this paper are to review current practice in the processing of mentally ill offenders, assess societal and economic costs associated with recidivism and insufficient care for this population, and highlight promising strategies to tackle challenges involved in the reintegration of mentally ill offenders into society.

This paper is organized as follows. First, we review the operational definition of mental illness as used in this paper as well as in the literature and legislative documents. Second, we provide an overview of the methodology used in this study to conduct a comprehensive review of current practice related to the treatment and management of mentally ill individuals in the criminal justice system. The paper outlines procedures used for collecting and synthesizing prior research and legislative documents regarding mental health treatment in the criminal justice system. Third, we present findings on the current landscape of mental health care for criminal justice populations, including a review of the costs associated with managing mentally ill persons in the criminal justice system, followed by a state-by-state scan of relevant statutes and codes that provide a framework for the definition and treatment of mentally ill offenders in each state. On the basis of prior research on reentry and diversionary programs for mentally ill offenders, we also identify evidence-based strategies to manage and treat mentally ill offenders in the criminal justice system. Finally, we identify gaps in empirical research on this topic and

discuss societal and economic implications of inadequate mental health care in the criminal justice system.

Research Questions Presented by Janssen Pharmaceuticals

- State-by-state analysis: How are mentally ill offenders defined, processed, and treated differently across states, and what are the implications for recidivism?
- National trends: What are the national trends regarding individuals with mental health problems in the criminal justice system and associated costs related to recidivism?
- Costs: What are the societal and economic costs associated with managing and treating mentally ill persons in the criminal justice system?
- Promising criminal justice policies and programs: What does research say about effective strategies to address mental health needs of individuals involved in the criminal justice system?

II. Research Objective and Focus: Severe Mental Illness among Individuals Involved in the Criminal Justice System

One objective of this background analysis is to shed light on how the criminal justice system recognizes the status of being mentally ill and addresses the mental health needs of individuals diagnosed with mental illness. These findings provide the framework for an analysis of the costs associated with mental illness in the criminal justice system. As such, we are most interested in the extent to which mentally ill individuals are held liable for criminal acts; on what basis claims of mental incompetence can be made; how the mental health needs of individuals involved in the criminal justice system are addressed; and what criminal justice interventions or policies have proven effective in improving mental health outcomes, as well as in reducing criminal behavior, among known offenders who have mental health issues. Thus, it seems relevant to focus on severe mental illness that significantly impairs mental functioning rather than more minor symptoms such as anxiety or sleep disorders. Severe mental illness is distinct from general mental health maintenance. Nonetheless, it is notable that neither exists in a vacuum, and the two cannot be completely separated from each other. This is especially true in jails and prisons, where many inmates have multiple diagnoses and co-occurring disorders, and where preexisting mental health conditions are often exacerbated by prison environments, causing the escalation of mental illness among those who are predisposed (Angelotti and Wycoff 2010).

Given the vast array of terminology used to describe mentally impaired conditions, we will refer to these impairments collectively as *mental illness* in this report unless otherwise noted. Also worth noting is that most of the literature examined for this report, explicitly or inexplicitly, focuses on severe mental illness among incarcerated populations. This working definition of mental illness generally fits the established categories of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) as stated below:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g.,

> political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual. (American Psychiatric Association 2013)

Occasionally, criminal justice research examines mental health problems broadly. For example, the most comprehensive correctional mental health data from BJS show "a recent history or symptoms of a mental health problem," defined as a clinical diagnosis or treatment by a mental health professional (James and Glaze 2006, p. 1). Our report makes a distinction when the focus of prior research is broadly directed at mental health problems.

In addition to distinguishing between serious mental illness by the DSM-5 standards and other definitions of mental illness or mental health problems, we also distinguish between jail and prison populations frequently in this study. *Jails* are generally short-term city- or county-level facilities housing inmates who are awaiting trial or sentencing, as well as those who are serving relatively brief sentences (usually less than one year). *Prisons*, in contrast, are generally longer-term correctional facilities operated at the state or federal levels. It is important to note that these two terms are not interchangeable, especially in descriptions of correctional treatment programs, which tend to be more extensive in prisons because of their longer-term nature.

III. Data and Methodology

This paper highlights how mentally ill persons are managed and treated in the criminal justice system by synthesizing information about policies and programs in place for such individuals. Recognizing the potential for state-level similarities and differences in the management and treatment of mentally ill offenders, we conducted a thorough review of the current state of policies and practice. Given the extensive body of literature surrounding mentally ill offenders, this study presents two targeted research initiatives: (1) a state-specific scan of practice, identifying how mentally ill offenders are defined and handled by the criminal justice system in each state, and (2) a literature review and synthesis on the treatment of mentally ill offenders and their reentry into society and the costs associated with this treatment or, in some cases, lack of treatment. In the following subsections, we describe the research protocols and procedures used in each of these initiatives.

1. Scan of Practice

In order to capture how mentally ill offenders are managed and treated in prisons throughout the United States, we conducted a state-by-state scan of practice. Systematically gathering information about how mentally ill offenders are handled by the criminal justice system in each state allowed us to uncover patterns and trends, as well as variations, regarding how such individuals fit into each state's criminal justice system.

The state-specific scan of practice targeted information about how mentally ill individuals are handled in several stages of the criminal justice system, with special attention to the legal status and rights of mentally ill offenders. We used LexisNexis and Westlaw to examine statutory provisions and the rules made under these provisions to determine how the status of mental illness or other mental health impairments is recognized in each state's criminal justice system and how the legal rights of mentally ill offenders are recognized in court proceedings.

2. Research Synthesis

In addition to the state scan of practice, we reviewed the current body of literature surrounding mentally ill offenders in the criminal justice system to identify promising practices in the treatment and supervision of these individuals. All 50 states and the District of Columbia have some statutory

language in their codes that refers to the mental health needs of individuals involved in the criminal justice system. While the state scan provides information about the policies in place for recognizing the legal status and rights of mentally ill individuals involved in the criminal justice system, the comprehensive research synthesis identifies promising and cost-effective programs and policies for those with mental illness. Below, we describe the procedures we used to search and sort through relevant empirical studies on such criminal justice interventions targeted at mentally ill offenders.

Literature Search Protocols

We made a comprehensive search of rigorous, quantitative criminal justice interventions and programs for mentally ill offenders conducted in the past 25 years, as well as their ability to alleviate societal and economic costs associated with managing mentally ill offenders. In conducting our search, we used three types of sources to identify these studies: (1) digital libraries and databases, including ProQuest Criminal Justice, National Criminal Justice Reference Service, JSTOR, Ebsco, Google Scholar, and SAGE Publications; (2) citations in other systematic reviews of criminal justice interventions and programs for mentally ill offenders; and (3) websites of criminal justice agencies (e.g., departments of corrections) or research organizations cited in relevant studies. We systematically searched those sources by first targeting publications broadly focused on mentally ill individuals in the criminal justice system and then narrowing our search to studies about specific policies, interventions, or programs. To ensure that our search comprehensively covered the scope of literature, we cross-referenced the citations in relevant studies for other potentially relevant publications. Many of the studies identified through the databases were published in peer-reviewed academic journals. Because peer-reviewed publications may be biased to show positive program effects (Lipsey and Wilson 2001), we also included non-peer-reviewed yet high-quality studies, such as government reports or policy briefs. This approach ensured that our search yielded a wide variety of empirical reviews, data publications, and policy briefs.

Study Selection

Relevant studies were carefully reviewed for methodological rigor. We required empirical analyses to use advanced statistical analyses and techniques appropriately, limiting the potential for confounding factors or biases. Additionally, meta-analyses needed to have clear, targeted search strategies and rigorous selection criteria so as to capture a complete picture of current research. A high-quality study is defined as meeting Level 3 or above on the Maryland Scientific Methods Scale, which requires the use

of a comparison group in quasi-experimental or experimental settings (Sherman et al. 1998).[1] Studies that suffer from substantial deficiencies (e.g., selection bias, reporting bias, data attrition, and other sources of bias) in their ability to identify the causal effect of criminal justice interventions were not included in our review.

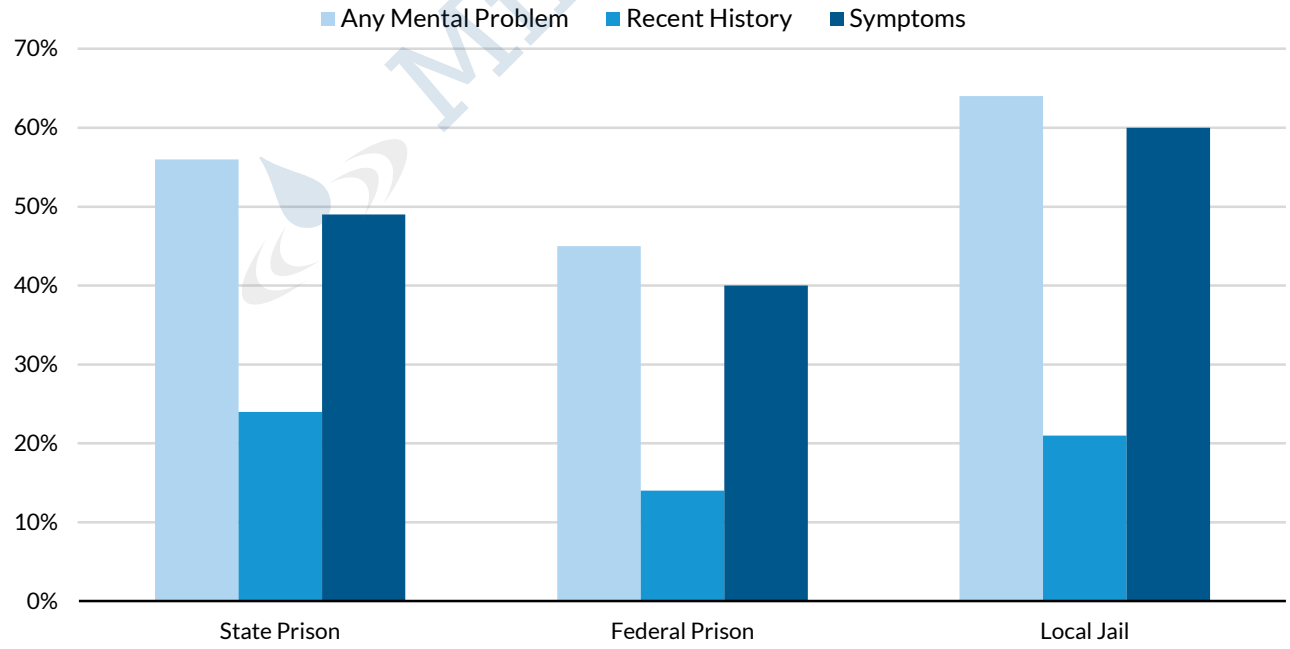
IV. Findings

1. Scope of the Problem

BJS periodically conducts a survey on inmates in local, state, and federal correctional facilities. As of this writing, the most recent reliable survey data of national scope available to the public were collected in 2004 for state and federal prisoners and in 2002 for jail inmates. These interview data provide the most representative estimates for the prevalence of mental health problems among individuals involved in the criminal justice system, and they indicate that 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates had a mental health problem at the time of the interviews (James and Glaze 2006). As shown in figure 1, at the time of the survey, 49 percent of state prisoners, 40 percent of federal prisoners, and 60 percent of jail inmates had a symptom of a mental disorder, such as developmental and personality disorders, as well as clinical symptoms as specified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV).

FIGURE 1

Percentage of Inmates with Mental Health Problems

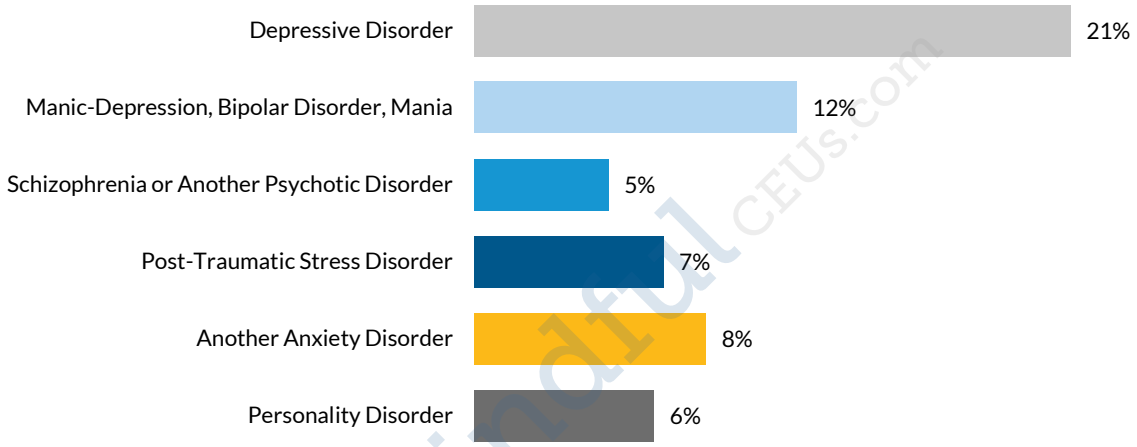


Source: James and Glaze 2006.

Regarding particular symptoms and disorders, the *Survey of Inmates in State and Federal Correctional Facilities, 2004* reported that one in five state and federal prisoners suffered from depressive disorder. As shown in figure 2, a substantial proportion of state and federal prisoners had also been diagnosed with mania symptoms (12 percent), schizophrenia or another psychotic disorder (5 percent), post-traumatic stress disorder (7 percent), another anxiety disorder (8 percent), or a personality disorder (6 percent).

FIGURE 2

History of Mental Disorders among State and Federal Inmates



Source: US Department of Justice, Bureau of Justice Statistics 2007.

These data also indicate that, among state prisoners who reported a mental health problem, 49 percent had a violent offense as their most serious offense, followed by property crimes (20 percent) and drug offenses (19 percent). With respect to gender differences, female inmates had higher rates of mental health problems than male inmates (73 percent of female inmates and 55 percent of male inmates in state prisons).

The prevalence of mental illness among offender populations indicates a substantial need for mental health treatment. Today, the largest US jails and prisons hold more people with mental illnesses and co-occurring substance use disorders than many inpatient psychiatric facilities (McCuan, Prins, and Wasarhaley 2007). Almost three-quarters of state prisoners with mental health problems reported co-occurring substance dependence (James and Glaze 2006). Further, inmates with mental illness often have additional social and criminogenic needs. Prisoners suffering from mental illness are more likely to have experienced homelessness, prior incarceration, and substance abuse than those without mental

illness (Cloyes et al. 2010), and, cyclically, these factors common among offenders also predispose them to mental illness (Chiu 2010).

However, many prisons and jails are not equipped to handle this population with special needs. Prison conditions often exacerbate preexisting mental illness, especially as a result of fear of victimization, which can particularly affect older prisoners (Angelotti and Wycoff 2010). Older prisoners generally have higher rates of mental illness than their younger peers, and the present "graying" of the prison population is well documented in the corrections literature, indicating that, as prison populations grow older, the percentage of mentally ill inmates will increase as well (Chiu 2010; Sterns et al. 2008).

In spite of these needs for mental health care, only one in three state prisoners and one in six jail inmates who suffer from mental health problems report having received mental health treatment since admission, and although the use of prescribed medications for a mental health problem by state prisoners rose slightly between 1997 and 2004 (from 12.3 to 15.1 percent), the percentage of those who received professional mental health therapy showed little change (from 12.3 to 12.7 percent) (James and Glaze 2006). This situation is further complicated by prison overcrowding: The US prison population has quadrupled over the past 25 years, and correctional institutions are now responsible for meeting the health care needs of approximately 2.3 million US inmates (Wilper et al. 2009). As a result, prisons often struggle to adequately provide basic services and security, not to mention to address special medical and mental health needs.

In the next section, we further describe how individuals with mental health needs are processed in the criminal justice system; specifically, we focus on the implications of this treatment—or lack thereof—by analyzing the costs associated with holding mentally ill offenders in jails and prisons and treating them in community-based settings.

2. Costs Associated with Managing Mentally Ill Individuals in the Criminal Justice System

Mental health care is expensive for any population, and the range of mental health treatment services is broad. However, little empirical research exists to directly quantify the costs of mental health problems and severe mental illness in the criminal justice system. Where prison health care cost estimates exist (e.g., Kinsella 2004; McNeil, Binder, and Robinson 2005; Project Link 1999), they are often anecdotal and outdated and do not focus specifically on mental health costs as opposed to physical health costs.

Despite these shortcomings, several studies indicate that prisons today need to spend more on prisoner health care, including expenditures on mental health care specifically (Kinsella 2004; Office of the Inspector General 2008; Stephan 2004; Sterns et al. 2008). This is in large part because of the aging of prisoner populations. Data from the National Association of State Budget Officers, synthesized by the Council of State Governments, indicate that, from 1998 to 2001, state corrections budgets grew an average of 8 percent each year, and during that same three-year period, correctional health care costs grew by 10 percent annually. Mental health care costs are listed as one of the major contributors to this growth: in 1998, states spent between 5 and 43 percent of their health care budgets on mental health (Kinsella 2004).

In addition to direct mental health care costs, mentally ill prisoners have higher rates of misconduct and accidents in prisons (Fellner 2006; Toch and Adams 2002), thereby incurring higher indirect or collateral costs in prisons. According to BJS's 2006 report (James and Glaze 2006), about 24 percent of state prisoners with mental health problems, compared with 14 percent of those without, had been charged with a physical or verbal assault on a prison staff member or fellow inmate since admission. Among federal prisoners, the same trend held: 15 percent of federal prisoners with mental health problems, compared with 7 percent without, had been charged with assault during incarceration. Among state and federal prison inmates and local jail inmates, the percentage of those who reported being injured in a fight was more than double among those with mental health problems than among those without mental health problems (James and Glaze 2006). Rule violations and fights have economic costs for corrections facilities, including staff time spent on discipline, physical and pharmaceutical resources spent on subduing violent prisoners, and treatment associated with injuries incurred in fights.

Further, prior research indicates that prisoners with mental health problems have higher recidivism rates than those without mental health problems, thereby resulting in higher societal costs (Baillargeon et al. 2009; Cloyes et al. 2010; Feder 1991). Although little research has been done to directly quantify the cost of recidivism among prisoners with mental illness, several studies of specific state prison systems have examined recidivism rates within this population. These state-specific studies provide some idea of the costs of recidivism among mentally ill offenders, and in this report they serve as a starting point for further discussion and research.

For example, one study of the nation's largest state prison system, that of Texas, examined the likelihood of returning to prison during a six-year period among recently released inmates with major psychiatric disorders, including major depressive disorder, bipolar disorder, schizophrenia, and nonschizophrenic psychotic disorders. The researchers found that formerly incarcerated persons

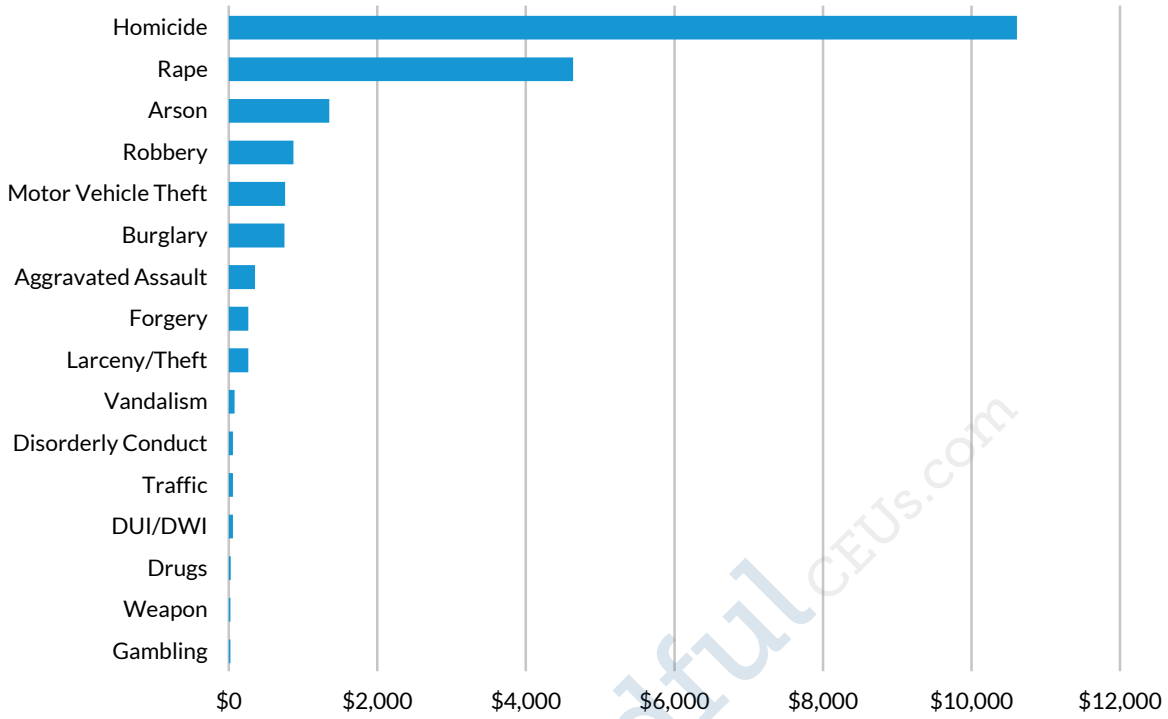
suffering from any of these disorders were substantially more likely to be reincarcerated, especially inmates with bipolar disorder (Baillargeon et al. 2009). Specifically, inmates with any major psychiatric disorder were found to be 2.4 times more likely to have four or more repeat incarcerations than inmates with no major psychiatric disorder, and this same number rose to 3.3 for inmates with bipolar disorder (Baillargeon et al. 2009). Another study of Utah's state prison population found that offenders with severe mental illness returned to prison an average of 358 days—nearly one full year—sooner than offenders without diagnosed mental illness, and 77 percent of offenders with severe mental illness were reincarcerated within 36 months, compared with 62 percent of offenders without severe mental illness (Cloyes et al. 2010).

Similarly, a longitudinal multistate study on returning prisoners by the Urban Institute, *Returning Home: Understanding the Challenges of Prisoner Reentry*, found higher rates of criminal involvement after release from prison among individuals with mental health conditions (Mallik-Kane and Visher 2008). The *Returning Home* study was an in-depth examination of the reentry process through a series of interviews with a representative sample of returning prisoners from Maryland, Illinois, Ohio, and Texas before and after their release. The study is among just a few multistate sources that can shed light on reentry challenges and the risk of recidivism. Mallik-Kane and Visher (2008) also found that respondents with mental health conditions reported poorer housing, employment, and to some extent, family support outcomes than returning prisoners without mental health conditions.

All in all, substantial criminal justice costs, broadly defined as all costs incurred by justice agencies (such as the police, courts, jails, parole, probation, and prisons), and societal costs, defined as the sum of societal loss in value (such as victimization and reduced educational or employment opportunities), arise from the offender population with mental illness. It is feasible to some extent to quantify these costs, despite the lack of rigorous research on this topic. For example, based on published research and agency budgets, the operating cost per day or per case for each criminal justice agency can be roughly estimated, as shown in figure 3. There is also an established research domain that focuses on how to estimate the costs of crime, which can also shed light on the social costs associated with mentally ill offenders (Cohen 2000; Cohen, Miller, and Rossman 1994; Roman and Harrell 2001). The primary question for many policymakers and researchers is whether or not these costs, which can be averted if mentally ill offenders are adequately treated and supervised, exceed the costs of treatment and supervision.

FIGURE 3

Commonly Used Cost Estimates of Arrest (2005 Dollars)



Source: Rossman et al. 2012.

However, existing knowledge about these costs is prohibitively fragmented, making it difficult to generate system-level inferences about the cost-effectiveness of current policy and practice in the management of mentally ill individuals involved in the criminal justice system. In particular, we know relatively little about the total resources used in processing and treating mentally ill offenders. Insomuch as emphasis is placed on a multidisciplinary team approach to addressing the needs of mentally ill offenders (see subsection 4, "Criminal Justice Programs and Interventions for Mentally Ill Individuals," for a discussion of such approaches), typically a large number of individuals and organizations is involved in any intervention targeted toward mentally ill offenders. Thus, it is often impractical even for a single intervention or prevention program to maintain a centralized records management system that reliably tracks all services provided to mentally ill offenders. Therefore, it is a much greater challenge at the system level (i.e., local or state criminal justice systems) to quantify the total resources actually spent on mentally ill offenders.

That said, Farabee and colleagues (2006) and Mayfield (2009) present good examples of how cost analysis can be conducted on a criminal justice program for mentally ill offenders and how useful such

an analysis may be for planning and policymaking. In their evaluation of the Mental Health Services Continuum Program (MHSCP)—a multidisciplinary approach to delivering treatment services before and after release from state prison to parole—Farabee and his colleagues found that receiving one or more contacts with the parole outpatient clinic yielded averted costs (savings) of $4,890 per parolee in one of the aspects of the program in question. Similarly, Mayfield (2009) examined the cost-effectiveness of the Dangerous Mentally Ill Offender (DMIO) program in Washington, whose primary goals were to identify mentally ill prisoners who pose a threat to public safety and to provide them with services and treatment up to five years after their release from prison. Mayfield estimated the averted costs of crime to be in excess of $20,000 per program participant—costs that would have been incurred by taxpayers and crime victims. As elaborated by Rossman and colleagues (2012), considerable challenges are associated with collecting cost data from mental health service providers and criminal justice stakeholders, but analysis of the costs and benefits of processing and treating mentally ill offenders is critical to effective planning and program development.

3. Current Practice and Policy

After examining the costs associated with treating mentally ill offenders, we moved on to conduct a state-by-state scan of practice to understand how the criminal justice system in the United States processes these individuals, which could in turn have implications for the associated costs and vice versa. This scan of practice focuses on how the legal system identifies the status of being mentally ill and recognizes the rights of mentally ill offenders in all 50 states and the District of Columbia. We also conducted a comprehensive search for information regarding protocols for identifying, classifying, and treating mentally ill offenders in correctional facilities, but such information is not consistently available for all 50 states. Thus, a few key examples are presented following the discussion on how mentally ill offenders are defined and processed in courts, to provide a more complete picture of this stage of treatment in the criminal justice system without attempting to make broad, national-level generalizations where specific data or policies are not systematically available.

Scan of Practice in Court Proceedings

To understand the nature of the policies and practices in place regarding how mentally ill individuals are processed in court, we need first to examine how states define who these individuals are and what characterizes mental health needs, mental illness, or both. Every state's statutes stipulate procedures

for processing individuals whose mental competency is in question, thus providing a context for understanding how mentally ill individuals are defined and recognized. Mental health disorders and illnesses manifest themselves in various ways, thus leaving room in their definition for interpretation. The second column of table 1 provides information about the terminology used to refer to mental health impairments in state statutes. Our scan focused on the specific language provided in each statute regarding individuals with mental health issues, including whether these impairments are referred to as illnesses, diseases, disorders, or disabilities. As discussed previously, we refer to these impairments collectively as *mental illness* for the purpose of this review.

Mentally ill individuals in the criminal justice system have a unique set of circumstances, which raises the question of their criminal responsibility. Because mentally ill individuals could have had an unstable or disordered state of mind at the time of the offense, each state is tasked with determining whether they should be held liable for their criminal acts. In doing so, states call upon a variation of one of three specific methods to determine the sanity of an individual at the time of the offense: the M'Naghten Rule, the Model Penal Code Rule, or the Durham Rule.

Under the M'Naghten Rule, an individual is presumed sane unless the defense proves that "at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing or, if he did know it, that he did not know what he was doing was wrong."[2] The Model Penal Code Rule also emphasizes whether an individual is able to distinguish right from wrong. This rule specifies that a defendant suffering from a mental disease or defect is not responsible for criminal actions during which he or she lacked "substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law" (American Law Institute 1962, sec. 4.01(1)). Both of these rules leave substantial room for interpretation on behalf of the jury, though they are more specific than the Durham Rule. The Durham Rule, the most liberal approach of all three, states "an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect."[3] The rule that each state uses to determine the sanity of a defendant is presented in columns three through five of table 1.

Column seven of table 1 indicates whether a verdict of not guilty by reason of insanity is permissible in each state. The final column of the table provides information about whether or not a test or clinical assessment for insanity is required for all cases in which the mental competency of an individual is in question. In some states, the clinical assessment is provided only at a party's request. In the latter case, a state, court, or defense counsel, for example, may request an examination to determine the defendant's competency.

A. DEFINITION OF MENTAL HEALTH IMPAIRMENTS PROVIDED IN THE STATUTES

All 50 states and the District of Columbia provide a definition for a mental health impairment in criminal proceedings, including mental illness, mental disease or defect, mental or psychiatric disorder, and mental or psychiatric disability. The language used to describe these mental conditions varies greatly from state to state and often includes some degree of subjectivity, because most states craft a definition that functions for them procedurally, rather than focusing on clinical definitions. Many states approach defining mental illness from a behavioral or symptomatic perspective, whereas others focus on specific abnormalities or treatment requirements. Despite this variation, it is these definitions that establish the basis for classifying and treating individuals whose mental competency is in question.

The most common term used to describe individuals with mental health needs is "mental illness," for which 36 states list a definition. Although there is much inconsistency in the thoroughness of these definitions, most states' definitions share the common themes of psychological impairment and inability to meet the demands of daily life. There is also great variation in the level of specificity within each state's definition. Whereas the District of Columbia defines mental illness simply as "a psychosis or other disease which substantially impairs the mental health of a person," Michigan defines mental illness as "a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life" (DC Code Ann. § 21-50; MCLS § 330.1400[4]).

Most of these 36 states list vague or generic definitions of mental illness, though a few cite specific manifestations of and treatment protocols for the impairment. Both Hawaii and Minnesota, for example, reference specific disorders indicative of mental illness directly in their statutes, with Hawaii stating that mental illness is inclusive of schizophrenia, severe depression, bipolar disorder, severe panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (Cor.10.1G.04). Minnesota's definition of mental illness is uniquely thorough, referencing the vast scope of symptoms, conditions, and diagnostic criteria associated with mental illness (see box 1).

BOX 1

Minnesota's Definition of Mental Illness: Subd. 20. *Mental Illness*

a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

   1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;
   2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;
   3) the adult has been treated by a crisis team two or more times within the preceding 24 months;
   4) the adult:
      i. has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder;
      ii. indicates a significant impairment in functioning; and
      iii. has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;
   5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or;
   6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; or
   7) the adult was eligible as a child under section 245.4871, subdivision 6, and is age 21 or younger. (Minn. Stat. § 245.462)

Although other states provide less comprehensive definitions, some include conditions that are not necessarily associated with mental illness—such as intellectual or developmental disabilities—in their definitions of mental illness. Mental illnesses and intellectual or developmental disabilities are separate conditions, though they may co-occur in some cases. Most notably, intellectual and developmental disabilities refer to sub-average intelligence or intellectual development, and generally, they can be expected to be permanent. On the other hand, people with mental illness may have average or even above-average intelligence, and mental illnesses, unlike intellectual disabilities or developmental disabilities, are medical diseases that can be treated or even overcome with medication, psychotherapy, and the like (Burke et al. 2012). Additionally, several states reference the need for treatment and specialized care for individuals with mental illness. For example, Massachusetts's and Wisconsin's definitions of mental illness are nearly identical and hinge on the need for care: "'Mental illness' means mental disease to such extent that a person so afflicted requires care and treatment for his or her own welfare, or the welfare of others, or of the community" (ALM GL ch. 123 App. § 1-1; Wis. Stat. § 51.01). Although most states allude to the severity of mental illness in their definition, three states—Nebraska, South Dakota, and California—refer to this specifically by defining "mentally ill and dangerous person," "severe mental illness," and "severe mental disorder," respectively.

The remaining states that provide a definition for mental health impairment use slightly different terms to refer to similar phenomena. For example, Alaska is one of eight states that defines "mental disease or defect," listing it as a "disorder of thought or mood that substantially impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life" (AS § 12.47.130). However, unlike the states that provide definitions for mental illness, states that provide a definition for "mental disease" or "mental deficiency" incorporate intellectual or developmental disabilities into their definitions differently: Alaska, Arkansas, and Wyoming consider intellectual disabilities to be a mental disease or defect, whereas Montana excludes them from its definition (AS § 12.47.130; Ark. § 5-2-301; MCA § 46-14-101; Wyo. Stat. § 7-11-301).

Six states, including Connecticut, Maryland, Nevada, Rhode Island, South Carolina, and Washington, use different terminology to reference mental health impairments, specifically, "mental disorder," "psychological disorder," "mental disability," and "psychological disability." Again, these terms reference some sort of psychological impairment and need for care. However, in addition to encompassing psychological disorders, they may incorporate emotional disorders and disturbances into their definitions by referencing disturbed moods or impaired emotional functioning (Ala. Code 1975 § 22-52-1.1; Md. Crim. Proc. Code Ann. § 3-101).

B. CRIMINAL RESPONSIBILITY OF MENTALLY ILL INDIVIDUALS

The protocol for determining the criminal responsibility of mentally ill defendants also varies from state to state (see figure 4). The key question here is whether the mental state of an individual at the time of a crime dictates whether he or she should be held legally responsible for the offense. It is thus necessary for each state to assess the mental capacity at the time of the crime for individuals whose competency is in question. This review of criminal responsibility is not merely a summary of legal technicalities; it can also provide a sense of which states are more open or amenable than others to recognizing the needs of mentally ill individuals in the criminal justice system. Recognizing the needs of this population is essential to the development of effective policies for intervention, treatment, and legal processing.

In determining the mental state of an individual at the time of offense, the majority of states appeal to a variant of either the M'Naghten Rule or the Model Penal Code Rule to test for insanity. Twenty-five states have adopted a variant of the M'Naghten Rule in some form and thus emphasize in their statutes the importance of the defendant being able to distinguish right from wrong at the time of the offense. For example, Georgia's code states that a "person shall not be found guilty of a crime if, at the time of the act, omission, or negligence constituting the crime, the person did not have mental capacity to distinguish between right and wrong in relation to such act, omission, or negligence," alluding to how the criminal responsibility of mentally ill individuals depends on whether they could determine the morality of their conduct (O.C.G.A. § 16-3-2).

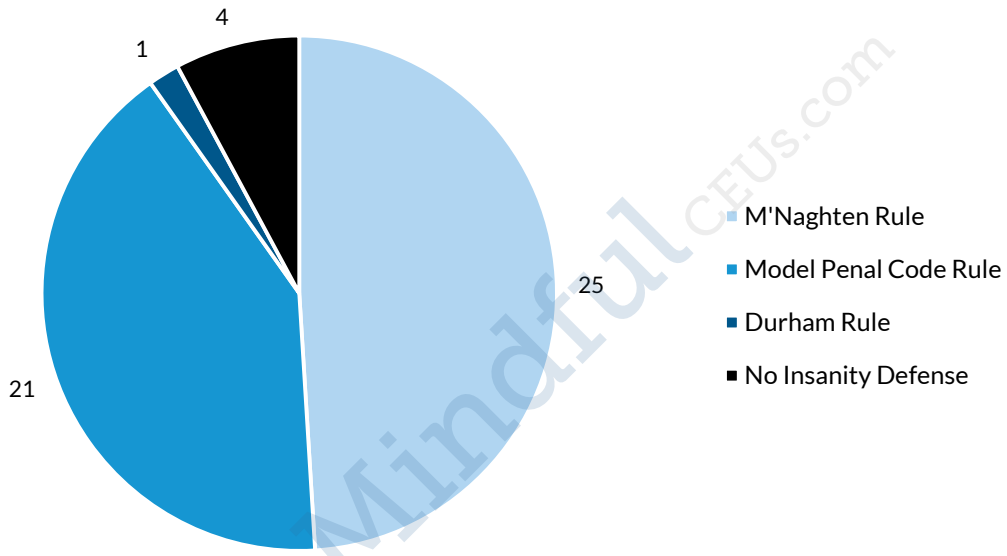
Twenty-one other states appeal to the Model Penal Code Rule in determining the liability of mentally ill defendants, emphasizing their ability to appreciate the illicit nature of a criminal act or abide by the law. Maryland's statute regarding criminal responsibility targets these principles: "a defendant is not criminally responsible for criminal conduct if, at the time of that conduct, the defendant, because of a mental disorder or mental retardation, lacks substantial capacity to: (1) appreciate the criminality of that conduct; or (2) conform that conduct to the requirements of law" (Md. Crim. Proc. Code Ann. § 3-109).

New Hampshire is the only state that uses the Durham Rule and states that "a person who is insane at the time he acts is not criminally responsible for his conduct" (RSA 628:2). New Hampshire's approach to determining criminal responsibility is more liberal and broader than other states, and notably, it does not directly address the definition of insanity as it affects criminal liability but rather simply states that a person who is deemed insane, presumably by any measure, therefore lacks criminal liability.

Four states do not appeal to any of these rules: Idaho, Kansas, Montana, and Utah. These states consequently do not allow for a verdict of not guilty by reason of insanity, and the mental condition of a defendant cannot be used as a direct defense to a criminal charge. However, in Montana, evidence of a mental disease can be used during the trial to determine the appropriate sentence, and Utah allows mental illness to "be evidence in mitigation of the penalty" (MCA § 46-14-102; Utah Code Ann. § 76-2-305).

FIGURE 4

Number of States Using Different Rules to Determine Criminal Responsibility



Source: See appendix.

C. CLINICAL ASSESSMENTS OF INSANITY

All 50 states and the District of Columbia use some sort of clinical assessment or test to assess the culpability of an individual. Such an assessment is either required by law in all cases in which the person's sanity is in question or needs to be requested by a particular party. Nineteen states require clinical assessments for defendants whose mental state is in question. In the remaining 32 states, mental health evaluations are called for only by the request of a particular party. Thirteen of these states perform clinical assessments by request of the court, and 11 allow these evaluations at the request of any party. The remaining states perform such assessments at the request of the state, the defendant, or a detention facility.

TABLE 1

Legislative Definitions of Mental Illness

State (1)	Term defined in statute (2)	Specific severe mental illness or diseases mentioned? (3)	M'Naghten Rule (4)	Model Penal Code Rule (5)	Other rule (6)	Not guilty by reason of insanity verdict allowed (7)	Test/clinical assessment of insanity specified (8)
Alabama	Mental illness	N	√			Y	Required for all cases where sanity/competence at issue
Alaska	Mental disease or defect	N	√			Y	Required for all cases where sanity/competence at issue
Arizona	Mental disease or defect	N	√			Y	By any party's request
Arkansas	Mental disease or defect	N		√		Y	Required for all cases where sanity/competence at issue
California	Severe mental disorder	N	√			Y	By state or detention facility's request
Colorado	Mental disease or defect	N	√			Y	Required for all cases where sanity/competence at issue
Connecticut	Psychiatric disability	N		√		Y	By any party's request
Delaware	Mental illness or psychiatric disorder	N		√		Y	By court's request
District of Columbia	Mental illness	N		√		Y	By any party's request
Florida	Mental illness	N	√			Y	Required for all cases where sanity/competence at issue
Georgia	Mental illness	N	√			Y	Required for all cases where sanity/competence at issue
Hawaii	Mental illness	N		√		Y	By court's request
Idaho	Mental illness	N			No insanity defense; guilty but insane verdict available	N	Required for all cases where sanity/competence at issue
Illinois	Mental illness	N		√		Y	Required for all cases where sanity/competence at issue

State (1)	Term defined in statute (2)	Specific severe mental illness or diseases mentioned? (3)	M'Naghten Rule (4)	Model Penal Code Rule (5)	Other rule (6)	Not guilty by reason of insanity verdict allowed (7)	Test/clinical assessment of insanity specified (8)
Indiana	Mental illness	N		√		Y	Required for all cases where sanity/competence at issue
Iowa	Mental illness	N	√			Y	By court's request
Kansas	Mental illness	N			No insanity defense	N	By any party's request
Kentucky	Mental illness	N		√		Y	By defendant's request
Louisiana	Mental disease or defect	N	√			Y	Required for all cases where sanity/competence at issue
Maine	Mental disease or defect	N		√		Y	By any party's request
Maryland	Mental disorder	N		√		Y	By court's request
Massachusetts	Mental illness	N		√		Y	By court's request
Michigan	Mental illness	N		√		Y	Required for all cases where sanity/competence at issue
Minnesota	Mental illness	Y	√			Y	Required for all cases where sanity/competence at issue
Mississippi	Mental illness	N	√			Y	By any party's request
Missouri	Mental disease or defect	N	√			Y	Required for all cases where sanity/competence at issue
Montana	Mental disease or defect	N			No insanity defense; guilty but insane verdict available	N	By any party's request
Nebraska	Mentally ill and dangerous	N	√			Y	By court's request
Nevada	Mental disorder	N	√			Y	Required for all cases where sanity/competence at issue
New Hampshire	Mental illness	N			Durham Rule	Y	By court's request
New Jersey	Mental illness	N	√			Y	By any party's request
New Mexico	Mental illness	N	√			Y	Required for all cases where sanity/competence at issue
New York	Mental illness	N		√		Y	By court's request

State (1)	Term defined in statute (2)	Specific severe mental illness or diseases mentioned? (3)	M'Naghten Rule (4)	Model Penal Code Rule (5)	Other rule (6)	Not guilty by reason of insanity verdict allowed (7)	Test/clinical assessment of insanity specified (8)
North Carolina	Mental illness	N	√			Y	By court's request
North Dakota	Mental illness	N		√		Y	By court's or state's request
Ohio	Mental illness	N	√			Y	By court's request
Oklahoma	Mental illness	N	√			Y	By court's request
Oregon	Mental illness	N		√		Y	By state's request
Pennsylvania	Mental illness	N	√			Y	By agreement of all parties or by court order
Rhode Island	Mental disability	N		√		Y	By any party's request
South Carolina	Mental disability	N	√			Y	By defendant's or state's request
South Dakota	Severe mental illness	Y	√			Y	By any party's request
Tennessee	Mental illness	N		√		Y	By court's request
Texas	Mental illness	N	√			Y	Required for all cases where sanity/competence at issue
Utah	Mental illness	N			No insanity defense; guilty but mentally ill verdict available	N	By court's request
Vermont	Mental illness	N		√		Y	By any party's request
Virginia	Mental illness	N	√			Y	By state's request
Washington	Mental disorder	N	√			Y	Required for all cases where sanity/competence at issue
West Virginia	Mental illness	N		√		Y	Required for all cases where sanity/competence at issue
Wisconsin	Mental illness	N		√		Y	By defendant's or court's request
Wyoming	Mental illness or deficiency	N		√		Y	Required for all cases where sanity/competence at issue

Note: N = No; Y = Yes.

Classification and Treatment of Mentally Ill Offenders in Correctional Facilities

Every state corrections department has policies for how to classify prisoners with mental illness and maintains programs or facilities for prisoners with mental health needs. However, internal policies and program descriptions are not consistently available for all states, making state-level comparisons difficult to conduct. We thus present a few examples below, describing how mentally ill offenders are commonly classified and treated in prison.

Maintaining one of the largest corrections systems in the United States, New York state can serve as a useful example because it has an elaborate diagnosis and treatment system for mentally ill inmates. Approximately 54,700 prisoners are held in 58 state facilities (NYS DOCCS 2014). New York state classifies correctional facilities by the level of mental health service capacities and assigns prisoners to an appropriate facility based on their mental health needs (NYS DOCCS 2011). As summarized in box 2, there are five mental health service levels:

BOX 2

New York State Mental Health Service Levels

Level 1: Office of Mental Health (OMH) staff is assigned on a full-time basis and able to provide treatment to inmate-patients with a major mental disorder. The array of available specialized services include residential crisis treatment, residential/day treatment, case management, medication monitoring by psychiatric nursing staff, and potential commitment to the Central New York Psychiatric Center.

Level 2: OMH staff is assigned on a full-time basis and able to provide treatment to inmate-patients with a major mental disorder, but such disorder is not as acute as that of inmate-patients who require placement at a Level 1 facility.

Level 3: OMH staff is assigned on a part-time basis and able to provide treatment and medication to inmate-patients who either have a moderate mental disorder or who are in remission from a disorder, and who are determined by OMH staff to be able to function adequately in the facility with such level of staffing.

Level 4: OMH staff is assigned on a part-time basis and able to provide treatment to inmate-patients who may require limited intervention, excluding psychiatric medications.

Level 5: Not used.

Level 6: No assigned staff from OMH.

Notably, the classification of prisoners is centered around the mental health service capacities of each facility. Although the department specifies criteria for seriously mentally ill inmates, who are to be assigned to Level 1 facilities, no other mental health service levels designate specific mental disorders or conditions. Further, as shown in box 3, the operational definition of serious mental illness used by the New York State Department of Corrections and Community Supervision generally follows the DSM-IV Axis I diagnosis. The California Department of Corrections and Rehabilitation Mental Health Services Delivery System also has similar protocols to classify inmates and define their mental health status (California Department of Corrections and Rehabilitation 2014).

BOX 3

Definition of Seriously Mentally Ill in New York State Department of Corrections and Community Supervision

- Inmates determined by the OMH to have a current diagnosis or a recent significant history of any of the following types of DSM-IV Axis I diagnoses:

  Schizophrenia (all subtypes); Delusional Disorder; Schizophreniform Disorder; Schizoaffective Disorder; Brief Psychotic Disorder; Psychotic Disorder Not Otherwise Specified; Major Depressive Disorders; Bipolar Disorder I and II; Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal)

- Inmates who are actively suicidal or who had a recent, serious suicide attempt
- Inmates diagnosed with serious mental illness, organic brain syndrome, or a severe personality disorder that is manifested in significant functional impairment, such as acts of self-harm or other behaviors, that has a serious adverse effect on life or on mental or physical health

When it comes to the classification of mentally ill prisoners, internal policies tend to describe administrative procedures by which clinical assessment and screening should be performed but do not typically specify decision-making heuristics from clinicians (e.g., Michigan Department of Corrections 2014; Texas Department of Criminal Justice 2014). Overall, it seems evident that considerable state-level variation exists in the ways correctional departments identify and treat mentally ill offenders. Moreover, it is worth noting that a particular focus in the clinical assessment of prisoners is not merely on their mental status but also on their risk of incidents in prison (e.g., suicide, violence, substance dependence).

4. Criminal Justice Programs and Interventions for Mentally Ill Individuals

We conducted a comprehensive review of research on criminal justice programs and policies, as well as diversionary policies, for mentally ill individuals. These policies and programs addressing the needs of mentally ill offenders are implemented at all stages of the criminal justice system, from the arrest stage

to the post-release stage, and effective interventions have the potential to mitigate societal and economic costs associated with the processing of mentally ill defendants. Because numerous such policies and programs exist in local, state, and federal justice systems and in nonprofit and private sectors, a state-by-state comparison of those policies and programs would not be feasible within the scope of this research synthesis. Instead, we identify promising programs based on prior research on criminal justice interventions for mentally ill individuals and synthesize research findings in this section. These interventions, ranging from mental health courts and pretrial diversion programs to discharge planning and in-prison and community-based treatment programs, have the potential to mitigate the social and economic costs associated with the recidivism of mentally ill offenders.

Mental Health Courts

A. OVERVIEW

One way jurisdictions can alleviate the strain on resources caused by incarcerating the mentally ill and providing treatment for them in prison is to divert them to community-based mental health treatment programs. Mental health courts (MHCs) are one such diversionary mechanism that relies on community justice partnerships, involving mental health treatment and social services providers. MHCs are specialized court dockets for individuals with mental health problems. In place of traditional court processing, in which the judge reviews the culpability of a case and imposes a sentence, MHCs offer problem-solving solutions for mentally ill offenders.

Similar to other types of problem-solving courts, such as drug courts and reentry courts, MHCs are viewed as an analogous application of therapeutic jurisprudence.[5] They identify eligible participants through mental health screenings and assessments and place them in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals (Rossman et al. 2012). When an offender successfully completes the program, MHCs may vacate an alleged charge or modify the original sentence.

On the premise that mental health treatment and ongoing judicial monitoring provided through MHCs improve mental health outcomes and reduce criminal behavior and associated costs, MHCs have become increasingly popular in the United States. As of 2011, the Criminal Justice/Mental Health Consensus Project listed more than 240 court-based mental health interventions within its Local Programs Database. MHCs are located primarily in the western (37 percent) and southern (37 percent)

regions, with fewer courts in the Midwest (15 percent) or Northeast (11 percent) (Council of State Governments 2005).

B. MHC OPERATIONS

Because local priorities and contexts vary across jurisdictions, the operation of MHCs varies substantially in each jurisdiction. Generally, there are two types of MHCs: (1) the pre-adjudication model, in which prosecution is deferred until the defendant completes the mutually agreed-upon program, and (2) the post-adjudication model, in which the defendant is required to submit a guilty plea to participate in the program. The split between the pre-adjudication and post-adjudication models within the 240 MHCs that exist today is unknown.[6]

MHCs also operate differently in terms of eligibility criteria. Largely, two types of eligibility criteria are considered: clinical eligibility and legal eligibility. Courts vary with respect to which mental health problems are acceptable for participation in MHC programs. Some MHCs use a legal definition of mental illness, whereas others specify a clinical definition, which often encompasses Axis I disorders, to establish program eligibility (Rossman et al. 2012). Legal eligibility typically defines what types of offenses are eligible for participation in MHC programs. Some MHCs accept more serious and violent cases, whereas others only accept non-violent misdemeanors.

In addition to those key functional variations, several aspects of MHCs create substantial variation in how they operate, including screening procedures, program services, court supervision and monitoring protocols, and the range of sanctions used for non-compliance. It would be of great significance to understand the extent to which these variations explain the effectiveness of MHCs. However, our current understanding of MHCs is rather limited in terms of its ability to inform how to optimize program settings for MHCs, let alone how much MHCs vary in terms of their focus, size, and operations.

C. EFFECTIVENESS OF MHCS

The popularity of MHCs in recent years has outgrown empirical evidence on their effectiveness. Our knowledge base around MHCs has steadily grown in recent years, but studies with a strong evaluation design are still rare. The effectiveness of any intervention can be assessed through a counterfactual question; that is, what outcomes would have been observed had MHC participants not participated in the MHC program? The most unequivocal way to answer this question is through a randomized controlled trial (RCT), in which study subjects are randomly allocated to receive treatment or no (or alternative) treatment. Because the random assignment, if implemented properly, ensures equivalence

between those who did and did not receive treatment, any difference in outcomes between the two groups can be attributed to treatment. We have identified only two RCT studies to date that evaluate the effectiveness of MHCs. Based on 50 individuals who received MHC treatment and 43 control individuals in Butte County, California, Gary Bess Associates (2004) found a statistically significant improvement in clinical outcomes for the treatment group but no measurable improvement in recidivism rates. Similarly, Cosden and her colleagues (2005) found no measurable difference in recidivism between 137 MHC participants and 98 nonparticipants in their RCT.

All other evaluations of MHCs that we identified rely on quasi-experimental or non-experimental designs. The research findings in these evaluations are less reliable because of the potential for selection bias, a threat to internal validity. Studies at risk for selection bias are those in which participants could have self-selected to participate in MHC treatment because of personal attributes and motivations. In other words, those who received treatment might show an improvement in outcomes not because of treatment effect but because they were more motivated to improve upon themselves in the first place than those in the comparison group. One notable quasi-experimental evaluation substantially minimizes this selection bias and presents plausible analyses of the impact of two MHCs on recidivism. Based on propensity score matching techniques, which mimic features of an RCT, Rossman and her colleagues (2012) examined the effectiveness of the Bronx and Brooklyn MHCs. They found that MHC participation was effective at reducing recidivism in both MHCs, although the degree of reduction in recidivism rates differed between the programs. Contrary to findings of the two RCT studies, those who participated in these MHC programs had significantly lower recidivism rates than nonparticipants by 6 to 17 percentage points.

When evaluations use weaker research designs that do not adequately address potential threats to validity, such as selection bias and attrition bias, they complicate our ability to interpret the results of existing research on MHCs. The extent to which MHCs improve clinical outcomes and reduce criminal recidivism can be explained by the efficacy of MHC programs, as well as the fidelity of treatment delivery. Put differently, when MHCs fail to yield an expected outcome, it could be the underlying MHC model that is not effective *or* the inadequate quality and manner in which the model was implemented. Poorly designed or executed evaluations make those differences difficult to discern because the failure to detect anticipated outcomes can also be attributed to methodological issues germane to such research designs.

In their meta-analyses examining empirical studies on the effectiveness of MHCs, Cross (2011) and Sarteschi, Vaughn, and Kim (2011) both recognize that the existing research on MHCs suffers from considerable methodological shortcomings. In particular, Sarteschi, Vaughn, and Kim (2011) remark

that most quasi-experimental evaluations did not use statistical controls for differences between MHC participants and nonparticipants. They also note that prior research lacks the external validity (i.e., generalizability) of research findings, because most studies were based on non-representative samples, and MHC models vary greatly.

Despite these challenges, the two meta-analyses suggest that MHCs can be a moderately effective intervention in reducing recidivism. Sarteschi, Vaughn, and Kim (2011) report that the overall mean effect for recidivism outcomes was statistically significant (effect size = −54.95, $p < .001$). Whether MHCs can improve clinical outcomes, however, remains to be seen. Most evaluations reviewed by Cross (2011) and Sarteschi, Vaughn, and Kim (2011) failed to detect a significant effect of MHC treatment on clinical outcomes. Griffin and Dematteo (2009) also suggest that the mixed evidence on the efficacy of MHCs does not provide a clear indication of whether the provision of MHC treatment leads to measureable reductions in clinical symptoms. Overall, MHCs seem to be a promising approach to diverting mentally ill offenders from the criminal justice system, and the success of MHCs is cautiously suggested by several evaluation studies; however, again, further research is needed.

Other Criminal Justice Programs and Policies

Numerous mentally ill offenders do not qualify for diversionary programs at the pretrial or adjudication stage for a variety of different reasons, such as jurisdiction or type of crime. Thus, these men and women may find themselves in a local or state correctional facility, and if they do not receive adequate mental health treatment and discharge planning while incarcerated, their risk of recidivism may increase because they fall back into the revolving cycle of incarceration (Baillargeon et al. 2009; Mallik-Kane and Visher 2008; Walters 2005). We evaluated a number of studies that measure post-release outcomes for mentally ill offenders who participated in various programs while incarcerated and shortly after incarceration (see section III, “Data and Methodology,” for an explanation of the criteria for studies to be included in our analysis). A few programs and policies targeted toward mentally ill offenders stood out for having been rigorously evaluated and for demonstrating evidence of beneficial mental health and criminal justice outcomes for mentally ill offenders. Below, we describe these programs and policies, as well as their evaluative findings, followed by a discussion of more recent legislative policy reforms that may deserve careful attention for future research and practice.

A. RIGOROUSLY EVALUATED PROGRAMS

Given the high rates of recidivism in the United States,[7] offender reentry has garnered considerable attention from researchers and practitioners alike. Returning to the community from incarceration is an uphill battle for former prisoners, complicated by struggles with substance abuse, lack of adequate education and job skills, limited housing options, and mental health issues (Travis 2000). This situation gave rise to strategic system changes that involve developing an individualized reentry plan before release from incarceration and mobilizing an interdisciplinary, collaborative team approach to guiding returning prisoners through the reentry process (Baer et al. 2006; Mallik-Kane and Visher 2008). Much of what we found promising for mentally ill offenders can be understood within this reentry framework. Several programs that focus on multidisciplinary, collaborative planning and risk management have shown positive results.

One such program is the Mentally Ill Offender Community Transition Program (MIOCTP), which was implemented in 1998 in Washington state as a collaboration between the Department of Corrections and the Department of Mental Health. Under this program, corrections and mental health staff work together to provide mentally ill prisoners with care management and coordinated services, including risk assessment, treatment planning, service referrals, and applications for entitlements, before their release from state prison (Arnold-Williams, MacLean, and Vail 2008). MIOCTP aims to provide seriously mentally ill inmates with proper treatment and stabilization while they are in prison so they are able to transfer this stability to their lives outside the prison walls, thus reducing their risk of recidivism. The program defines serious mental illness as "a major thought or mood disorder that produces substantial distress, impairs normal functioning, and requires continuing treatment" (Theurer and Lovell 2008, p. 391). Candidates are referred to the program by mental health risk management specialists based on a variety of factors, including willingness to participate in the program, the presence of a major mental illness that influenced previous criminal activity, and a judgment by Department of Corrections staff that the individual would be less likely to recidivate if provided with ongoing mental health treatment (Theurer and Lovell 2008).

The post-release stage of the program takes a highly multidisciplinary approach, with a community-based team including a mental health case manager, psychiatrist, nurse practitioner, registered nurse, substance abuse counselor, community corrections officer, and residential house manager (Arnold-Williams, MacLean, and Vail 2008). This team works together to ensure that seriously mentally ill offenders continue their psychotherapy and pharmaceutical course of treatment; have access to housing, drug treatment, and other basic services; and report as required to their parole officers. The post-release program includes structured programming, access to daily contact with team members,

bimonthly home visits, and 24-hour crisis response plans. Housing subsidies and onsite housing management and monitoring are provided as part of the residential support services offered by the program (Theurer and Lovell 2008).

Based on a quasi-experimental design, Theurer and Lovell (2008) examined the effectiveness of this program, with a sample consisting of a high percentage of women (44 percent) and drug offenders (47 percent). Primary diagnoses among sample members included 56 percent with psychotic disorders, 20 percent with severe depression, 20 percent with bipolar disorder, and 3 percent with other conditions. Nearly 90 percent of the sample had co-occurring chemical dependency issues, and 52 percent suffered from a personality disorder. The treatment group was matched to a comparison group (N = 64 in each group) based on a number of factors, including past felonies, past misdemeanors, whether the individual was a first-time sex offender, infraction rate, mental health residential time, age at release, ethnicity, and gender. During a two-year follow-up period, program participants showed a recidivism rate of 19 percent, measured as felony conviction for any new offense, compared with 42 percent for matched controls.

Another notable multidisciplinary program, the Connections program, targets mentally ill probationers released from jail in San Diego, California. The Connections program is a case management initiative based on the principles of assertive community treatment, a model of intensive services that revolves around a multi-disciplinary team with 24-hour availability to clients in a non-institutional setting. The Connections program provides pre-release treatment planning, referrals to community-based services and mental health clinics, substance abuse monitoring and intervention, and coordinated involvement of family and partners in the reentry process (Council of State Governments 2012). Each program team consists of a social worker, a deputy probation officer, and a correctional deputy probation officer, and no team serves more than 30 clients at a time. After program clients have received services for nine months following their release, they are evaluated for discharge or continuation of services with a new probation officer from the program (Burke and Keaton 2004).

The effectiveness of this program was assessed through an RCT (Burke and Keaton 2004). All individuals in the study (N = 548) had a DSM-IV Axis I Psychiatric Diagnosis and a Global Assessment of Functioning Axis V score equal to or less than 50. The treatment group was 55 percent male and 45 percent female, and the control group was 63 percent male and 36 percent female. Both groups had a similar racial and ethnic makeup, and the only identified statistically significant difference between groups was age.

During the 12-month treatment phase, program participants were significantly less likely than nonparticipants to return to jail on a new charge, with 35 percent and 46 percent of each group returning, respectively ($p < .05$). The treatment group also spent significantly less time in jail on average than the control group (20.2 and 34.6 days, respectively; $p < .01$). This program impact continued even after treatment ended but decreased in size to a level that was not statistically significant. These findings are promising yet underscore the challenges involved in producing an enduring treatment effect on criminal behavior and mental health outcomes.

The final intervention we highlight is the Mental Health Services Continuum Program in California. Much like MIOCTP and the Connections program, MHSCP takes a multidisciplinary approach, including both social workers and parole officers, and delivering services both before and after release from state prison to parole. Within 90 days of a program participant's release, transitional case managers assess the inmate's mental health needs and send the assessment to the participant's parole officer. Then, within one week of the date of release (or three days for clients with more severe mental illnesses), the parolee attends a prescheduled appointment at a parole outpatient clinic, which ensures continuity of care for the client's mental health needs. All parolees with qualifying mental health issues have access to the parole outpatient clinics, but only those in the MHSCP program have an initial appointment scheduled by the care management program (Farabee et al. 2006).

Farabee and his colleagues (2006) conducted a quasi-experimental evaluation to assess the program impact of MHSCP for mentally ill parolees and found that the program had a beneficial effect on a number of post-release outcomes. Both the treatment group ($N = 32,322$) and the comparison group ($N = 28,590$) had diagnosed mental health problems and were eligible for pre-release assessments and the parole outpatient clinics, but the comparison group did not receive the pre-release assessments and service referrals. Key findings include that receiving a direct referral and assessment from the transitional case management program was associated with a higher rate of seeking treatment at the parole outpatient clinics and that attending parole outpatient clinics was in turn associated with lower recidivism rates over 12 months post-release.

In addition to underscoring the importance of continuity of care from pre-release to post-release stages through a multidisciplinary team, this program's success highlights the value of direct, structured referrals as opposed to mere eligibility for care in getting mentally ill ex-offenders the help they need. Once offenders with mental illness leave jail or prison, even if they remain on probation or parole, they may become overwhelmed by the stresses and challenges associated with reentry into society and lose track of treatment goals or ideations that they formed while receiving treatment within the highly

structured environment of prison. Thus, as this study demonstrates, it is helpful for them to be discharged with an already scheduled appointment at a comprehensive mental health treatment clinic.

B. POLICY EVALUATIONS

There are numerous policies pertaining to the treatment and management of mentally ill individuals involved in the criminal justice system. This report focuses on only those that have been subjected to rigorous evaluation. Below, we discuss two examples of such efforts that were found to reduce recidivism rates among mentally ill offenders as well as associated societal and economic costs. We then discuss several recent, notable policies that intersect with mental health and criminal justice issues.

First, the Washington state legislature created programs in the late 1990s to reduce recidivism among persons with mental illness after release from prison, including Washington's DMIO program, also referred to as the Community Integration Assistance Program, and encompassing the aforementioned MIOCTP. A series of these policy directives in Washington instructed staff from the Washington State Department of Social and Health Services, Department of Corrections, Regional Support Networks, and treatment providers to plan and deliver transitional support services to offenders classified as "dangerously mentally ill," with a goal of improving their access to community-based services post-release (Council of State Governments 2012; Lovell, Gagliardi, and Phipps 2005; Mayfield 2007). A number of evaluative assessments of the policy's effectiveness were embedded in the policy directives.

In particular, the Washington State Institute for Public Policy has conducted several evaluations over time of the DMIO program and found a beneficial program impact on the timing and extent of service receipt (Lovell 2007). Moreover, using a matched comparison group analysis, Mayfield (2009) reports that participation in the DMIO program is associated with significant decreases in felony recidivism and violent felony recidivism over a period of four years after release from prison. Furthermore, the study calculates the estimated benefits of the DMIO program by applying the reductions in recidivism attributable to the DMIO program to the lifetime distribution of criminal offenses expected from those released from prison. This cost-benefit analysis concludes that the state spends $33,866 (in 2007 dollars) per DMIO participant over four years and that the DMIO program returns $1.64 in benefits for every dollar spent.

Another policy that research has found to be effective is Medicaid enrollment at the time of jail release for offenders with severe mental illness. The policy has become common practice in a number of jurisdictions across the country (Koyanagi and Blasingame 2006; Morrissey 2004), but many others still do not typically offer eligible jail inmates the opportunity to apply for Medicaid before or at release. It is

important to understand that this discussion strictly refers to the policy of allowing mentally ill offenders to apply for Medicaid at release; it does not evaluate or recommend specific interventions that promote access to Medicaid or ease the enrollment process.

Morrissey (2004) employed a quasi-experimental design to assess the impact of Medicaid enrollment in two sites: Pinellas County, Florida, and King County, Washington.[8] The treatment groups in each jurisdiction were inmates diagnosed with severe mental illnesses who left jail with Medicaid benefits (N = 1,877 in Pinellas County; N = 3,346 in King County), and the comparison groups were inmates diagnosed with severe mental illnesses who were eligible for Medicaid but who left jail without benefits (N = 542 in Pinellas County; N = 1,843 in King County). Notably, Medicaid benefits and services vary in every state, and the study's findings apply only to individuals who enroll in Medicaid while in jail or retain their Medicaid benefits during their jail sentence, which is less likely for those serving longer sentences in prisons (Council on State Governments 2012). Thus, Morrissey (2004, v, 20) warns:

> Caution must…be exercised in drawing conclusions about state prison populations from the jail data reported here. What is generalizable to mentally ill prisoners from these data is that having Medicaid on the day of release will likely help them obtain needed services in the community just as they helped the jail detainees in this study.....What is not generalizable to prisons is the high rate of Medicaid enrollment at release for detainees with severe mental illness. Prisons are long stay institutions (the average length of incarceration for prisoners is over five years) so 100% of those who enter prison with Medicaid lose it before they are released....Jails, in contrast, are short stay institutions. Detainees in this study only spent an average of 16–32 days in jail so virtually all those with severe mental illness who had Medicaid at jail entry (about 65–78% in the two counties) also had it upon release. [Emphasis in original.]

With these cautions noted, the study found that accessing services through Medicaid significantly reduced jail detention among severely mentally ill offenders during a 12-month follow-up period.

New Bills Enacted in 2013

Rigorous evaluation of policies is scarce but much needed. It thus seems worth noting several recently enacted state bills that intersect criminal justice and mental health issues and deserve careful consideration for evaluation in future research. These legislative changes are discussed in a comprehensive state legislation report released by the National Alliance on Mental Illness (NAMI) at the end of 2013. We highlight those that could be effectively evaluated in the future to measure their potential to improve public safety and criminal justice outcomes.

A. PRE-CONVICTION AND COURT POLICIES

Most of the relevant legislation related to pre-conviction and court policies enacted in 2013 relates to either MHCs or the evaluation and processing of mentally ill defendants whose sanity or fitness to proceed is in question. In Arizona, House Bill 2310 institutes standards for the design, training, and procedures necessary to establish effective mental health courts in the state.[9] In its 2013 state legislation report, NAMI notes that this bill has notable promise to serve the interests of mentally ill individuals in the criminal justice system. Louisiana also enacted legislation authorizing mental health court treatment programs in 2013 (Senate Bill 71).[10]

Additionally, South Dakota, Oklahoma, and North Dakota all updated their policies with regard to clinical examinations and assessments of defendants whose sanity or capacity to proceed is in question. In South Dakota, Senate Bill 70 stipulates that magistrate and circuit court judges should be trained on behavioral health assessments, as well as other evidence-based principles.[11] Oklahoma's House Bill 1109 provides that after a person charged with a felony offense makes his or her initial court appearance, the individual may be required to submit to an approved mental health and substance abuse assessment, as well as a general risk assessment.[12] Finally, North Dakota's recently enacted House Bill 1116 effectively disallows human services centers from serving as the evaluators of a mentally ill defendant's fitness to proceed, unless an inquiry has already been made into the facility which confirmed that the facility has the appropriate resources to conduct the evaluation.[13]

Tennessee and North Carolina both enacted bills in 2013 that address the release of defendants who lack the mental capacity to proceed with trial. In North Carolina, the bill stipulates that the charges against a defendant who lacks the capacity to proceed should be dismissed as soon as the defendant has been held pending the regaining of his or her capacity for the maximum term of imprisonment or involuntary commitment. Before discharge from the custody of his or her incarceration or commitment, the defendant must be evaluated, and a report of that evaluation must be filed with the court (Senate Bill 45/House Bill 88).[14] In Tennessee, Senate Bill 180 and House Bill 174 set a time limit of 11 months and 29 days from the date of arrest on the amount of time any misdemeanor charge can remain pending against a defendant found incompetent to stand trial.[15]

B. SENTENCING AND INCARCERATION POLICIES

Two important bills were enacted in 2013 in Maine and North Carolina that relate to the processing of mentally ill offenders during sentencing and while incarcerated, and these legislative changes could affect recidivism rates and public safety. In Maine, Legislative Document 1433/HP 1022 instructs that an incarcerated person found not criminally responsible by reason of insanity for a second offense must

finish serving his or her current prison term before the commitment proceedings as part of the second offense can be commenced.[16] NAMI suggests that this legislation could pose potential threats to the interest of mentally ill offenders, presumably because it lengthens their time in prison and puts off their access to treatment under civil commitment (National Alliance on Mental Illness 2013).

North Carolina enacted Senate Bill 45/House Bill 88 in 2013,[17] which provides that a district or superior court judge who orders a clinical examination of a defendant at trial must also order the release of the defendant's confidential mental health records to the examiner to aid the examiner in the clinical assessment. The bill also revises the holding protocol for a defendant who lacks the capacity to proceed in court. Once the defendant has been held in any court-ordered confinement (including jail, prison, or involuntary commitment to an inpatient facility) for the maximum term of imprisonment permissible for a prior record Level VI for felonies or prior conviction Level II for misdemeanors (considering only the most serious offense charged), the court must dismiss the charges against that defendant and proceed according to standard procedures following dismissal of charges against defendants found unfit to proceed.

C. RELEASE, PROBATION, AND PAROLE POLICIES

A number of state bills were enacted in 2013 in the areas of release, probation, and parole for seriously mentally ill offenders who were either sentenced directly to probation or were released to probation or parole following a period of incarceration. In Montana, Senate Bill 11 and House Bill 68 were enacted to reduce recidivism rates among mentally ill ex-offenders.[18] Senate Bill 11 makes a number of revisions to the parole and probation systems to better serve mentally ill probationers and parolees, and House Bill 68 creates a pilot reentry task force and requires the Department of Corrections to consult with the task force to develop contracts with community-based organizations that provide mental health services to ex-offenders. The community-based organizations provide other services which are intended to reduce recidivism among mentally ill offenders as well, including substance abuse treatment, employment and housing services, general health care, and faith-based services.

In Nevada and Virginia, two bills were enacted that involve access to mentally ill offenders' medical records and evaluations related to their care. Nevada's Senate Bill 519 authorizes the state's Department of Corrections to apply for a determination of Medicaid eligibility on behalf of a currently incarcerated mentally ill offender.[19] This practice may have the potential to speed up the Medicaid application process of offenders upon their release. In Virginia, House Bill 2148/Senate Bill 1217 authorizes the Department of Corrections to exchange offenders' mental health records and reports with any local department of social services, including the Department for Aging and Rehabilitative

Services and the Department of Social Services, for reentry planning and coordination of post-release programs and services.[20]

V. Research and Policy Recommendations

In light of the findings discussed in this report, any definitive guidance on how to change the current practice and policy regarding mentally ill offenders and mitigate associated costs would be premature. With genuine interest in improving mental health and criminal justice outcomes, practitioners, policymakers, and researchers alike strive to understand issues related to the treatment and management of mentally ill offenders. New statutory changes and programs are implemented every year for offenders diagnosed with mental health issues to provide them with improved access to services and justice. However, existing knowledge on the effectiveness of such approaches is very limited. The scarcity of rigorous evaluation studies, further complicated by the mixed findings of these studies, prohibits a consensus on effective strategies and policy options, as well as the circumstances under which the impact of such strategies and policy options can be optimized. Much evaluative research is needed to inform sound policy and practice with a higher degree of certainty.

Nonetheless, our comprehensive review did uncover some important lessons that deserve careful consideration. Challenges of reintegrating into society have been well documented (Baer et al. 2006; Mallik-Kane and Visher 2008). Returning prisoners with mental illness will face exacerbated challenges if their needs for mental health services are not adequately addressed. In particular, the continuation of care from prison to community settings is a core principle of prisoner reentry (Baillargeon et al. 2009; Cloyes et al. 2010) and is critical for individuals with mental health issues. Given that many mentally ill individuals already have difficulty managing their basic needs without substantial distress (Theurer and Lovell 2008), it is important to ensure that offenders leaving prison are given structured guidance and support to maintain a healthy, crime-free lifestyle in the community. As suggested by Theurer and Lovell's evaluation of the MIOCTP, a multidisciplinary team approach can be potentially effective at mitigating such challenges, thereby reducing recidivism rates and associated societal and economic costs. Further, there is a great potential in expanding Medicaid eligibility and enrollment for this population. Implementation of the Affordable Care Act permits the expansion of Medicaid coverage to nearly all childless adults with incomes up to 138 percent of the federal poverty level (Kenney et al. 2012). Coverage will be extended to millions of low-income people, many of whom have been involved with the criminal justice system, in states that move forward with the expansion (Community Oriented Correctional Health Services 2011).

As evidenced by the sheer number of MHCs in operation in the United States today, another promising practice in the criminal justice system would be to expand diversion programs and mechanisms for mentally ill offenders. Social stigma for individuals with a criminal record can have a detrimental impact on subsequent criminal justice involvement, as well as on such individuals' well-being (Pager 2003; Weiman 2007; Western 2002). By facilitating early intervention and diverting mentally ill individuals from potentially harmful experiences in the criminal justice system, MHCs provide a practical platform to decrease the number of mentally ill offenders in correctional facilities while linking defendants to effective treatment and supports (Almquist and Dodd 2009).

Much of the debate over MHCs is not about whether we should promote diverting mentally ill offenders through MHCs but about how we can optimize settings and practices for MHCs. For example, little is known about what types of offenders should be focused on as a target population of MHC treatment. Future research should address the extent to which court settings, treatment programs, and offender profiles can contribute to the effectiveness of MHCs.

VI. Conclusion

The goals of this background analysis were to summarize and synthesize the state of mental health care for seriously mentally ill individuals in the criminal justice system, and to examine the societal and economic costs associated with recidivism and insufficient care for this population. Through a comprehensive scan of policy and practice at the state level and a rigorous review of national-level data and studies that focus on the processing of mentally ill defendants, we extracted estimates of the costs of managing and treating offenders with mental illness from a fractured body of research that requires significant expansion in quantity and rigor. The lack of reliable research on the incarceration of mentally ill defendants, as well as the paucity of cost-benefit analyses on this topic, is an important finding in and of itself.

We also reviewed a number of general policy recommendations, including the expansion of multidisciplinary treatment teams, continuity of care, and MHCs, as well as early Medicaid enrollment for incarcerated individuals with serious mental illness. New policies and practices for offenders with mental illness should be implemented and evaluated, and those few programs that have been shown to be successful through rigorous evaluation should be considered for expansion both in scope and in application as we move forward.

Although a number of important gaps in the current literature and, particularly, in rigorous quantitative evaluations of the success of programs and their costs have limited our ability to arrive at more concrete conclusions, the data remain clear about one thing: individuals with mental illness are still largely overrepresented in the criminal justice system. With such high numbers, their care and treatment is not just a humanitarian concern; it is a critical economic, societal, and public safety issue.

Appendix. Statutory Sources of Information

State	Source
Alabama	Ala. Code 1975 § 15-16-20, § 22-52-1.1
Alaska	AS § 12.47.070, § 12.47.130
Arizona	A.R.S. § 13-502, § 13-4503
Arkansas	A.C.A. § 5-2-301, 305
California	CA PENAL § 28, § 2962, § 4011.6
Colorado	C.R.S. 16-8-101, 101.5, 103.7, 106
Connecticut	C.G.S.A. § 54-56D, L
Delaware	Del. C. § 11-401 et seq.
District of Columbia	DC ST § 21-501, § 24-531.03, DC Code Ann. § 21-50
Florida	Fla. Stat. § 916.12, 106, 115, 145
Georgia	O.C.G.A. § 16-3-2, 17-7-130.1, 131, § 37-1-1
Hawaii	HRS § 334-1, § 704-404, Cor.10.1G.04
Idaho	Idaho Code § 18-207, 211, § 66-317
Illinois	§ 720 ILCS 5/6-2, 5/6-4, § 725 ILCS 5/104-13
Indiana	IC 12-7-2-117.6, 35-36-2-2
Iowa	Iowa Code § 229.1, § 701.4, § 812.3
Kansas	K.S.A. 22-3302, 59-2946
Kentucky	KRS § 431.2135, § 504.020, § 504.060, § 504.090
Louisiana	La. C.Cr.P. Art. 641, Art. 643, Art. 644, Art. 650, Art. 654
Maine	15 M.R.S. § 101-D, 17-A M.R.S. § 39
Maryland	Md. Crim. Proc. Code Ann. § 3-101, 105, 107, 109, 111
Massachusetts	ALM GL ch. 123 § 15-16, 123 App. § 1-1
Michigan	MCLS § 330.1400, § 768.20, § 768.21a, § 768.36
Minnesota	Minn. Stat. § 245.462, § 611.026; Minn. R. Crim. P. 20.01, P. 20.04
Mississippi	Miss. Code Ann. § 41-21-61, § 99-13-3, § 99-13-11
Missouri	R.S. Mo. § 552.010, § 552.020
Montana	MCA § 46-14-101 – 103
Nebraska	R.R.S. Neb. § 29-1823, § 71-908
Nevada	Nev. Rev. Stat. Ann. § 178.3985, § 178.415, § 178.455, § 194.010
New Hampshire	RSA 135-C:2, 135:17, 628:2
New Jersey	N.J. Stat. § 2C:4-1, § 2C:4-4, § 2C:4-5, § 30:4-27.2
New Mexico	N.M. Stat. Ann. § 24-7B-3, § 31-9-1.1, § 31-9-1.4
New York	NY CLS CPL § 220.15, § 330.20, § 730.20
North Carolina	N.C. Gen. Stat. § 15A-1001-1002, § 122C-3
North Dakota	N.D. 12.1-04.1, 25-03.1
Ohio	ORC Ann. 2901.21-22, 2945.371, 5119.01

State	Source
Oklahoma	22 Okl. St. § 152, 1161, 1175.3; 43A Okl. St. § 1-103
Oregon	ORS § 161.095, § 161.295, § 161.315, § 426.005
Pennsylvania	Pa. R. Crim. P. 569; 18 Pa.C.S. § 314-315; 42 Pa.C.S. § 9727
Rhode Island	R.I. Gen. Laws § 40.1-5.3-3, 4, 6
South Carolina	S.C. Code Ann. § 17-24-10, 20, 30, 40; § 44-22-10
South Dakota	S.D. Codified Laws § 23A-10-3, 4, 7, § 23A-10A-2, § 27A-1-1
Tennessee	Tenn. Code Ann. Tenn. Code Ann. § 33-1-101, § 39-11-301, 501, § 40-35-205
Texas	Tex. Code Crim. Proc. art. 16.22, art. 46B.001, art. 46C.051
Utah	Utah Code Ann. § 76-2-305, § 77-16a-103
Vermont	13 V.S.A. § 4801, 4814; 18 V.S.A. § 7101
Virginia	Va. Code Ann. § 19.2-168.1, 182.2, § 37.2-100
Washington	§ 10.77.010, 030, 060, 110, § 71.05.020
West Virginia	W. Va. Code § 27-1-2, § 27-6A-4
Wisconsin	Wis. Stat. § 51.01, § 971.15, 16
Wyoming	Wyo. Stat. § 7-11-301, 303, 304, § 25-10-101

Notes

1. In 1996, federal legislation mandated that the US Attorney General provide Congress with an independent review of the effectiveness of state and local crime prevention assistance programs funded by the US Department of Justice. In evaluating the scientific rigor of evaluations on such interventions, a cadre of researchers developed a standardized scoring system known as the Maryland Scientific Methods Scale, ranging from Level 1, referring to correlational analysis between a crime prevention program and crime at a single point in time, to Level 5, referring to causal analysis based on high-fidelity randomized controlled trials (Sherman et al. 1998). This scale (and its modified versions) has been used widely to screen for quality research in systematic reviews in the field of crime and criminal justice (e.g., Farrington 2003; Gill and Spriggs 2005).
2. *M'Naghten's Case,* 8 Eng. R. 718, [1843] UKHL J16 (19 June 1843), p. 200.
3. *Durham v. United States*, 214 F.2d 862 (1954), pp. 874-875.
4. See appendix for full list of state statutes cited in this section and in table 1.
5. The notion of therapeutic jurisprudence refers to ways in which the practice of the law can be used to support and enhance beneficial outcomes beyond the immediate case disposition (Wexler and Winick 1996). It thus seeks to achieve therapeutic outcomes through the legal system without compromising due process and other justice values. In other words, it aims to practice law in a way that supports the health and well-being of those being tried in a court of law (Rottman and Casey 1999).
6. A 2003 survey of 20 MHCs across the country reported that approximately half required a "guilty" or "no contest" plea to participate in the MHC program (Bernstein and Seltzer 2003).
7. BJS reports that among nearly 300,000 prisoners released in 15 states in 1994, 67.5 percent were rearrested within three years (Langan and Levin 2002).
8. Although the particular intervention of interest in Morrissey (2004) did not result from a policy change regarding the Medicaid eligibility of offenders, the expansion of Medicaid benefits among offenders is much discussed in the context of offender reentry and can be implemented through a policy reform.
9. An Act Relating to the Administrative Office of the Courts; Providing for Conditional Enactment, Arizona HB 2310, 51st legislature, 1st sess. (April 30, 2013).
10. Mental Health: Authorizes and Provides for Mental Health Courts, Louisiana SB 71, SLS 13RRS-311 (August 1, 2013).
11. An Act to Improve Public Safety, South Dakota SB 70, 88th sess. Legislative Assembly (2013).
12. Mental Health; Peer Recovery Support Specialists; Effective Date, Oklahoma HB 1109, 54th legislature, 1st sess. (May 24, 2013).
13. An Act to Amend and Reenact Section 12.1-04-06 of the North Dakota Century Code, Relating to an Evaluation to Determine a Defendant's Fitness to Proceed, North Dakota HB 1116, 63rd legislature (April 8, 2013).
14. An Act to Amend the Laws Governing Incapacity to Proceed, North Carolina SB 45/HB 88, Session Law 2013-18 (April 3, 2013).
15. An Act to Amend Tennessee Code Annotated, Title 33, Chapter 7, Part 3, Relative to Competency to Stand Trial Reports and Retirement of Misdemeanor Charges for Individuals Incompetent to Stand Trial, Tennessee SB 180/HB 174 (2013).
16. An Act to Amend the Laws Governing Mental Responsibility for Criminal Conduct, Maine Legislative Document 1433/HP 1022, 124th legislature, 1st sess., item 1 (April 23, 2013).
17. See note 14.

18. An Act Generally Revising Criminal Justice System Laws Related to Offenders with Mental Illness; Revising Requirements for Parole and Probation Officers and Members of the Board of Pardons and Parole; Revising Laws Related to Conditions of Release, Bail, and Parole of Offenders with Mental Illness; Revising the Definition of "Mental Disease or Defect"; Amending Sections 2-15-2302, 46-9-108, 46-9-301, 46-14-101, 46-23-201, and 46-23-1003, MCA; and Providing an Applicability Date, Montana SB 11, 63rd legislature (2013); An Act Establishing a Statewide Multiagency Reentry Task Force for Paroled Offenders at High Risk of Recidivism; Specifying Department of Corrections Duties; Providing an Appropriation; and Providing and Effective Date, Montana HB 68, 63rd legislature (2013).

19. An Act relating to Medicaid; Authorizing the Director of the Department of Corrections to Apply on Behalf of a Prisoner for a Determination of Medicaid Eligibility; and Providing Other Matters Properly Relating Thereto, Nevada SB 519 (May 24, 2013).

20. An Act to Amend and Reenact § 53.1-40.10 of the Code of Virginia, Relating to the Department of Corrections; Exchange of Medical Records with the Department of Aging and Rehabilitative Services and with Departments of Social Services, Virginia HB 2148/SB 1217 (2013).

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