



Public Defender Attitudes Toward People With Mental Disorders: Does Mental Health Court Practice Reduce Stigma?

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Public defender attitudes toward people with mental disorders: Does mental health court
practice reduce stigma?

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Abstract

This study investigated whether legal defense practice in mental health court reduced negative/stigmatizing attitudes and beliefs public defense attorneys may have toward people with mental disorders. The study hypothesized a lower level of negative/stigmatizing attitudes toward people with mental disorders in the sample of public defenders who had practiced in mental health courts as compared to public defenders who had never practiced in mental health court. Attitudes were measured by scores on the Community Attitudes Towards the Mentally Ill scale (“CAMI”) administered via an online survey. The survey also captured information about the participants’ demographic and professional characteristics.

No significant difference in CAMI scores was found between public defenders with experience in mental health court and public defenders with no such experience. The data did show that respondents who had received a mental health diagnosis, and/or whose family, friends or colleagues had received such a diagnosis, had fewer negative/stigmatizing attitudes towards people with mental disorders than respondents reporting no such mental health diagnosis. Similarly, respondents who had used mental health services of any kind, and/or whose family, friends or colleagues had used mental health services, also had fewer negative/stigmatizing attitudes. Female respondents had fewer negative/stigmatizing attitudes towards people with mental disorders than male respondents. No other demographic, training or employment factor had a significant impact on CAMI scores.

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Chapter I.

Introduction

Does legal defense practice in a mental health court reduce negative/stigmatizing attitudes and beliefs public defenders may have toward people with mental disorders? People with mental disorders are subjected to negative stereotyping and stigma in many arenas, and the criminal justice system is no exception. Law enforcement personnel, prosecutors, judges and even defense attorneys may have negative attitudes about, and display negative behavior toward, defendants with mental disorders (Perlin, 2000). This is of special concern because people with mental disorders are much more likely to be arrested, charged with a crime, and/or incarcerated than a person without a mental disorder (Burns, Hiday & Ray, 2013; Sarteschi, 2013). A recent development in criminal justice that may affect defense attorney attitudes is the proliferation across the US of mental health courts, special adjudication fora that divert defendants with mental disorders from criminal court into treatment. In mental health court, a team consisting of the judge, prosecutor, defense attorney, case manager and others, work together to connect defendants with mental disorders to community mental health treatment programs as an alternative to criminal penalties (Almquist & Dodd, 2009). Defendants with mental disorders participate more actively and directly in mental health court proceedings than in criminal court, often conversing directly with the judge instead of sitting silently while

their defense attorney speaks for them (Boothroyd, *et al.*, 2003; Lerner-Wren, 2002). Defense counsel in mental health court must protect their clients' rights as they do in criminal court, but their role is less adversarial and more collaborative as they work with the mental health court team toward treatment goals (Meekins, 2007).

Hypothesis

It was hypothesized that public defenders with experience in mental health court would have fewer negative/stigmatizing attitudes and beliefs about people with mental disabilities than public defenders without experience in mental health court. Public defenders with experience practicing in mental health court, unlike those who practice only in criminal court, have contact with defendants with mental disorders in an atmosphere that affirms positive expectations for these defendants to benefit from mental health treatment and empowers defendants with mental disabilities to participate in the proceedings (Corrigan & Blink, 2016; Ware, *et al.*, 2007).

This hypothesis was tested by a comparison of responses to online survey questions from public defenders who have practiced in mental health court, and those who have not, regarding attitudes and beliefs about people with mental disorders. The survey used The Community Attitudes Towards the Mentally Ill scale ("CAMI"), a validated, standardized tool which measures attitudes toward the mentally ill (Taylor & Dear, 1981), and also gathered demographic and professional characteristics that could influence attitudes toward people with mental disabilities.

Definitions

Mental Health Court: Mental health courts are specialized courts for defendants with one or more mental disorders that substitute a problem-solving model in place of traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals (Almquist & Dodd, 2009).

Mental Disorder: “Mental disorder” can be defined as a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013).

Serious Mental Illness: “Serious mental illness” refers to a mental disorder that extends to a functional impairment that substantially interferes with or limits one or more of the activities of daily living, such as self-care, household and financial management, and social, vocational and educational pursuits (Substance Abuse and Mental Health Services Administration, 2017a).

Public Defender: A “public defender” as used herein means a defense attorney appointed and paid by the government to represent an indigent criminal defendant who cannot afford to hire a private attorney, as required by the Fifth and Sixth Amendments to the US Constitution (Gideon v. Wainwright, 1963).

Stigma: “Stigma” refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses (President’s New Freedom Commission, 2003).

The Community Attitudes Towards the Mentally Ill Scale: Abbreviated herein as “CAMI,” a validated, standardized instrument measuring attitudes toward people with mental disorders (Taylor & Dear, 1981).

Background of the Problem

People with mental disorders have substantially higher arrest and incarceration rates compared to those of the general population (Burns, Hiday & Ray, 2013; Sarteschi, 2013) and are overrepresented in all detention conditions: in local jails awaiting trial, awaiting sentencing, awaiting competency hearings or serving short sentences, and in federal or state prisons after conviction. The US Department of Justice Bureau of Justice Statistics concluded, based on data in the 2004 Bureau of Justice Statistics Survey of Inmates in State and Federal Correctional Facilities and the 2002 Bureau of Justice Statistics Survey of Inmates in Local Jails, that 56% of state prisoners, 45% of federal prisoners, and 64% of jail detainees had “a mental health problem,” defined as a recent history (a clinical diagnosis or treatment by a mental health professional) or symptoms (based on criteria in the DSM-IV) of a mental health problem (James & Glaze, 2006). A more recent study of over 800 inmates in two jails in Maryland and three in New York found that 14.5% of male inmates and 31% of female inmates (females constitute approximately 12.9% of jail admissions) were diagnosed with serious mental illness, defined as major depressive disorder; depressive disorder not otherwise specified; bipolar

disorder I, II, and not otherwise specified; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder not otherwise specified (Steadman, *et al.*, 2009). The researchers noted that if post-traumatic stress disorder were included as a serious mental illness, these rates would climb to 17.1% of male inmates and 34.3% of female inmates. For comparison, the National Institute of Mental Health (2017) estimated the overall prevalence of serious mental illness among US adults in 2015 to be only 4.0% (3.0% among men and 5.0% among women).

The Eighth Amendment to the US Constitution guarantees detainees and prisoners the right to medical care (*Estelle v. Gamble*, 1976), including mental health care (*Brown v. Plata*, 2011). However, except when questions of legal competency are raised (and often not even then), many incarcerated defendants with mental disorders receive only minimal attention to their mental health conditions (Osher & Levine, 2005). The US Department of Justice Bureau of Justice Statistics reported that among those who had mental health problems, only 34% of state prisoners, 24% of federal prisoners and 17% of local jail inmates received mental health treatment after incarceration (James & Glaze, 2006). This lack of or poor treatment while in custody contributes to the risk of worsening symptoms due to the stress surrounding arrest and incarceration (Sarteschi, 2013). Worsening symptoms among defendants with mental disorders may contribute to, and be exacerbated by, longer incarceration periods as compared to defendants without mental illness. The Council of State Governments Justice Center found that New York inmates with mental illness remained incarcerated nearly twice as long as other inmates (Council of State Governments Justice Center, 2012; *see also* Torrey, *et al.*, 2010). Poor

re-entry services often leave defendants with mental disorders without social, medical or financial resources when they are released, while repeated incarcerations prevent the formation of community ties, employment opportunities (and associated health insurance benefits), and secure housing options – making future involvement with the criminal justice system even more likely (Almquist & Dodd, 2009).

Stigma and Criminal Justice

The overrepresentation of defendants with mental disorders in the criminal justice system is a result of complex and intersecting causes. Deinstitutionalization without corresponding community support may have resulted in the incarceration of many people with mental disorders who previously were or would have been hospitalized in residential mental health care facilities (Osher & Levine, 2005; Torrey, 2013). Drug-related arrests of defendants with mental disorders who have co-occurring substance use/abuse issues is also a factor (Almquist & Dodd, 2009); the US Department of Justice Bureau of Justice Statistics estimates approximately 74% of state prisoners and 76% of local jail inmates who had a mental health problem also met DSM-IV criteria for substance dependence or abuse (James & Glaze, 2006). But stigma and negative beliefs about people with mental disorders, especially exaggerated fears of dangerousness, also have relevance to criminal justice proceedings. Stigma can lead to criminalization of disconcerting or unappealing behaviors that pose no real threat to society, lackluster defense efforts and adjudication results that have more to do with a defendant's mental state than with the individual facts of the case or relevant law (Corrigan & Penn, 1999; Perlin, 2000).

Stigma surrounding mental disorders, especially with respect to serious mental

illnesses, is widespread throughout the US and other Western nations (President's New Freedom Commission, 2003; Corrigan & Penn, 1999). Goffman (1963), whose sociological theories about stigma formed the basis for much modern research on the topic, describes stigma as a discrediting attribute that reduces the stigmatized person to a lesser, discounted individual. Today, stigma has taken on psychological dimensions as well, and generally refers to a cluster of negative attitudes and beliefs, often unfair or unfounded, that motivate the fear, rejection, avoidance, and discrimination against a disparaged group of people. Link and Phelan (2001) postulate that initiation of the stigma-forming process begins with identifying and/or labeling differences that are socially relevant, such as mental health status. Goffman (1963) distinguished between "discredited" groups whose socially relevant differences are relatively easy to identify, like race or gender, and "discreditable" groups whose characteristics, such as mental disorders, may be less readily observable. For the latter groups, labeling (including diagnoses) may serve to identify differences. When negative traits are linked to identified and/or labeled socially relevant differences, damaging stereotypes are created leading to the stigmatized group experiencing loss of status, segregation and discrimination (Link & Phelan, 2001).

Stigma is a broad concept that encompasses several variations. The term "public stigma" refers to the general population's negative attitudes about and resulting discriminatory behavior toward people with mental disabilities (Corrigan & Blink, 2016), while "structural stigma" refers to the policies of private or government institutions that intentionally or unintentionally restrict opportunities of people with mental disorders (Corrigan & Blink, 2016). Two concepts of stigma from the point of view of the

stigmatized person or group have also been identified: “perceived stigma,” which occurs when a person with a mental disorder recognizes negative attitudes emanating from others, and “self-stigma,” when a person with a mental disorder internalizes these perceived attitudes and begins to believe them about him or herself (Corrigan *et al.*, 2014).

Mental disorders certainly may be accompanied by symptoms which inhibit social functioning. But stereotypes and stigma may be as detrimental to the lives of people with mental disorders as the direct effects of their disorders, contributing to negative outcomes in health care, housing, employment, social engagement, and within the criminal justice system (Corrigan, 2004; Corrigan & Penn, 1999). Common stereotypes about people with mental disorders include the belief that they are to blame for their illness and/or do not try hard enough to recover; the belief that anyone with a mental disorder is generally incompetent and incapable of independent living and decision-making; and, especially relevant to criminal justice, the belief that people with mental disorders are dangerous, unpredictable and violent (*see* Corrigan, 2004; Perlin, 2000).

These negative attitudes have persisted over time despite progress in treatment, disability rights advocacy, and anti-stigma efforts (Pescosolido, *et al.*, 2013). One study compared over 300 responses from a 1950 survey with over 600 responses to similar questions posed in 1996 and found that three indicators of perceived dangerousness did not decrease over the period, but rather showed a significant increase: the percentage of respondents associating violence with mental illness rose from 7.2% to 12.1% ($p < .05$); the mean number of times respondents mentioned an association of non-violent yet frightening behaviors with mental illness rose from .23 to .31 ($p < .05$); and the

percentage of respondents associating mental illness with violent psychosis rose from 6.8% in 1950 to 12.4% in 1996 ($p < .01$) (Phelan, *et al.*, 2000). Several of the same researchers revisited the issue more recently and found that the percentage of respondents who endorsed a belief that people with mental illness were likely to be violent toward others increased from 54% in 1996 to 60% in 2006; the study found no significant decrease in any stigma indicator measured during this period (Pescosolido, *et al.*, 2010).

The association between mental illness and dangerousness is difficult to measure (see Corrigan & Watson, 2005; Desmarais, *et al.*, 2014; Elbogen & Johnson, 2009; Grann, Danesh & Fazel, 2008; Johnson, *et al.*, 2016) and politically controversial. Corrigan & Watson (2005) analyzed a 5,865 survey subset of data from the over 8,000 surveys collected from the National Comorbidity Study (a congressionally-mandated survey designed to study the comorbidity of substance use and non-substance use disorders in the US between 1990 and 1992) and found that while the risk of violence among people with mental disorders is between two to ten times greater than the general public depending on diagnosis, demographic characteristics such as age, gender and ethnicity were significantly better predictors of violence than mental illness alone. The researchers concluded that the association between mental disorders and violence in the community was weak (Corrigan & Watson, 2005). Elbogen and Johnson (2009) analyzed 34,653 surveys collected as part of the National Epidemiologic Survey on Alcohol and Related Conditions (conducted under the auspices of the National Institutes of Health) between 2001 and 2005 to examine whether mental disorders predict future violent behavior. The researchers found that a lifetime diagnosis of "severe mental illness" alone did not rank among the strongest predictors of violent behavior in the sample. While the

incidence of violence was higher for people with a diagnosis of severe mental illness at some point in their lives, this was true only for those with co-occurring substance abuse and/or dependence. Further, future violence was more strongly associated with historical, clinical, demographic, and contextual factors than with mental illness alone (Elbogen & Johnson, 2009). More recently, researchers using the same data but different statistical tests found that people with a past year diagnosis of severe mental illness, irrespective of substance abuse status, were significantly more likely to be violent than those with no mental or substance use disorders, although people with comorbid mental and substance use disorders had the highest risk of violence (Van Dorn, Volavka & Johnson, 2012). Another study found that among a sample of almost 5,000 Swedish criminal offenders who were assessed by a psychiatrist between 1988 and 2001, and followed up for five years, only substance use disorders and personality disorders related to recidivism risk, with hazard ratios for violent offending approximately double in individuals diagnosed with either of these disorders. However, diagnostic information on these mental disorders provided minimal additional predictive value beyond that provided by widely accepted predictors of age, sex and criminal history (Gran, Dinesh & Fazel, 2008).

While these studies may reveal nuances in the complex - and arguably weak - connection between mental disorders and dangerousness, few people derive their beliefs on the topic from scholarly research. The popular press continues to disproportionately attribute violence to mental disorders in a manner that reinforces fear and stigma according to researchers at the Johns Hopkins Bloomberg School of Public Health who analyzed over 400 print and television news stories covering mental health issues between 1995 and 2014. The study found that 55 percent of these stories linked violence

to mental disorders, with 38 percent of those mentioning violence against others, 29 percent mentioning suicide and only eight percent noting that most people with mental disorders rarely if ever commit violent acts against others (McGinty, *et al.*, 2016).

Because of the generally acknowledged detrimental effects of stigma, and the persistence of negative attitudes toward people with mental disorders, a range of stigma reduction efforts have been introduced. Interventions include advocacy and protest against discrimination; education efforts which attempt to replace erroneous negative beliefs with factual information; and increase of contact between people with mental disorders and those without. Protest initiatives generally highlight the injustice of stigma and chastise or condemn offenders for objectionable attitudes (Corrigan & Bink, 2016). Educational efforts, including public service announcements, challenge inaccurate stereotypes about mental disorders and seek to replace them with factual information (Substance Abuse and Mental Health Services Administration, 2006). Contact initiatives may involve in-person interaction or video programming where a person with a mental disability talks openly about their challenges and abilities (Watson & Corrigan, 2005). Effectiveness of anti-stigma efforts are difficult to discern, but a 2012 meta-analysis of 72 outcome studies from 14 countries reported some generalizable findings (Corrigan, *et al.*, 2012). This analysis found that protest efforts did not significantly improve stigmatizing attitudes, but were somewhat effective in changing behaviors and pressuring media outlets and others to change negative portrayals and language. The study also reported that education efforts had a small effect in improving attitudes and behavioral intentions (.286; $p < .001$), as did contact programs (in-person and video) (.282; $p < .001$). Examining contact programs further, however, the researchers found that among adults,

in-person contact yielded a significantly greater change than any other intervention studied, with a moderate effect size of .516 ($p < .01$) compared with .155 ($p < .05$) for video-only programs (*see also* Watson & Corrigan, 2005). Corrigan and Blink (2016) reported several components that seemed to improve the stigma-reducing effects of interpersonal contact: the contact situation should be non-competitive, participants ideally should be of similar social status and person with mental disability should not be too different from the stereotype held or the label-challenging effect could be neutralized. Ware (2007) noted that attention to abilities, competencies and successful community integration of people with mental disabilities may offer some promise in combatting stigma over traditional efforts, and Corrigan & Blink (2016) suggest that anti-stigma efforts aimed at reducing negative stereotypes should also be balanced with efforts to increase affirmative attitudes and positive expectations that people with mental disabilities can improve, recover and/or make independent life choices.

Celebrity self-disclosure of mental disorders may not be "contact" or "education" *per se*, but in today's media-saturated climate, many mental health advocacy organizations encourage and/or honor public figures who "come out" about their struggles with mental disorders to raise awareness and arguably reduce stigma. For example, Substance Abuse and Mental Health Services Administration "Voice Award" winners are often television and film performers, and the U.K. mental health non-profit "Heads Together" has garnered enormous exposure due to public support from the royal family and Prince Harry's disclosure of his emotional struggles in the wake of Princess Diana's death. Scholarly research regarding the stigma-reducing effects of celebrity self-disclosure is limited, but one study of female undergraduates found that the use of

celebrity interviews as narratives to teach about mental illness in a college abnormal psychology course resulted in reduced stigma toward mental illness and help-seeking as compared to non-celebrity narratives (Ferrari, 2016).

Mental Health Courts

As policy makers, criminal justice professionals and mental health advocates reach consensus that incarceration is an expensive and anti-therapeutic way to deal with many defendants with mental disorders, especially those who repeatedly cycle through the criminal justice system (Steadman, *et al.*, 2009), a variety of interventions have been suggested. One rapidly proliferating response to the overrepresentation of people with mental disorders in jails and prisons has been the establishment of mental health courts as alternative adjudication fora. Since the first mental health court was established in Florida in 1997, almost 350 adult mental health courts have been created across the US (Goodale, Callahan & Steadman, 2013; Substance Abuse and Mental Health Services Administration, 2016). Broadly defined, a mental health court is a specialized courtroom for certain defendants with mental disorders, handled by a particular judge, with a primary goal of redirecting defendants with mental disorders from the correctional system into treatment. Qualifying offenders with mental disorders voluntarily agree to court-mandated treatment programs in exchange for dismissal or reduction of criminal charges. Mental health courts are “problem solving” courts in that they attempt to address mental illness as a contributing element of criminal behavior in an effort to diminish future criminality.

Recent research on the effectiveness of mental health courts indicates that

completion of mental health court programs reduces recidivism among defendants with mental disorders (Burns, Hiday & Ray, 2013; Goodale, Callahan & Steadman, 2013; Sarteschi, *et al.*, 2011). A 2011 multi-court study comparing mental health court participants before and after enrollment, as well as with a comparison group of defendants in criminal court, found that mental health court participants had 38% fewer arrests in the 18 months after enrollment than before enrollment; the comparison group had a 23% reduction in arrests in the same 18-month period. The mental health court participants also had a significantly smaller increase (12% increase) in jail days in the 18-month post-enrollment period than the criminal court comparison group (105% increase) (Steadman, *et al.*, 2011). Research also suggests that mental health court participation increases access to and utilization of mental health care; for example, a comparison of mental health court participants in Florida with matched defendants in misdemeanor court found the use of mental health services by defendants with mental disorders whose cases were heard in mental health court increased significantly during the eight months following entry into the program (from 36% to 53%), while the use of services among defendants with mental disorders in the comparison court did not change (Boothroyd, *et al.*, 2003; *see also* Sarteschi, *et al.*, 2011).

Most jurisdictions that establish mental health courts have primary goals of reduced recidivism, lower corrections costs and improved mental health treatment for defendants with mental disorders. But mental health courts are also supported by progressive legal theories that incorporate anti-stigma agendas. In the early 1990s, around the same time that the first mental health courts were established, the concept of “Therapeutic Jurisprudence” was developing (Wexler, 1992). Therapeutic jurisprudence,

which recognizes that the law can have therapeutic or anti-therapeutic effects on participants, urges that a positive therapeutic effect should be an active goal of all involved, provided that defendants' due process rights and society's safety interests remain protected (Johnston, 2012). Therapeutic jurisprudence is often mentioned explicitly as a foundation for mental health court policies. An example of therapeutic jurisprudence at work in the mental health court context is the judges' use of reintegrative shaming (condemning unacceptable behavior while demonstrating respect and forgiveness to the defendant) as opposed to stigmatizing shaming (condemning unacceptable behavior while demonstrating disapproval of the defendant and labeling them as bad or deviant) (Dollar & Ray, 2015). Dollar and Ray cite reintegrative shaming as an element of mental health court success in reducing recidivism and improving treatment compliance. Therapeutic jurisprudence theory also suggests that when a defendant publicly agrees to treatment and life change in mental health court, they may be more likely to adhere to treatment (Wexler, 2008). The voluntariness of a defendant's entry into mental health court, and reduction of the perceived coercion of mandated treatment (Polythress, *et al.*, 2002), may also have a positive result; perceived coercion may lead to what social scientists call "reactance," or behavior that is contrary to the intent of the coercion (Corrigan, 2002).

Another legal theory that may support mental health courts as anti-stigmatizing institutions is that of "Procedural Justice." Procedural justice suggests that satisfaction with legal or clinical interactions is determined more by the process than the outcome (Kopelovich, *et al.*, 2013). Adults who experience stigma have been found to be less compliant with recommended mental health care and prescribed medications (Sirey, *et*

al., 2001; Smith & Cashwell, 2011), and members of a stigmatized group, such as defendants with mental disorders, may be especially sensitive to procedural justice issues (Kopelovich, *et al.*, 2013). A defendant's experience of being "heard" and treated with respect, dignity and concern by a decision-maker or authority figure increases the perception of fairness and may improve cooperation with legal outcomes (Lind & Tyler, 1988), which in the mental health court context includes treatment compliance.

Defendant satisfaction with mental health court outcomes has been linked to procedural justice dimensions such as "voice" and "respectful treatment by authority" (Poythress, *et al.*, 2002). Unlike criminal court, where the defendant will usually remain silent while the attorneys, judge and perhaps jury discuss the facts, law and determine the outcome of a case, in mental health court the defendant is an active participant. First, by voluntarily accepting diversion into the mental health court, then as a vocal presence in the proceeding, the defendant has an opportunity to assert their individuality, explain their situation and life story, often in direct conversation with the ultimate legal authority, the judge (*see*, Lerner-Wren, 2002). In a Florida mental health court, researchers observed that hearings were essentially a dialogue between the judge, who accounted for 47% of the courtroom utterances and defendants, who accounted for 33% (Boorthroyd, *et al.*, 2003). In addition, the mental health court team, by working with defendants to facilitate treatment instead of incarceration, implicitly and explicitly expresses optimism that the defendant will improve and is capable of living safely in the community. In this process, the defendant's human dignity and agency, despite their mental health and legal problems, is acknowledged (Perlin, 2013).

It should be noted, particularly when considering issues of stigma, that a defendant must assert or admit that they have a mental disorder to become eligible for diversion into mental health court. Tyuse & Linhorst (2005) argue that mental health courts thus increase the labeling and stigmatization of defendants individually, and more generally increase the stigmatization of all defendants with mental disorders by formalizing a connection between mental disorders and criminality. However, other researchers report reduced self-stigma and other benefits of openly discussing mental health issues have been demonstrated (Watson & Corrigan, 2005) and proponents of mental health courts argue that they in fact de-couple, rather than connect, mental disorders and criminality (Perlin, 2013). Judge Ginger Lerner-Wren explicitly cited stigma reduction among her goals in establishing and presiding over the first US mental health court (2002).

Public Defender Attitudes

Scientific literature addressing attorney attitudes toward people with mental disorders is sparse. One survey of 255 attorneys found that 43% of public defenders and 47% of private defense attorneys would rather represent defendants who do not have mental illness, suggesting that stigma could affect the degree of advocacy defendants with mental disorders receive (Frierson, *et al.*, 2015). However, the survey also found that attorneys (including defense attorneys, prosecutors and judges) with more than six cases involving defendants with mental disorders were *less* opposed to working with defendants with mental disorders, leading the study authors to conclude that attitudes toward clients with mental disorders became more positive with increased exposure to

such clients (Frierson, *et al.*, 2015). Legal scholar Michael Perlin (2000) has written extensively about what he calls “sanism,” *i.e.*, an irrational prejudice against people with mental disabilities, based upon stereotype, myth, superstition, and de-individualization, in the context of criminal justice. Perlin argues that sanism taints jurisprudence and lawyering practices, and that attorneys share many of the same negative attitudes toward defendants with mental disorders as the general public.

Despite the paucity of research, it is not unreasonable to speculate that stigmatizing beliefs about people with mental disorders are held by many criminal defense attorneys; perhaps a notional parallel can be drawn between attitudes of defense attorneys and attitudes of mental health care providers (sometimes called “provider stigma” or “provider-based stigma”).

Provider stigma is viewed as a serious barrier to treatment-seeking (President’s New Freedom Commission, 2003) and therefore has been studied widely. While contact (and education to a lesser extent) has been found to reduce stigma among the general public, research on attitudes among mental health care professionals reveal persistent negative beliefs about and behaviors toward their clients (Hinshaw & Stier, 2008), despite high levels of knowledge about mental disorders and frequent interpersonal contact with people with mental disorders. A survey of over 1,000 Swiss mental health professionals found that stigma attitudes regarding dangerousness did not differ between the general public and health care professionals (Lauber, *et al.*, 2006). In the US, a survey of over 306 clinical psychologists throughout the US and found that the respondents considered clients with borderline features 39% more dangerous than the general public and people with schizophrenia 24% more dangerous than the general

public, and respondents rated people with borderline features and schizophrenia more than three times more dangerous than themselves (Servais & Saunders, 2007).

Researchers have hypothesized various reasons why this counter-intuitive provider stigma may develop. Mental health care training may inadvertently encourage rigid distinctions between expert and client, resulting in de-identification with and negative attitudes toward people with mental disorders (Servais & Saunders, 2007). Some have suggested that provider stigma arises from feelings of helplessness and futility among mental health professionals who may not receive adequate support and validation for their work (Smith & Cashwell, 2011), and may themselves be victims of “associative stigma” by working with a stigmatized population (Verhaeghe & Bracke, 2012).

Professional burnout, which can result in pessimistic or even cynical views of clients’ prognosis, has also been suggested as contributing to the development of provider stigma (Henderson, *et al.*, 2014). Importantly, mental health care providers’ contact with people with mental illness is of a different nature than that of the general public. Health care providers often have the greatest contact with their clients at points of high symptom levels and/or low treatment compliance, which may confirm stereotypes instead of challenging them (Reinke *et al.*, 2004). Finally, even with high levels of contact and training, mental health care providers are still subject to the same influences that produce stigma as any other person, including negative portrayals in mass news and entertainment media (Schulze, 2007).

Many of the factors suggested as contributing to provider stigma also may be present among public defenders. Public defenders are likely to encounter a high proportion of defendants with mental disorders in their practice as compared with private

attorneys (Frierson, *et al.*, 2015). A study conducted by the US Department of Justice Bureau of Justice Statistics on indigent defense reported that over 80% of defendants in large US state court systems utilize public defenders (Smith & DeFrancis, 1996), and a recent study found that 94% of the participants in the Bronx mental health court relied on public defenders (Rossman *et al.*, 2012). Add to this the long-recognized association between poverty and mental disorders (Hudson, 2005), confirmed by recent data from the Substance Abuse and Mental Health Services Administration (2013) showing the percentage of adults with any mental illness (26.8%) and serious mental illness (7.2%) was highest among people living below the federal poverty level. Despite a lack of reported national data, these factors taken together suggested that public defenders will come into frequent contact with defendants with mental disorders.

Like mental health care providers, public defenders are recipients of prevailing negative myths and attitudes about people with mental disorders that circulate among the general public (Perlin, 2000). While public defenders may or may not have special training in mental health issues, they, similarly to mental health care providers, are likely to have significant contact with people with mental disorders in their practice, but this contact may be of a nature as to confirm and reinforce negative stereotypes instead of challenging them. Like mental health care providers, public defenders' contact with people with mental disorders is most frequent when these individuals may be "at their worst," with high symptom levels and under stress from arrest and/or incarceration. In addition, contact with the criminal justice system resulting in the need for a defense attorney and/or indigence resulting in the need for a public defender, may themselves re-confirm fears of dangerousness and incorrigibility. Defendants with mental disorders who

are recidivists and/or whose symptoms worsen over repeated encounters may create a cynicism or pessimism among public defenders that there is little hope for improvement or recovery, leaving attorneys feeling that their work is essentially futile. This, combined with heavy workloads and relatively low pay could also lead to professional burnout and the resulting frustration with or resentment toward clients with mental disorders that has been noted among mental health care professionals. Like mental health care providers, attorneys who defend people with mental disorders may suffer associative stigma, and be faced with suspicion instead of support for their efforts to achieve acquittals or lesser penalties for their clients. The negative reaction public defenders perceive from the public and their peers could result in antipathy and even hostility toward clients with mental disorders. Attorneys and mental health care providers both have an ethical duty to serve the best interests of their clients, but both are also often in positions of professional, social and economic power relative to their clients, which may foster stigma (Link & Phelan, 2001) and undermine the stigma-reducing benefits of contact (Corrigan, *et al.*, 2002). Like mental health care providers, attorneys may de-identify with their clients who have mental disorders and set themselves apart as professional experts, reluctant or unable to see their clients as anything but “other” or “lesser.”

Corrigan (2002) proposes three criteria that allow for more positive attitudes among health care providers toward people with mental disorders - a focus on recovery rather than poor prognosis; replacing coercive treatment with collaboration; and support for community based services - which may also be applicable to improving public defender attitudes. All three of these elements are present in mental health court, perhaps allowing a public defender practicing in mental health court to develop less stigmatizing

attitudes than a public defender practicing in criminal court. In mental health court, defense attorneys may see their clients recidivate less and comply with treatment more, witness and adopt the respectful, affirming attitudes and behaviors toward defendants with mental disorders modeled by the mental health court judge, experience the positive effects of therapeutic jurisprudence and procedural justice, and observe the empowerment of their clients to participate actively in life and treatment goals despite their mental disorders.

Therefore, it was hypothesized that public defenders who have practiced in mental health courts would report lower levels of negative, stigmatizing attitudes toward people with mental disorders, as compared with public defenders without mental health court experience

Chapter II.

Method

This study measured and compared the attitudes toward people with mental disorders among public defense attorneys who have experience practicing in mental health courts and public defenders without such experience. Information regarding demographic characteristics, length of defense practice, and level of training in, and personal experience with, mental health issues was also gathered. The study was conducted using an online survey administered via Survey Monkey. The target sample was 100 participants, 50 participants who had mental health court experience and 50 participants who did not. Participants were recruited through emailed requests for participation containing a link to the survey.

Participants

Attorneys admitted to practice law in the United States who represent or have represented indigent defendants in criminal matters within a jurisdiction that has a mental health court, whether they practiced in the mental health court or not, were eligible to participate in the study.

A total of 283 participants submitted surveys. Six participants did not confirm eligibility and ten participants did not consent to participate; these participants exited the survey before completion. 267 eligible participants agreed to participate in the survey and continued to the questionnaires. After data cleaning to exclude any participants who did

not complete the CAMI portion of the survey, 258 usable surveys were analyzed. Of the 258 usable surveys, 162 (62.79%) participants reported experience representing clients in mental health court and 96 (37.21%) reported no experience in mental health court.

Jurisdictions with mental health courts were identified through the Substance Abuse and Mental Health Services Administration's online database (Substance Abuse and Mental Health Services Administration, 2017). Potentially eligible participants and their e-mail contact information were identified through professional and academic contacts and internet research.

Participants were solicited through a request for participation (Appendix I) containing a link to the survey delivered via e-mail. The Request for Participation identified the researcher, stated the name of the study, the purpose of the study, participant eligibility requirements, the voluntary nature of the study, and option to withdraw from the study at any time without penalty. Potential participants were informed that upon survey completion they would have an opportunity to provide an e-mail address (not linked to survey responses) to receive a \$10 Amazon gift card and entry into a drawing to win an Apple iPad. Potential participants were directed to click, or copy into their browser, a link to access the survey.

Due to practical considerations, the sample collected for this study does not represent a true randomized sample of eligible public defenders. Because potential participants were difficult to identify and/or obtain e-mail contact information for, the request for participation encouraged recipients to forward the e-mail to colleagues whom they thought might be eligible. In addition, the request for participation was sent to professional contacts (judges and prosecutors, for example) who were not eligible

themselves to participate but expressed a willingness to forward the request to public defenders whom they believed eligible. This non-probability “snowball” sampling may have contributed to the vast percentage of respondents (79.77%) reporting they worked in “large urban” jurisdictions rather than rural or suburban jurisdictions, although the comparative density of public defenders working in large cities and the greater likelihood of a mental health court being established in more densely populated areas may also be factors. Although the request for participation or survey itself did not mention mental health courts other than as an eligibility requirement, more responses were collected from public defenders who had practiced in mental health court (62.79%) than those who had no mental health court experience (37.21%). This may be another result of the “snowball” sample, or may reflect a greater interest in mental health issues among public defenders with experience in mental health court.

Measures

The survey used in this study (Appendix III) consisted of four parts. The first portion of the survey, entitled “Introduction to the Study, Eligibility and Consent” explained the survey purpose, identified researcher and IRB contact information, stated the voluntary nature of the survey and asked participants to confirm eligibility. The second portion of the survey, entitled “Participation Consent” asked the participant to confirm voluntary consent to participate in the study. The third portion of the survey, entitled “Demographic and Participant Background” consisted of 15 questions aimed to collect demographic, personal and professional characteristics, special training in or personal experience with mental health issues and similar questions, and a question

asking participants to confirm whether or not they had ever represented a client in mental health court. These questions were answered by selecting options from drop-down menus. No open-ended questions were included.

The fourth part of the survey, entitled “Attitudes Toward People with Mental Disorders” was based upon the CAMI (Dear & Taylor, 1979) (Appendix V), a standardized tool which measures community attitudes toward the mentally ill. Written permission was received from S. Martin Taylor and Michael Dear to utilize the CAMI scale in this study (Appendix VI). Dr. Taylor provided the CAMI scale, scoring key, and the paper asserting the validity tests of the scale (Taylor & Dear, 1981). With the approval of the Harvard IRB, the CAMI was modified to reflect current language usage, for example, the phrase “the mentally ill” from the original CAMI has been changed to “people with mental disorders,” and gender pronouns/assumptions have been modernized.

The CAMI is a self-report survey consisting of 40 items including four sub-scales of ten items each, measuring the following factors: Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. “Authoritarianism” implies that people with mental illness are inferior and require coercive handling by others. “Benevolence” evidences a kindly and sympathetic attitude toward people with mental illness. “Social Restrictiveness” implies endorsement of limits on behaviors and activities of people with mental illness such as marriage, having children and other civil liberties. Lastly, “Community Mental Health Ideology” reflects attitudes toward mental health services provided within one’s community. Five items in each subscale are positively worded and five are negatively worded. Each item asked for the respondent’s

agreement with declarative statements on a five-point scale: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree which were numerically coded in accordance with the key provided by the scale developer (Appendix V). Scores range from 10-50 on each subscale, with 30 indicating a neutral attitude. Scores higher than 30 on the Authoritarian and Social Restrictiveness subscales indicate more negative/stigmatizing attitudes toward people with mental disabilities, while scores higher than 30 on the Benevolence and Community Mental Health Ideology indicate more positive/less stigmatizing attitudes. To reach an overall score on the CAMI, the scores of the Benevolence and Community Mental Health Ideology sub-scales are subtracted from the scores from the Authoritarianism and Social Restrictiveness subscales (Masuda *et al.*, 2007), resulting in possible overall CAMI scores of -80 to 80, with higher scores being indicative of more negative/stigmatizing attitudes.

Procedure

All data were collected through an online survey administered via SurveyMonkey. The study was conducted entirely online and was open for seven days, from April 19, 2017 until April 25, 2017. After collection and cleaning, data were uploaded to the statistical software program GNU-PSPP for analysis. This is a free data analysis software developed by GNU.

Data Collection

Prior to the data collection, the proposed study was granted “exempt” status by Institutional Review Board (IRB) of Harvard University (See Appendix II). The surveys

were conducted exclusively online via SurveyMonkey. In accordance with IRB requirements, no personal identifying information was collected from participants, and the survey responses were not linked to the contact information used to deliver incentives. The data collected were initially stored through SurveyMonkey. Later, they were downloaded and transferred for analysis to PSPP, an open source free statistical analysis application licensed to GNU through the Free Software Foundation. The data were transferred to a password-protected computer.

A pilot test with five volunteers (two attorneys and three law students) was conducted to ensure that the purpose of the study, criteria for eligibility, instructions for the study, and required information and disclaimers were expressed clearly, to ensure the questionnaire could be completed within approximately 10-15 minutes, and to eliminate potential technical problems with the link connecting participants to the survey on SurveyMonkey. Based on feedback from pilot testing, minor modifications were made to make navigation easier and faster, and to make it more clear that incentive delivery e-mail addresses could not be connected with survey responses. The modified survey was re-piloted with seven additional law student volunteers, and typical time required to complete the modified survey was under ten minutes. Volunteers reported they would feel comfortable entering an e-mail address for incentive delivery without concern that e-mail addresses could be associated with their survey responses.

A link to the modified survey was created and included in the request for participation letter (See Appendix I). Participants who clicked the link in the request for participation or copied and pasted into their browser were directed to the study's SurveyMonkey page. The entire survey questionnaire is included as Appendix III (see

also Measures section above). Each participant was asked to confirm that they meet the eligibility requirements for participation, i.e., that they were an attorney licensed to practice law in the United States who had represented indigent defendants in criminal matters within a jurisdiction that has established a mental health court. If eligibility was not confirmed, the survey closed with a thank you message. If eligibility was confirmed, a page requiring consent to participate opened. Participants were asked to confirm that whether they agreed, or did not agree to participate in the study. If agreement to participate was not confirmed, the survey closed with a thank you message. If agreement to participate was confirmed, the survey questionnaire opened.

Time spent on the survey ranged from 14 seconds to eight hours, seven minutes and 37 seconds. Eliminating outliers who spent less than 1 minute and more than 60 minutes, participants spent an average of seven minutes and 54 seconds completing the survey.

At the end of the survey, participants were prompted to click “Done” to complete the survey and access thank you gift options. After clicking “Done,” a message appeared asking whether participants wished to accept a \$10 Amazon gift card and entry into a drawing for an Apple iPad. If gifts were declined, the survey closed with a thank you message. If gifts were accepted, the survey internally closed and a new incentive survey (Appendix IV), unconnected to the main survey responses, opened and prompted participants to enter an e-mail address for delivery of the incentives. 220 participants elected to receive the incentives and entered their e-mail address and 41 declined the incentives. Most incentives were delivered within 12 hours to encourage participants to forward the request for participation and increase “snowballing.” After the survey was

closed, one participant who had elected to receive incentive gifts was randomly selected to receive an Apple iPad. The selected participant was given the choice to have an iPad purchased (\$358.20 including tax) and shipped to them (which required a name and shipping address), have an Apple Store gift certificate or an Amazon gift certificate in the amount of \$360 emailed to them at their previously supplied email. The winner selected to receive an Amazon gift card.

The survey collection was closed at 9am on April 25. If recipients of the request for participation clicked the survey link after this time, they would be directed to a SurveyMonkey page stating that the survey was closed.

Data Analysis

Data were analyzed using PSPP version 3 statistical software. It is a free, open source software licensed under GNU General Public License through the Free Software Foundation. PSPP does not have an official acronymic expansion, but has been in use since the 1990s and is often suggested as an alternative to IBM-SPSS for introductory and basic statistics.

CAMI scores (see Measures section above) for each participant were calculated and inferential statistical analysis was conducted to compare the CAMI scores of both groups and test the central hypothesis of this study: that mental health court practice alters attitudes, in a positive way, toward people with mental disorders. Further statistical analysis explored the relationship of additional survey data such as demographics, training, or personal experience with mental illness to the CAMI and subscale scores for

the entire sample, as well as within and between the Mental Health Court sample and No
Mental Health Court sample.

Chapter II.

Results

The final sample included 258 usable surveys, with 162 (62.79%) participants reporting experience representing clients in mental health court (hereafter referred to as the Mental Health Court sample) and 96 (37.21%) reporting no experience in mental health court (hereafter referred to as the No Mental Health Court sample). The demographic details of the sample are shown in Table 1.

The total sample consisted of 158 females (61.24%), 98 males (37.98%), with one respondent selecting “other” and one respondent choosing not to answer the gender question. The sample was somewhat skewed toward female respondents.

One hundred nineteen respondents (46.12%) were between 25 and 35 years old, 61 (23.64%) were between 36 and 45 years old, 40 (15.50%) were between 46 and 55 years old, 27 (10.47%) were between 56 and 65 years old, with nine older than 65. Two respondents declined to supply an age range.

One hundred eight respondents (41.86%) had been in practice from zero to five years, 44 respondents (17.05%) had been in practice from six to ten years, 23 respondents (8.91%) had been in practice from 11 to 15 years, 26 respondents (10.08%) had been in practice from 16 to 20 years, 18 respondents (6.98%) had been in practice from 21 to 25 years, 39 respondents (15.12%) had been in practice 26 years and above.

Table 1

Select Demographic Characteristics of Entire Sample (Percentage)

Characteristic	Answer Category	Entire Sample (N=258)	Mental Health Court (N=162)	No Mental Health Court (N=96)
Gender	Male	37.98	37.04	39.58
	Female	61.24	61.73	60.42
Age	25-35 years	46.12	39.51	57.29
	36-45 years	23.64	25.31	20.83
	46-55 years	15.50	18.52	10.42
	56-65 years	10.47	11.11	9.38
	6 years and over	3.49	4.32	2.08
Years in Practice	0-5years	41.86	33.95	55.21
	6-10 years	17.05	17.28	16.67
	11-15 years	8.91	11.11	5.21
	16-20 years	10.08	12.96	5.21
	21-25 years	6.98	9.26	3.13
	26 years and above	15.12	15.43	14.58
Employment at current job	0-5years	49.61	41.98	62.50
	6-10 years	18.60	19.75	16.67
	11-15 years	10.08	12.96	5.21
	16-20 years	7.75	9.88	4.17
	21-25 years	4.65	4.94	4.17
	26 years and above	9.30	10.49	7.29
Percentage client with mental health issues	0-20%	18.99	17.90	20.83
	21-40%	41.86	42.59	40.63
	41-60%	24.03	23.46	25.00
	61-80%	9.69	9.26	10.42
	More than 80%	5.04	6.17	3.13
Jurisdiction	Rural	4.65	5.56	3.13
	Suburban	14.73	16.67	11.46
	Large urban	79.46	75.93	85.42
Special training	Yes	53.49	46.91	45.83
	No	46.51	53.09	54.17

One hundred twenty-eight respondents (49.61%) had been in their current job from zero to five years, 48 respondents (18.60 %) had been in their current job from six to ten years, 26 respondents (10.08%) had been in their current job from 11 to 15 years, 20 respondents (7.75%) had been in their current job from 16 to 20 years, 12 respondents (4.65%) had been in their current job from 21 to 25 years, 24 respondents (9.30%) had been in their current job 26 years and above. With almost half the respondents being between 25 and 35 years old, in practice from zero to five years, and in their current job from zero to five years, the sample is relatively young and reflects relatively short professional legal experience.

When asked about training in mental health issues, only 138, slightly more than half (53.49%), stated they had received some form of specialized training (Figure 1), with most such training consisting of undergraduate courses or seminars or workshops. Very little continuing legal education, graduate level work, or employer-sponsored training was noted.

Forty-nine respondents (18.99%) estimated that between zero and 20 percent of their clients had a diagnosed mental disorder other than or in addition to substance use/abuse disorders, 108 respondents (41.86%) estimated that between 21 and 40 percent of their clients had such a diagnosed mental disorder, 62 respondents (24.03%) estimated that between 41 and 60 percent of their clients had such a diagnosed mental disorder, 25 respondents (9.69%) estimated that between 61 and 80 percent of their clients had such a diagnosed mental disorder, while 13 respondents (5.04%) reported more than 80 percent of their clients had a diagnosed mental disorder.

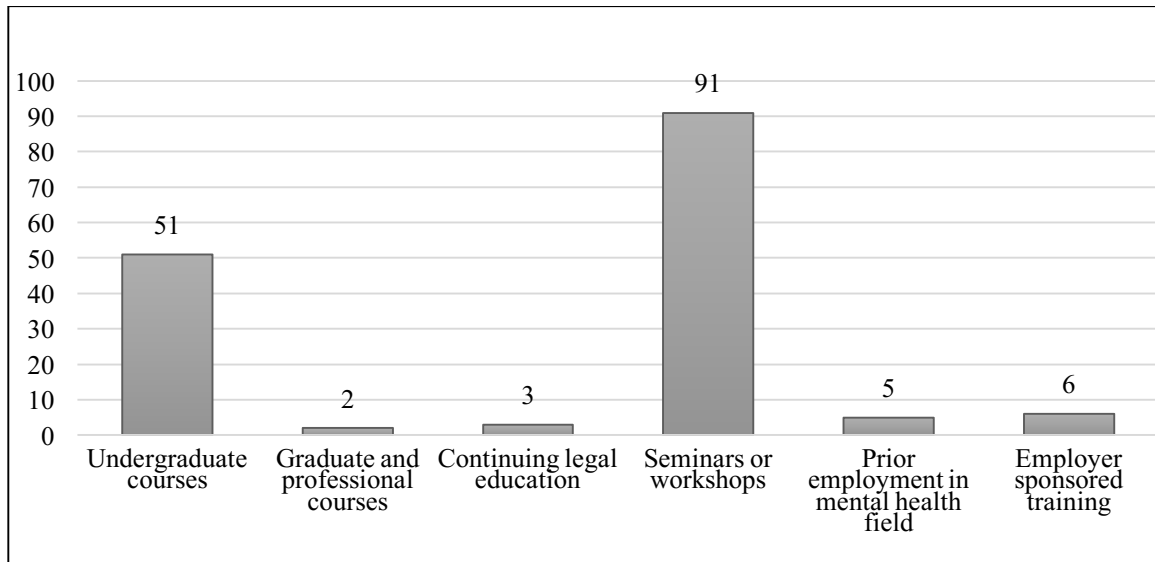


Figure 1. Frequency Distribution of Mental Health Training

This is consistent with existing literature estimating that approximately 64% of jail detainees (where many defendants await criminal adjudication) had “a mental health problem,” defined as a recent history (a clinical diagnosis or treatment by a mental health professional) or symptoms (based on criteria in the DSM-IV) of a mental health problem (James & Glaze, 2006). However, it was surprising in that more than half the respondents in the current study estimated that fewer than half their clients had a mental disorder; it was expected that public defenders would have a higher percentage of clients with mental disorders (Hudson, 2005; Rossman *et al.*, 2012, Substance Abuse and Mental Health Services Administration, 2013). Perhaps the literature reflects public defender representation of both diagnosed and undiagnosed mental disorders while the survey asked respondents to estimate only diagnosed mental disorders. Further, since the survey sample skewed young with relatively short professional histories, respondents may not

have accumulated enough experience to reach the expected higher proportion of clients with mental disorders.

Twelve respondents (4.65%) reported working in a rural jurisdiction, 38 (14.73%) suburban, while the vast majority - 205 respondents (79.77%) - reported working in a large urban jurisdiction. Two respondents chose not to answer and one respondent skipped the jurisdiction question. Although at first glance this seems consistent with U.S. Census Bureau estimates that 80.7% of the U.S. population lives in urban areas (U.S. Census Bureau, 2010), the Census Bureau does not have a "suburban" classification making a comparison with this study's data impossible. Other analysts have estimated that 26% percent of Americans describe where they live as urban, 53% suburban and 21% rural (Kolko, 2015). Using these figures, this study's sample is heavily skewed toward urban jurisdictions as compared to the U.S. general population, perhaps a result of snowball sampling.

Among the No Mental Health Court sample (N=96), the data showed that 91% (N=87) had not had an opportunity to practice in mental health court. There were only seven respondents (7.29%) who chose not to represent clients in mental health court, and two respondents did not answer the question. Since the vast majority of the No Mental Health Court sample reported never having an opportunity to practice in mental health court, it is unlikely that they had avoided or rejected such an opportunity. However, it is possible that No Mental Health Court respondents who did not have an opportunity to work in mental health court chose jobs or positions that they knew would not involve mental health court practice.

Twenty-one percent of respondents had personal experience with a mental health

diagnosis for themselves (Figure 2). The National Institute of Mental Health (2017a) estimates that for 2015, the overall prevalence of any mental illness among US adults to be 17.9%. The higher prevalence in this study's sample can perhaps be attributed to the survey question which asked more generally if the respondent had "received a mental health diagnosis (other than or in addition to substance abuse/use disorders)" without limiting it to a diagnosis within the prior year. Since mental health can fluctuate over time, the lifetime occurrence rate would be higher than a prior-year occurrence rate. Based upon World Health Organization data (subtracting substance use or abuse disorders), the U.S. adult lifetime prevalence for mental disorders has been estimated at 32.8% as of age 75 (Kessler, *et al.*, 2007); this study's lower 21% estimate may be attributable to the young age skew of the sample.

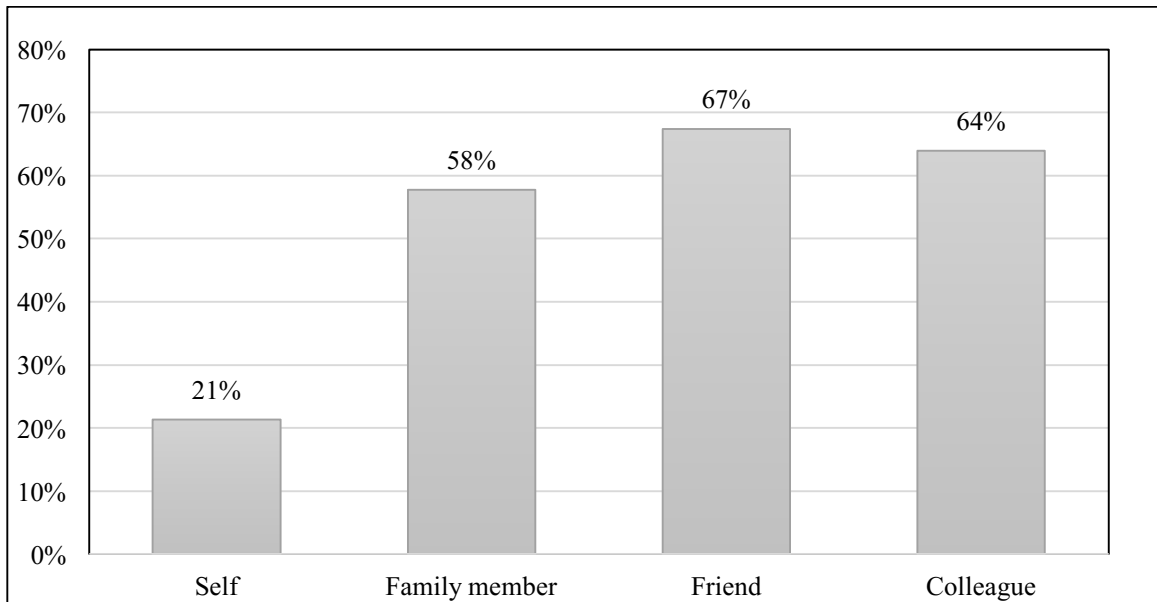


Figure 2. Frequency Distribution for Mental Health Diagnosis

More than half of respondents reported a mental health diagnosis for family (58%), friends (67%) or colleagues (64%) (Figure 2). An even higher percentage reported use of mental health services of any kind by themselves (42.25%), by family (62.79%), friends (72.09%) or colleagues (65.89%) (Figure 3).

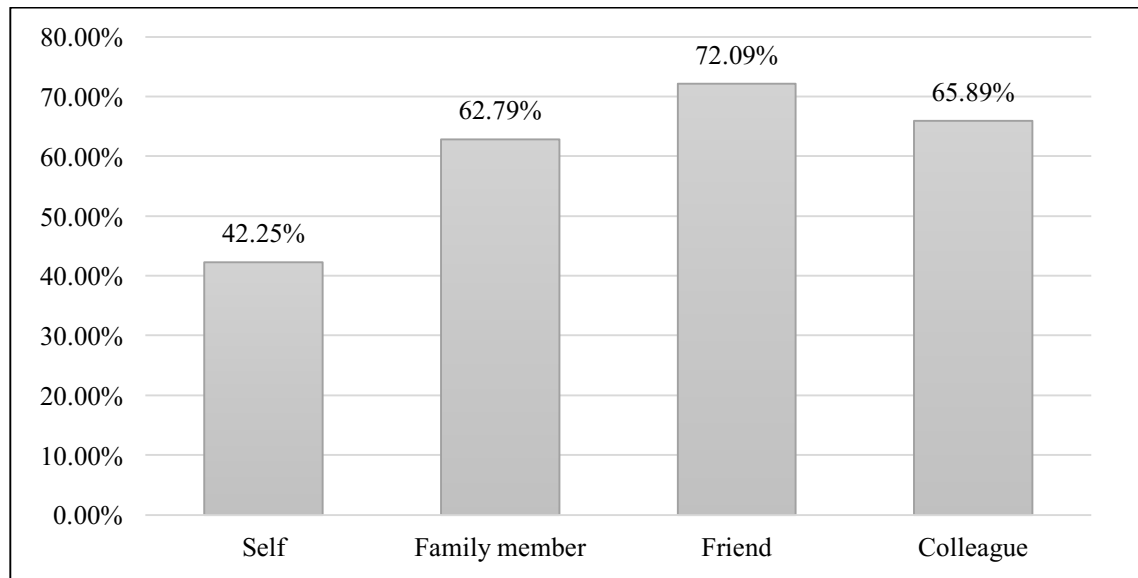


Figure 3. Frequency Distribution for Use of Mental Health Service

Demographic Characteristic Ratios in Sample Groups

Chi-square tests (Table 2) revealed that the Mental Health sample and the No Mental Health Court sample showed comparable ratios for gender ($\chi^2(3) = 1.31, p = .728$), age ranges ($\chi^2(5) = 9.42, p = .093$), estimated percentage of clients with mental disorders ($\chi^2(5) = 2.18, p = .824$), special training in mental health issues ($\chi^2(1) = .03, p = .866$), personal ($\chi^2(1) = .64, p = .425$) or family ($\chi^2(1) = 2.10, p = .147$) mental disorder diagnosis or personal ($\chi^2(1) = .14, p = .707$) or family ($\chi^2(1) = .53, p = .468$) use of mental health services. The Mental Health sample and the No Mental Health Court sample had different ratios for ranges of years in practice ($\chi^2(5) = 15.75, p = .008$) and

ranges of years at current jobs ($\chi^2(5) = 12.30, p = .031$) (Table 2), with the Mental Health Group skewing toward more years in practice and more years at their current jobs than the No Mental Health Court group.

Table 2

Chi-Square Comparison of Group Characteristics

Variable	Chi Square	Conclusion
Gender	1.31 (0.728)	Group ratios same with respect to gender
Training	0.03(0.86)	Group ratios same with respect to training
Age Group	9.42 (0.09)	Group ratios same with respect to age group
Practice term	15.75(0.008)	Group ratios different with respect to practice term
Employment Term	12.30(0.031)	Group ratios different with respect to employment term
Percent client with mental health issues	2.18 (0.82)	Group ratios same with respect to estimated percent of clients with mental disorders
Jurisdiction	3.74(0.29)	Group ratios same with respect to jurisdiction.

CAMI and Subscale Scores

Attitudes towards people with mental disorders were assessed using the CAMI (Dear & Taylor, 1979) (Appendix V), a standardized, validated instrument. The CAMI is a self-report survey consisting of 40 items including four sub-scales of ten items each, measuring the following factors: Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. “Authoritarianism” implies that people with mental illness are inferior and require coercive handling by others. “Benevolence”

evidences a kindly and sympathetic attitude toward people with mental illness. “Social Restrictiveness” implies endorsement of limits on behaviors and activities of people with mental illness such as marriage, having children and other civil liberties. Lastly, “Community Mental Health Ideology” reflects attitudes toward mental health services provided within one’s community.

Scoring

Five items in each subscale are positively worded and five are negatively worded. Each item asked for the respondent’s agreement with declarative statements on a five-point scale: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree which were numerically coded in accordance with the key provided by the scale developer (see Appendix V). Scores range from 10-50 on each subscale, with 30 indicating a neutral attitude. Scores higher than 30 on the Authoritarian and Social Restrictiveness subscales indicate more negative/stigmatizing attitudes toward people with mental disabilities, while scores higher than 30 on the Benevolence and Community Mental Health Ideology indicate more positive/less stigmatizing attitudes.

To reach an overall score on the CAMI, the scores of the Benevolence and Community Mental Health Ideology subscales are subtracted from the scores from the Authoritarianism and Social Restrictiveness subscales (Masuda *et al.*, 2007) as follows:

$$\text{CAMI score} = (\text{Authoritarianism score} + \text{Social Restrictiveness score}) - (\text{Benevolence score} + \text{Community Mental Health score})$$

This calculation results in possible overall CAMI scores of -80 to 80:

$$\text{Maximum} = (100 (\text{Authoritarianism } 50 + \text{Social Restrictiveness } 50) - 20(\text{Benevolence } 10 + \text{Community Mental Health Ideology } 10)) = 80$$

$$\text{Minimum} = (20 (\text{Authoritarianism } 10 + \text{Social Restrictiveness } 10) - 100(\text{Benevolence } 50 + \text{Community Mental Health Ideology } 50)) = -80$$

Higher CAMI scores indicate a more negative/stigmatizing attitude, and lower CAMI scores indicate a more positive/less stigmatizing attitude, toward people with mental disorders.

Reliability

The alpha coefficients of three of the four CAMI subscales (Table 3) indicate high internal consistency reliability: Community Mental Health Ideology ($\alpha = .86$); Social Restrictiveness: ($\alpha = 0.77$); and Benevolence ($\alpha = 0.73$), while the coefficient for Authoritarianism is lower ($\alpha = 0.64$) but still indicates reliability.

In addition, as Table 3 reports, overall CAMI scores were positively correlated with Authoritarian ($r = 0.86, p = 0.00$) and Social Restrictiveness ($r = 0.91, p = 0.00$) subscale scores (for these subscales and the CAMI scale, a higher score indicates a more negative/stigmatizing attitude toward people with mental disorders) while overall CAMI scores were negatively correlated with Benevolence ($r = -0.84, p = 0.00$) and Community Mental Health Ideology ($r = -0.91, p = 0.00$) subscale scores (for these subscales, a higher score indicates a more positive/less stigmatizing attitude toward people with mental disorders). These correlations further support the reliability of the CAMI instrument.

Table 3

Cronbach's Alpha and Correlations for CAMI and Subscale Scores

	Cronbach's alpha	Correlation with CAMI score (alpha level = $p < 0.05$)
CAMI score		
Authoritarianism	0.64	0.86***
Benevolence	0.73	-0.84***
Social Restrictiveness	0.77	0.91***
Community Mental Health Ideology	0.86	-0.91***

Note: *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.01$

Mean CAMI and Subscale Scores

Table 4 displays mean CAMI and subscale scores for the entire study sample, the Mental Health Court sample and the No Mental Health Court sample. The differences are small among and between samples.

The overall CAMI scores for the entire sample ranged from -80 to 23, with a mean of -50.47 ($SD = 15.30$). The range and mean scores for each of the four subscales were: Authoritarianism scores ranged from 10 to 32 ($M = 17.58$, $SD = 3.91$), Benevolence scores ranged from 30 to 50 ($M = 45.23$, $SD = 3.69$), Social Restrictiveness scores ranged from 10 to 37 ($M = 17.80$, $SD = 4.29$), and Community Mental Health Ideology scores ranged from 16 to 50 ($M = 40.78$, $SD = 5.22$).

The CAMI scores of the Mental Health Court sample ranged from -78 to 23 ($M = -50.49$, $SD = 15.70$) and the range and mean scores for each of the four subscales for the

Table 4

Mean CAMI and Subscale Scores

Variable	Entire Sample	Mental Health Court Sample	No Mental Health Court Sample
CAMI Score	-50.47	-50.49	-50.42
Authoritarianism Score	17.58	17.66	17.45
Benevolence Score	45.23	45.14	45.38
Social Restrictiveness Score	17.80	17.71	17.97
Community Mental Health Ideology Score	40.78	40.96	40.47
N	258	162	96

Mental Health Court sample are: Authoritarianism ranged from 10 to 32 ($M = 17.66$, $SD = 4.05$), Benevolence ranged from 30 to 50 ($M = 45.14$, $SD = 3.75$), Social Restrictiveness ranged from 10 to 37 ($M = 17.71$, $SD = 4.44$), and Community Mental Health Ideology ranged from 16 to 50 ($M = 40.96$, $SD = 5.29$).

The CAMI scores of the No Mental Health Court sample ranged from -80 to -10 ($M = -50.42$, $SD = 14.67$) and range and mean scores for each of the four subscales for the No Mental Health Court sample were: Authoritarianism ranged from 10 to 28 ($M = 17.45$, $SD = 3.68$), Benevolence ranged from 37 to 50 ($M = 45.38$, $SD = 3.62$), Social Restrictiveness ranged from 10 to 32 ($M = 17.97$, $SD = 4.04$), and Community Mental Health Ideology ranged from 27 to 50 ($M = 40.47$, $SD = 5.12$).

Figure 4 through Figure 8 display the frequency distribution of CAMI and subscale scores for the entire study sample. The distribution of CAMI and subscale scores are all heavily skewed toward positive/less stigmatizing attitudes, with only two respondents (both in the Mental Health Court sample) scoring zero or above on the overall CAMI. Similar distributions were found in the CAMI and subscale scores for the Mental Health Court sample.

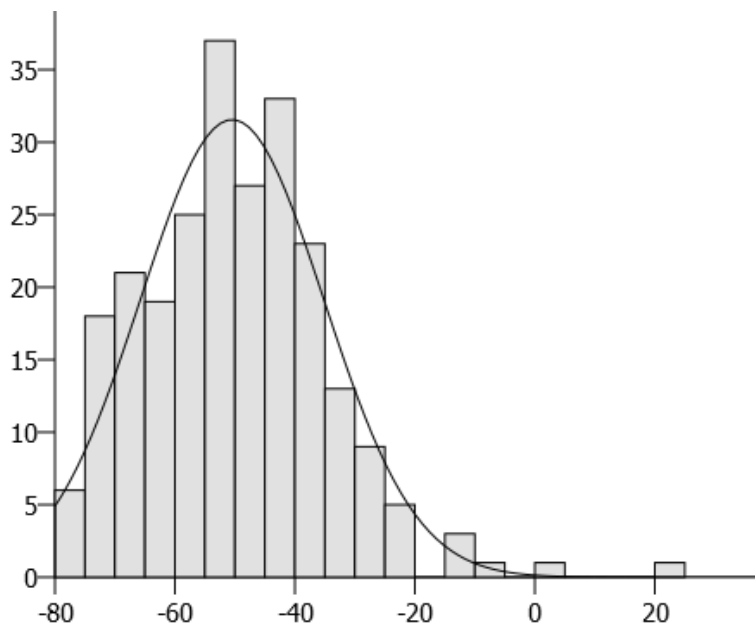


Figure 4. *Distribution of CAMI Scores.* Higher Scores indicate more negative attitudes

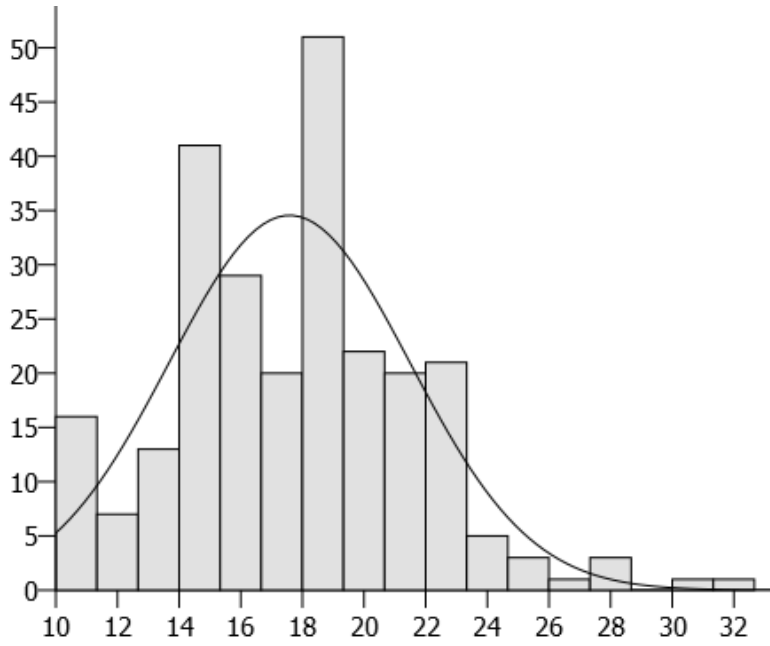


Figure 5. *Distribution of Authoritarianism Scores.* Higher Scores indicate more negative attitudes

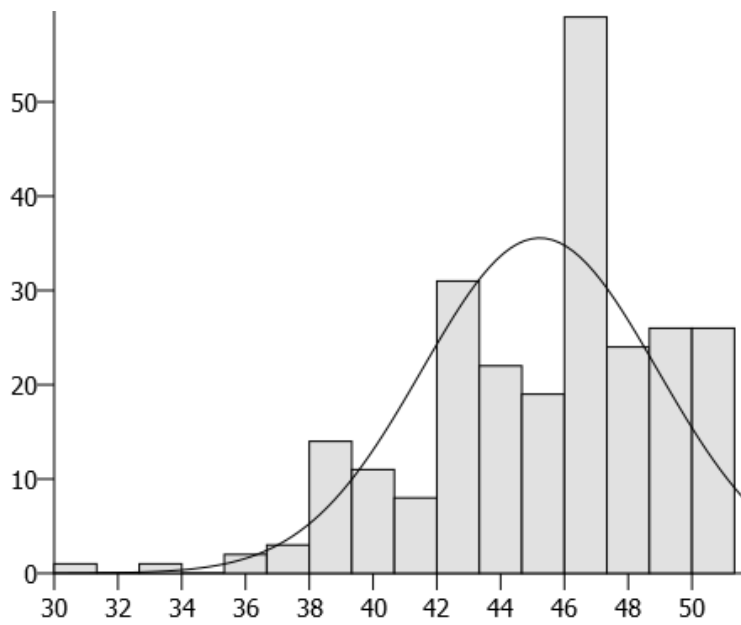


Figure 6. *Distribution of Benevolence Scores.* Lower Scores indicate more negative attitudes

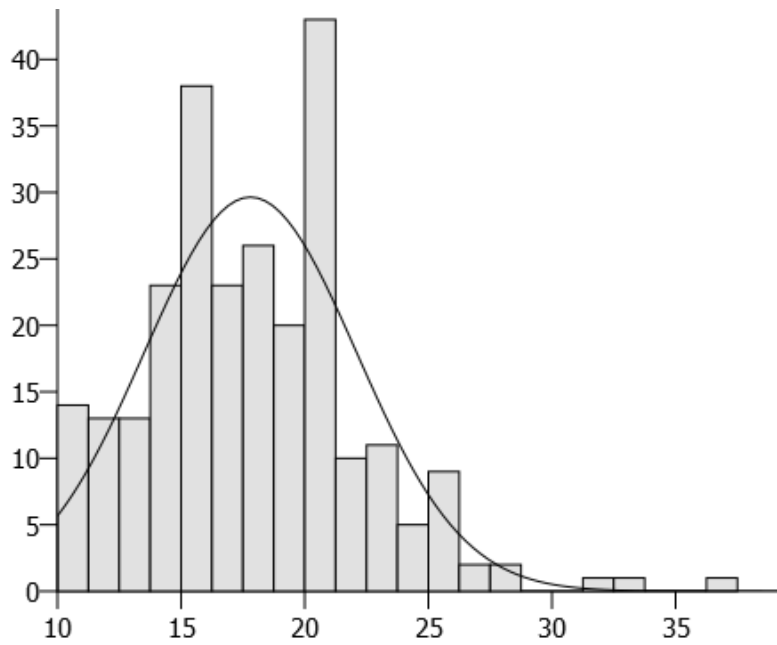


Figure 7. *Distribution of Social Restrictiveness Scores.* Higher Scores indicate more negative attitudes

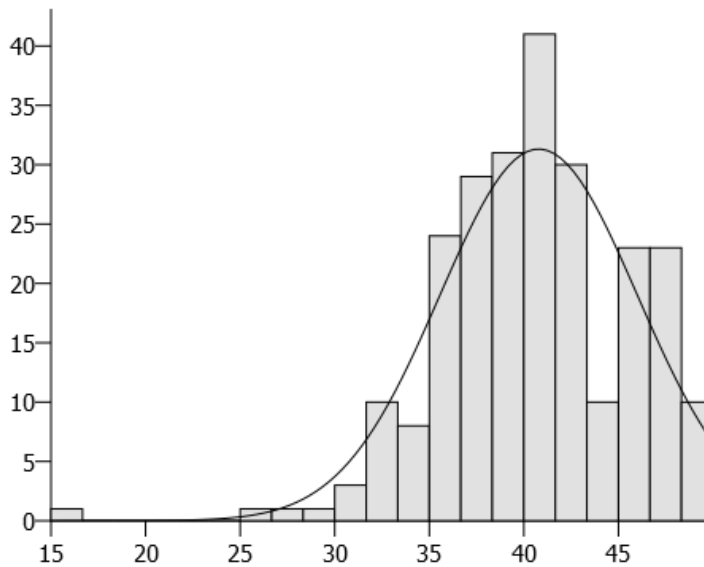


Figure 8. *Distribution of Community Mental Health Ideology Scores.* Lower Scores indicate more negative attitudes

Hypothesis Testing

The central hypothesis of the study was that practice in Mental Health Court would reduce negative/stigmatizing attitudes and beliefs among public defenders toward people with mental disorders. To test the hypothesis, the attitudes toward people with mental disorders, as measured by CAMI and subscale scores, of the Mental Health Court sample and the No Mental Health Court sample were compared (Table 5) using an independent samples t-test (Table 6).

Table 5

Comparison of Mean CAMI and Subscale Scores

Scale	Mental Health Court Experience	N	Mean	Standard Deviation	Standard Error of the Mean
CAMI	Yes	152	-50.49	15.70	1.27
	No	90	-50.42	14.67	1.55
Authoritarianism	Yes	160	17.66	4.05	.32
	No	94	17.45	3.68	.38
Benevolence	Yes	155	45.14	3.75	.30
	No	92	45.38	3.62	.38
Social Restrictiveness	Yes	160	17.71	4.44	.35
	No	95	17.97	4.04	.41
Community Mental Health Ideology	Yes	162	40.96	5.29	.42
	No	94	40.47	5.12	.53

The t-test results are reported on Table 6 and reveal no significant difference at $\alpha < .05$ in the mean CAMI scores ($MD = .07$) of the Mental Health Court sample ($M = -50.49, SD = 15.70$) and the No Mental Health Court sample; no significant difference in the mean Authoritarian subscale scores ($MD = -.22$) of the Mental Health Court sample ($M = 17.66, SD = 4.05$) and No Mental Health Court sample ($M = 17.45, SD = 3.68$), $t(252) = -.42, p = .672$; no significant difference in the mean Benevolence subscale scores ($MD = .24$) for the Mental Health Court sample ($M = 45.14, SD = 3.75$) and No Mental Health Court sample ($M = 45.38, SD = 3.62$), $t(245) = .50, p = .615$; no significant difference in mean Social Restrictiveness subscale scores ($MD = 1.46$) of the Mental Health Court sample ($M = 18.76, SD = 5.05$) and the No Mental Health Court sample ($M = 17.30, SD = 3.58$), $t(155.87) = 2.49, p = .014$; and no significant difference in mean

Table 6

T-Test results for CAMI and Subscale Scores for Mental Health Court and No Mental Health Court Samples

Scale	F	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
CAMI	.32	-.03	240.00	.972	-.07	2.04
Authoritarianism	.60	.42	252.00	.672	.22	.51
Benevolence	.03	-.50	245.00	.615	-.24	.49
Social Restrictiveness	1.72	-.47	253.00	.638	-.26	.56
Community Mental Health Ideology	.00	.73	254.00	.466	.49	.68

($M = -50.42, SD = 14.67$), $t(240) = .03, p = .07$

Community Mental Health Ideology subscale scores of the Mental Health Court sample ($M = 39.40, SD = 5.71$) and the No Mental Health Court sample ($M = 41.55, SD = 4.68$), $t(252.00) = -3.28, p = .001$.

The null hypothesis that there is no significant difference in the CAMI scores for the Mental Health Court sample and the No Mental Health Court sample could not be rejected. The main study hypothesis that the Mental Health Court sample would have less negative/stigmatizing attitudes toward people with mental disabilities was not proven.

Influence of Demographic and Professional Characteristics

One-way ANOVA and independent sample t-tests were performed to investigate the influence, if any, of the demographic/personal/professional demographic characteristics on CAMI and or subscale scores.

Gender

T-tests reported in Table 7 indicate a significant difference in the mean CAMI scores (MD = 7.03) of the male sample ($M = -46.03, SD = 17.33$) and female sample ($M = -53.06, SD = 12.99$), $t(161.65) = 3.38, p = .001$; a significant difference in the mean Authoritarian subscale scores (MD = 1.81) of the male sample ($M = 18.72, SD = 4.28$) and female sample ($M = 16.92, SD = 3.48$), $t(176.20) = 3.51, p = .001$; a significant difference in the mean Benevolence subscale scores (MD = -1.79) for the male sample ($M = 44.11, SD = 4.24$) and female sample ($M = 45.91, SD = 3.13$), $t(160.58) = -3.36, p = .001$; a significant difference in the mean Social Restrictiveness subscale scores (MD = 1.46) of the male sample ($M = 18.76, SD = 5.05$) and female sample ($M = 17.30, SD = 3.58$), $t(155.87) = 2.49, p = .014$; and a significant difference in mean Community Mental

Health Ideology subscale scores of the male sample (M = 39.40, SD = 5.71) and female sample (M = 41.55, SD = 4.68), $t(252.00) = -3.28, p = .001$.

These scores indicate that male respondents had more negative/stigmatizing attitudes toward people with mental disorders than female respondents. Supporting this conclusion, maleness was also found to have a significant positive correlation with CAMI scores ($r = .21, p = .001$) (see Table 10), indicating that men have more negative/stigmatizing attitudes toward people with mental disorders than women.

Table 7

Mean CAMI and Subscale Scores and t-test Results by Gender

	Gender	Frequency	Mean Score	t-test
CAMI score	Male	95	-46.03	3.38***
	Female	145	-53.06	
Authoritarian scale	Male	98	18.72	3.51***
	Female	154	16.92	
Benevolence scale	Male	96	44.11	-3.36***
	Female	149	45.91	
Social Restrictiveness scale	Male	97	18.76	2.49**
	Female	156	17.30	
Community Mental Health Ideology scale	Male	98	39.40	-3.28***
	Female	156	41.55	

Note: *= $p < .1$; **= $p < 0.05$, ***= $p < 0.01$

Personal Experience with Mental Health Issues

Independent samples t-tests show that respondents who reported personal experience with a mental health diagnosis had significantly lower mean scores on CAMI and Authoritarian and Social Restrictiveness subscales, indicating more positive/less stigmatizing attitude toward people with mental disabilities than respondents who did not have such personal experience with mental diagnosis; no significant differences were found for the Benevolence or Community Mental Health Ideology subscales.

T-test results reported in Table 8 show a significant difference in the mean CAMI scores ($MD = 4.71$) of participants who reported ever having a mental health diagnosis ($M = -54.20, SD = 14.18$) and participants who reported never having a mental health diagnosis ($M = -49.49, SD = 15.46$), $t(240) = 1.95, p = .053$; a significant difference in the mean Authoritarian subscale scores ($MD = 1.93$) of participants who reported ever having a mental health diagnosis ($M = 16.07, SD = 3.40$) and participants who reported never having a mental health diagnosis ($M = 18.00, SD = 3.95$), $t(252.00) = 3.30, p = .001$; no significant difference in the mean Benevolence subscale scores ($MD = -.36$) for participants who reported ever having a mental health diagnosis ($M = 45.51, SD = 3.50$) and participants who reported never having a mental health diagnosis ($M = 45.15, SD = 3.75$), $t(245) = -.61, p = .54$; a significant difference in mean Social Restrictiveness subscale scores ($MD = 1.54$) of participants who reported ever having a mental health diagnosis ($M = 16.60, SD = 3.98$) and participants who reported never having a mental health diagnosis ($M = 18.14, SD = 4.32$), $t(253.00) = 2.37, p = .018$; and no significant difference in mean Community Mental Health Ideology subscale scores of participants who reported ever having a mental health diagnosis ($M = 41.81, SD = 4.81$) and

participants who reported never having a mental health diagnosis ($M = 40.50$, $SD = 5.31$), $t(254.00) = -1.64$, $p = 1.31$.

Table 8

T-test for Influence of Mental Health Diagnosis or Use of Mental Health Services on CAMI and Subscale scores

Question Category	CAMI score	Authoritarian scale	Benevolence scale	Social Restrictiveness scale	Community Mental Health Ideology Scale
Diagnosis Self	1.95	3.30***	-0.61	2.37***	-1.64
Diagnosis Family	3.70***	3.85***	- 3.19***	3.22***	-3.11***
Diagnosis Friend	3.32***	3.37***	-1.93**	3.41***	1.95***
Diagnosis Colleague	2.62***	2.63***	-2.14**	2.87***	-3.05***
Used MH Services self	2.39***	3.41***	-1.06	2.03**	-2.42**
Used MH Services Family	3.31**	3.76***	-3.23***	2.71***	-2.69***
Used MH Services Friend	3.04**	3.04**	-2.35**	2.90**	-2.81**
Used MH Services Colleague	2.84**	2.70*	-2.39**	2.65***	-3.11***
df	240	252	245	253	254

Note. *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.01$

These results indicate that respondents reporting a mental health diagnosis for themselves, family, friends or colleagues had less negative/stigmatizing attitudes toward mental disabilities than respondents reporting no such diagnosis.

Similar differences were noted (Table 8) for participants who reported a family member having ever received a mental health diagnosis (CAMI and Authoritarian and Social Restrictiveness scores significantly lower; Benevolence and Community Mental Health ideology scores significantly higher), a friend ever receiving a mental health diagnosis (CAMI, Authoritarian and Social Restrictiveness scores significantly lower; Community Mental Health ideology scores significantly higher; no significant difference in Benevolence subscale) or a colleague ever receiving a mental health diagnosis (CAMI, Authoritarian and Social Restrictiveness scores significantly lower; Benevolence and Community Mental Health ideology scores significantly higher) as compared to respondents who reported no such family member, friend or colleague ever having received a mental health diagnosis.

Similar patterns emerged when t-tests were performed to determine the influence of use of mental health services of any kind on CAMI scores. T-test results reported in Table 8 show a significant difference in the mean CAMI scores ($MD = 4.72$) of participants who reported ever having used mental health services ($M = -53.20$, $SD = 13.29$) and participants who reported never having used mental health services ($M = -48.48$, $SD = 16.37$), $t(240) = 2.39$, $p = .018$; a significant difference in the mean Authoritarian subscale scores ($MD = 1.66$) of participants who reported ever having used mental health services ($M = 16.63$, $SD = 3.50$) and participants who reported never having used mental health services ($M = 18.29$, $SD = 4.06$), $t(246.02) = 3.49$, $p = .001$; no

significant difference in the mean Benevolence subscale scores ($MD = -.51$) for participants who reported ever having used mental health services ($M = 45.52, SD = 3.15$) and participants who reported never having used mental health services ($M = 45.01, SD = 4.05$), $t(245) = -1.06, p = .290$; a significant difference in mean Social Restrictiveness subscale scores ($MD = 1.07$) of participants who reported ever having used mental health services ($M = 17.19, SD = 3.82$) and participants who reported never having used mental health services ($M = 18.26, SD = 4.57$), $t(249.64) = 2.03, p = .044$; and a significant difference in mean Community Mental Health Ideology subscale scores ($MD = -1.55$) of participants who reported ever having used mental health services ($M = 41.68, SD = 4.73$) and participants who reported never having used mental health services ($M = 40.13, SD = 5.48$), $t(246.91) = -2.42, p = .016$. These results indicate that respondents who reported personal experience with mental health care services had more positive/less stigmatizing attitudes toward people with mental disabilities than respondents who did not have such use of mental health care services.

Similar differences were noted (Table 8) for participants who reported a family member ever having used mental health services (CAMI, Authoritarian and Social Restrictiveness scores significantly lower; Benevolence and Community Mental Health ideology scores significantly higher), a friend ever having used mental health services (CAMI, Authoritarian and Social Restrictiveness scores significantly lower; Benevolence and Community Mental Health ideology scores significantly higher) or a colleague ever having used mental health services (CAMI, Authoritarian and Social Restrictiveness scores significantly lower; Benevolence and Community Mental Health ideology scores

significantly higher) as compared to respondents who reported no family member, friend or colleague ever having used mental health care services.

A one-way ANOVA was performed to investigate whether additional demographic or professional characteristics influenced mean CAMI or subscale scores. A summary of which characteristics had a significant influence are found in Table 9.

Table 9

ANOVA Test for Influence of Select Demographics on CAMI and Subscale Scores

Variable	CAMI Score	Authoritarian Scale	Benevolence Scale	Social Restrictiveness Scale	Community Mental Health Ideology Scale
Age Group					
Years in Practice			$p = .026$		
Employment at Current Job			$p = .046$		
Estimated % of Clients with Mental Disorder	$p = .001$	$p = .002$	$p = .005$	$p = .002$	$p = .001$
Number of cases in Mental Health Court					
Jurisdiction type				$p = .049$	

Note: This table reports only those variables having a significant influence on scores at $p < 0.05$

Years in Practice and Years at Current Job

A one-way ANOVA found a significant difference on the Benevolence scale score for years in practice ($F(5, 241) = 2.61, p = .026$) (Table 9) and *post hoc* comparisons using the Tukey HSD test indicated that the mean Benevolence score for the respondents with 11-15 years in practice ($M = 43.48, SD = 3.59$) was significantly lower than the respondents with 21-25 years in practice ($M = 46.89, SD = 2.08$). This finding

suggests that respondents with more years of practice have more kindly and sympathetic view toward people with mental disabilities. The remaining categories did not significantly differ on CAMI or subscale scores.

A one-way ANOVA also found a significant difference on the Benevolence scale score for years in current job ($F(5, 241) = 2.29, p = .046$) (Table 9), and *post hoc* comparisons using the Tukey HSD test indicated that the mean Benevolence score for the respondents with zero to five years in their current job ($M = 45.76, SD = 3.62$) was significantly higher than the respondents with 11-15 years in their current job ($M = 45.33, SD = 3.53$). This finding suggests that respondents with only a few years in their current job have more kindly and sympathetic view toward people with mental disabilities. The remaining categories did not significantly differ on CAMI or subscale scores.

Percentage of Clients with Mental Disorders

A one-way ANOVA performed to investigate the influence of respondents' estimates of the percentage of clients with a diagnosed mental disorder on mean CAMI or subscale scores found main effects for CAMI ($F(5, 236) = 4.32, p = .001$) (Table 9), and *post hoc* comparisons using the Tukey HSD test indicated that the mean CAMI score for the respondents estimating 21-40% of their clients to have a mental disorder ($M = -49.49, SD = 15.93$) was significantly higher than the respondents estimating 41%-60% of their clients to have a mental disorder ($M = -54.96, SD = 15.05$), and respondents estimating more than 80% of their clients to have a mental disorder ($M = -59.00, SD = 11.84$). Similar patterns were found for Authoritarianism ($F(5, 248) = 3.98, p = .002$), with subscale scores for respondents estimating 21-40% of their clients to have a mental

disorder ($M = 19.22, SD = 3.50$) significantly higher than respondents estimating 41%-60% of their clients to have a mental disorder ($M = 16.62, SD = 3.94$); Social Restrictiveness ($F(5, 229) = 4.03, p = .002$), with subscale scores for respondents estimating 21-40% of their clients to have a mental disorder ($M = 19.78, SD = 4.02$) significantly higher than the respondents estimating 41%-60% of their clients to have a mental disorder ($M = 16.66, SD = 4.03$) and respondents estimating more than 80% of their clients to have a mental disorder ($M = 17.80, SD = 4.29$); Benevolence ($F(5, 241) = 3.49, p = .005$), with subscale scores for respondents estimating 21-40% of their clients to have a mental disorder ($M = 43.84, SD = 3.45$) significantly lower than the respondents estimating 41%-60% of their clients to have a mental disorder ($M = 46.22, SD = 3.54$) and respondents estimating more than 80% of their clients to have a mental disorder ($M = 45.23, SD = 3.69$); and Community Mental Health Ideology ($F(5, 250) = 3.33, p = .001$), with subscale scores for respondents estimating 21-40% of their clients to have a mental disorder ($M = 38.82, SD = 4.43$) significantly lower than the respondents estimating 41%-60% of their clients to have a mental disorder ($M = 42.11, SD = 5.28$) and respondents estimating more than 80% of their clients to have a mental disorder ($M = 43.92, SD = 4.05$). The other ranges of estimates of clients with mental disability did not differ.

These results suggest that as the estimated percentage of clients with mental disorders increases, the CAMI score decreases, indicating that public defenders with a higher percentage of clients with mental disorders have less negative/stigmatizing attitudes toward people with mental disorders. Supporting this conclusion, the estimated percentage of clients with mental disorders was also found to have a significant negative correlation with CAMI scores ($r = -.026, p = .000$), indicating that as the estimated

percentage of clients with a mental disorder increases, negative/stigmatizing attitudes toward people with mental disorders lessen (Table 10).

Jurisdiction

A one-way ANOVA was performed to investigate whether respondents' work jurisdiction influenced mean CAMI or subscale scores; no significant effects were noted except on the Social Restrictiveness subscale ($F(3, 250) = 2.65, p = .049$) (Table 9), and *post hoc* comparisons using the Tukey HSD test indicated that the mean Social Restrictiveness score for suburban public defenders ($M = 19.19, SD = 5.23$) was significantly higher than for rural public defenders ($M = 15.50, SD = 2.94$). These findings suggest suburban respondents endorse more limits on behaviors and activities of people with mental disorders than do rural public defenders, but the meaningfulness of this conclusion may be limited by the skewed distribution of respondents among the various jurisdictions (4.65% rural, 14.73% suburban and 79.77% urban). The remaining categories did not significantly differ on CAMI or subscale scores.

Non-Significant Variables

The results of the independent samples t-test examining the impact of special training in mental health issues on mean CAMI scores and subscale scores found no significant effect. A one-way ANOVA performed to investigate whether, for the Mental Health Court sample, the number of cases in mental health court influenced mean CAMI or subscale scores found no significant effect. A one-way ANOVA performed to investigate whether, for the No Mental Health Court sample, not having the opportunity

to practice in mental health court or choosing not to practice influenced mean CAMI or subscale scores found no significant effect. The results of the independent samples t-test examining the impact of special training in mental health issues on mean CAMI scores and subscale scores found no significant effect.

Correlations

Pearson correlation coefficients were computed to assess the relationship between CAMI and subscale scores and the demographic and professional characteristics of the sample (Table 10).

Table 10

Correlations of CAMI and Subscale Scores and Sample Characteristics

	CAMI Score	Authoritarianism	Benevolence	Social Restrictiveness	Community Mental Health Ideology
Maleness	0.23***	0.23***	-0.24***	0.17**	-0.20***
% Clients with Mental Disorder	-0.26***	-0.24***	0.22***	-0.24***	0.22***
Diagnosis Self	-0.12**	-0.20***	0.04	-0.15***	0.10
Diagnosis Family	-0.23***	-0.23***	0.20**	-0.20***	0.19***
Diagnosis Friend	-0.21***	-0.21***	0.12*	-0.21***	0.19***
Diagnosis Colleague	-0.17**	-0.16**	0.14**	-0.18***	0.16**
Mental Health Services Self	-0.15**	-0.21***	0.07	-0.12**	0.15**
Mental Health Services family	-0.21***	-0.23***	0.20***	-0.17***	0.17***
Mental Health Services Friend	-0.19***	-0.19**	0.15**	-0.18***	0.17***
Mental Health Services Colleague	-0.18***	-0.17**	0.15**	-0.18***	0.17***

Note. *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.01$

When gender data were recoded (male=1, female=0) for the correlation calculation, there was a significant positive correlation between maleness and CAMI, Authoritarianism and Social Restrictiveness scores, and a significant negative correlation between maleness and Benevolence and Community Mental Health Ideology scores, indicating that males have more negative/stigmatizing attitudes toward people with mental disorders than women.

There was a significant negative correlation between the estimated percentage of clients with a mental disorder and CAMI, Authoritarianism and Social Restrictiveness scores, and a significant positive correlation between the estimated percentage of clients with a mental disorder and Benevolence and Community Mental Health Ideology scores, indicating a reduction of negative/stigmatizing attitudes toward people with mental disorders as the estimated percentage of clients with mental disorders increased.

There was a significant negative correlation between diagnosis of mental disorder for the respondents and Authoritarianism and Social Restrictiveness scores, indicating respondents with a mental health diagnosis had fewer of certain negative/stigmatizing attitudes. There was a significant negative correlation between a family mental disorder diagnosis and CAMI, Authoritarianism and Social Restrictiveness scores, and a significant positive correlation between Benevolence and Community Mental Health Ideology scores, indicating a family diagnosis was associated with fewer negative/stigmatizing attitudes toward people with mental disorders. There was a significant negative correlation between a friend mental disorder diagnosis and CAMI, Authoritarianism and Social Restrictiveness scores, and a significant positive correlation between Benevolence and Community Mental Health Ideology scores, indicating a friend

diagnosis was associated with fewer negative/stigmatizing attitudes toward people with mental disorders. There was a significant negative correlation between a colleague mental disorder diagnosis and CAMI, Authoritarianism and Social Restrictiveness scores, and a significant positive correlation between Benevolence and Community Mental Health Ideology scores, indicating a colleague diagnosis was associated with a reduction of negative/stigmatizing attitudes.

There was a significant negative correlation between use of mental health services for the respondents and CAMI, Authoritarianism and Social Restrictiveness scores, and a significant positive correlation between use of mental health services and Community Mental Health Ideology scores, indicating that use of mental health services associated with a reduction of negative/stigmatizing attitudes toward people with mental disorders. There was a significant negative correlation between family, friend or colleague use of mental health services and CAMI, Authoritarianism and Social Restrictiveness scores, and a significant positive correlation between and Benevolence and Community Mental Health Ideology scores, indicating that family, friend or colleague use of mental health services are associated with a reduction of negative/stigmatizing attitudes toward people with mental disorders.

Regression

A linear regression was estimated to the CAMI score to model the influence of demographic and professional factors on the CAMI scores (Table 11).

The regression showed that 16 percent of variance in CAMI scores can be explained by the demographic and professional independent variables ($R^2=.16$,

Table 11

Regression Analysis of CAMI Scores and Selected Demographic and Professional Characteristics

Independent Variables	Unstandardized Coefficients		Standardized Coefficients	
	B	Std. Error	Beta	t
(Constant)	-48.63	5.48	.00	-8.88
Mental Health Court	-.28	1.99	-.01	-.14
Training	-.79	1.89	-.03	-.42
Diagnosis - Self	-4.10	2.91	-.11	-1.41
Mental Health Service Use - self	-2.85	2.40	-.09	-1.19
21%-40% MH Clients	-5.83	2.55	-.19	-2.28**
41%-60% MH Clients	-10.61	2.93	-.29	-3.62***
61%-80% MH Clients	-9.52	4.10	-.17	-2.32**
> 80% ClientsMH	-14.08	4.93	-.19	-2.86***
36-45 Years of Age	5.63	2.52	.15	2.23**
46-55 Years of Age	.84	2.85	.02	.29
56-65 Years of Age	.53	3.18	.01	.17
>65 Years of Age	1.34	5.33	.02	.25
Suburban Jurisdiction	8.33	4.78	.20	1.74*
Urban Jurisdiction	3.68	4.29	.10	.86
Gender	4.35	2.02	.14	2.15**

Note: *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.01$

$F(239)=2.91, p=.000$). If an independent variable was categorical (number of categories = n), then dummy variables (number of dummy variables = $n-1$) were created, with the first considered as the reference category.

It was found that gender (recoded male = 1, female = 0) was a strong predictor of CAMI score ($\beta= 4.35, p =.032$); the positive coefficient indicates that, holding all other variables constant, men have higher CAMI scores and thus more negative/stigmatizing views of mental disorders than women.

The dummy variables created to analyze the estimated percentage of clients with mental disorders have significant negative coefficients with CAMI scores. Holding the category of a zero-20% estimate as a reference ($M=-43.65$), the mean CAMI scores go down by 5.83 when the estimate changes to 21-40%; by 10.61 when the estimate changes to 41-60%; by 9.52 when the estimate changes to 61-80% and by 14.08 when the estimate changes to more than 80%. This indicates that as the estimated percentage of clients with mental disorders goes up, CAMI scores go down and thus respondents with a higher percentage of clients with mental disorders have less negative/stigmatizing views toward people with mental disorders.

Holding the CAMI score for the age category of 25-35 years as a reference ($M=-51.70$), the mean CAMI scores increases by 5.63 ($p = .026$) when the age category changes to 36-45. This indicates that compared to respondents aged 25-35, respondents aged 36-45 show the greatest positive difference in CAMI scores, indicating more negative/stigmatizing attitudes toward people with mental disorders.

The other independent variables do not show significant coefficients at $p < .05$ with CAMI, but their directionality supports the other findings of the study: as diagnosis

with a mental disorder and use of mental health services increase, CAMI scores decrease; as training and number of mental health court cases handled increase, CAMI scores decrease. Rural respondents show the lowest CAMI scores compared to suburban and urban, but not significantly so at $p < .05$ and the meaningfulness of directional trend may be limited by the skewed distribution of respondents among the various jurisdictions (4.65% rural, 14.73% suburban and 79.77% urban).

Chapter IV

Discussion

Stigma against people with mental disorders by their own attorneys could have detrimental effects on individual defendants and help perpetuate a system where people with mental disabilities repeatedly cycle through court, jail and/or prison at great human and economic expense. The purpose of this study was to investigate whether attitudes and beliefs public defenders may have toward people with mental disorders would be influenced by whether the public defender had represented criminal clients in a mental health court or not. The study hypothesized that the sample of public defenders with mental health court experience would have fewer negative/stigmatizing attitudes and beliefs toward people with mental disorders, as measured by CAMI and subscale scores, than the sample of public defenders with no mental health court experience.

Analysis of the survey data revealed no significant difference in mean CAMI or subscale scores between the Mental Health Court sample and the No Mental Health Court sample. Therefore, findings from this study do not support the main study hypothesis that mental health court experience would reduce negative/stigmatizing attitudes and beliefs public defenders may have toward people with mental disorders.

In addition to testing the main hypothesis, the study also explored gender, number of cases handled in mental health court, years of practice, personal experience with mental health issues and special training in mental health issues as potential influences on CAMI or subscale scores.

General Discussion

While the data collected in this study did not support the hypothesis that mental health court practice would improve attorney attitudes about people with mental disorders, there were several interesting findings.

The distribution of mean CAMI and subscale scores from all participants skewed very heavily away from negative/stigmatizing attitudes and beliefs and toward positive/less stigmatizing attitudes and beliefs. Possible CAMI scores range from -80 to 80, with higher scores being indicative of more negative/stigmatizing attitudes and scores of zero indicating neutral attitudes. The mean CAMI score for the entire sample in this study was -50.47 (SD=15.30) with only two respondents (both in the Mental Health Court group) out of 258 total scoring zero or above. As discussed in the limitations section below, these low CAMI scores may be a result of self-selection bias, in that public defenders more interested in and having more positive attitudes about mental health issues may have responded in greater numbers. In addition, attorneys who choose public defense as a career may have a more benevolent view toward justice-involved individuals, including those with mental disorders. CAMI score averages for the general public, or other specific populations such as private defense attorneys or prosecutors were not gathered for this study, so generalizations about the relative CAMI scores outside the study sample are speculative. Regardless, it is encouraging for criminal justice advocacy that this sample had median CAMI scores much lower than neutral.

It was also notable that the participant characteristics having the most significant impact on CAMI and subscale scores were gender, a personal experience with mental

health diagnoses and/or mental health treatment and the percentage of clients having a mental disorder.

Male respondents held more negative/stigmatizing attitudes and beliefs toward people with mental disorders than female respondents, as shown by t-tests, correlation and regression analysis. These findings are supported by existing stigma research suggesting that women are less likely than men to endorse prejudice or discrimination against people with mental disorders (Corrigan & Watson, 2007, Kobau, *et al.*, 2010), women are less likely to blame people for their mental disorders, women are less willing to endorse restrictions on civil rights of people with mental disorders, and women are more willing to volunteer in mental health patient care (Holzinger, 2012).

Respondents who had ever received a mental health diagnosis, and/or whose family, friends or colleagues had ever received such a diagnosis, had lower CAMI scores indicating fewer negative/stigmatizing attitudes towards people with mental disorders than respondents with no personal experience with mental health diagnosis, as shown by t-tests, correlation and regression analysis. Similarly, respondents who had ever used mental health services of any kind, and/or whose family, friends or colleagues had ever used mental health services, had lower CAMI scores indicating fewer negative/stigmatizing attitudes towards people with mental disorders than respondents with no personal experience with use of mental health. These findings are supported by existing stigma research suggesting that personal contact with people with mental disorders is the most effective means of stigma reduction (Corrigan, *et al.*, 2012) and by literature finding that people who themselves had, or knew people who had, mental disorders held fewer negative stereotypes about people with mental illness (Kobau, *et al.*,

2010), but does not support the hypothesized parallel between public defenders and mental health care professionals who have been reported to have negative attitudes toward their clients despite frequent contact (Schulze, 2007).

Taken together, the two ANOVA results regarding the relationship between Benevolence subscale scores and years in practice (Benevolence scores lower for 11-15 years in practice group than 21-25 years in practice group) and years in current job (Benevolent scores lower for 11-15 years in job group than 0-5 years in job group), seem to indicate that respondents with 11-15 years in practice and/or in their current job have the least kindly and sympathetic view toward people with mental disorders. Perhaps this 11-15-year cohort, having lost some of the idealism that led them to enter public defense work, has developed stigma-increasing burnout (Henderson, *et al.*, 2014) exacerbated by the difficult balance of work/family/economic pressures which may be highest at mid-career. Selective dropout from public defense work by people who hold more negative attitudes may also contribute to the finding that late-career public defenders have more positive attitudes. Further, those with long years in practice have more time to accumulate an increased level of personal, family, colleague and friend experience of mental health issues which this study and others have shown to reduce stigmatizing attitudes (Corrigan, *et al.*, 2012). Similarly, as the estimated percentage of clients with mental disorders increases, the levels of negative/stigmatizing attitudes decrease, as shown by ANOVA, correlation and regression analysis; this is supported in studies finding a stigma-reducing effects of greater professional experience (Frierson, 2006) and personal contact (Corrigan, *et al.*, 2012) with mentally disabled people.

Limitations and Future Research Directions

This research study has several limitations. CAMI utilizes self-reported, explicit attitudinal measures related to mental disorders, and as a result, may be susceptible to socially desirable response tendencies (Hinshaw & Stier, 2008). Participants, even though their answers are anonymous and online, may have felt obligated to respond in a manner that they believe the researcher wants. Further, some of non-CAMI survey questions, such as those asking about personal experience with mental health issues, may have created discomfort and resulted in answers that diverge from the truth. In addition to the effects of "snowball" sampling" (see Methods section above), online recruitment may have eliminated certain groups of otherwise eligible respondents, such as public defenders who were uncomfortable using the internet or are skeptical of the confidentiality in online surveys, although the difference such elimination would have made to the results is not known. In addition, attorneys with more knowledge about, or interest in, issues surrounding mental disorders may have been more likely to respond to the survey, while attorneys with more negative views about clients with mental disorders may have been less likely to respond. No racial, ethnic, religious or other similar characteristics that may have impacted attitudes were collected or analyzed. The survey questionnaire was kept relatively brief and easy to complete to encourage participation, but this resulted in generic questions which may have limited the construct and content validity of the survey. Neither the non-CAMI nor the CAMI survey questions differentiate between diagnoses and/or the level of severity of mental disorders; participants may have responded to the questions with different types or severity of mental disorders in mind, or interpreted questions differently depending on their training

and experience with mental health issues. To further encourage participation, response to each question (other than questions concerning eligibility, consent and mental health court experience) was not required for survey submission. Therefore, data loss due to non-response occurred in a few cases.

The CAMI scale was developed in the late 1970's, and perhaps the very low CAMI scores of this study's participants reflects an improvement in attitudes toward people with mental disorders within the general population; *i.e.*, the score considered "neutral" when the CAMI scale was developed may today be considered stigmatizing. However, this study was not designed to investigate whether CAMI scores for this study's sample differ from CAMI scores for the general population or other comparison groups of interest, so no concrete findings about relative CAMI scores can be claimed. Comparing public defender CAMI scores with other populations would provide invaluable context for further investigation into stigma-reducing efforts. In particular, investigation of the attitudes of prosecutors or judges who have experience in mental health court with those who do not would provide additional valuable insight into possible stigma among those groups, and it would be fascinating to compare attitudes of these groups of attorneys to the attitudes of public defenders. All attorneys and judges have significant impacts on the criminal justice experiences of defendants with mental disorders, and the existence of stigma or prejudice can only be eliminated if it is first identified and measured.

In addition, the CAMI questionnaire, although it has been validated for use in other contexts, was originally designed to measure attitudes regarding community treatment of people with mental disorders. It was not feasible to develop and validate a

new survey measure for this study, but perhaps an instrument more targeted to the experiences of attorneys, or public defenders specifically, would have revealed different data.

Future research could collect data from a more randomized, larger sample. Although the hypothesis that mental health court practice would improve defense attorney attitudes toward people with mental disorders (as measured by the CAMI scale) was not proven in this study, perhaps a larger sample would have yielded different results. In particular, the No Mental Health Court sample comprised only 37.21% of the total sample, while the Mental Health Court Sample comprised 62.79% and this disparity could have affected the validity of the findings. The data show that for the Mental Health Court sample, a greater number of cases in mental health court correlated with a lower CAMI score (indicating fewer negative/stigmatizing attitudes and beliefs about people with mental disorders), although this directional trend was not statistically significant. Perhaps with a larger sample this non-significant trend would have amounted to a significant difference in CAMI scores between the Mental Health Court group and the No Mental Health Court group, since, by definition, the number of cases tried in mental health court by the No Mental Health Court sample was zero.

Compared to an estimated 21% of the general U.S. population living in rural areas (Kolko, 2015), the proportion of rural respondents was quite low at only 4.65%. However, since this study only researched public defenders working in jurisdictions with mental health courts, this study did not investigate the distribution of mental health courts among rural, suburban and urban jurisdictions and no national study of such a distribution was located. Therefore, the representativeness of the study sample with regard to

jurisdiction type is unknown. Perhaps with a larger sample more robust conclusions regarding jurisdiction type and attitudes toward people with mental illness could be made.

Conclusion

Mental health courts have been shown to reduce recidivism and increase utilization of mental health care by defendants with mental disorders. Although this small study failed to demonstrate that trial experience within mental health court improved the attitudes and beliefs that public defenders have toward people with mental disorders, perhaps additional and more targeted measures would provide such evidence. Mental health courts are designed to give attention to the abilities, competencies, and community integration of people with mental disorders, and may yet offer some promise in addressing stigma (Ware, *et al.*, 2007). Corrigan and Blink suggest that anti-stigma efforts should be counterbalanced with “affirming attitudes” or “positive expectations” that people with mental illnesses are able to recover and make independent life choices (2016). Attorneys working in mental health court are participating in a process that embodies optimism that certain defendants with mental disorders can live safely in their communities rather than languishing behind bars. We must continue to look for innovative ways to reduce stigma and interrupt the painful and costly cycle of repeated contact with criminal justice system for some of our most vulnerable citizens.

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Appendix I.

Request for Participation

To:

From: Andrea Marber

Re: Harvard Research Study about Defense Attorneys - Participate and Receive \$10 Amazon Gift Card

Hello:

My name is Andrea Marber, Esq. I am a Master of Liberal Arts candidate in Psychology at Harvard University Extension School in Cambridge, Massachusetts.

I am conducting an online research survey entitled **Defense Attorney Attitudes Toward Clients with Mental Disorders**.

I am requesting your participation in this important research because you have been identified as meeting the following eligibility criteria:

- You are an attorney admitted to practice law in the United States.
- You represent or have represented indigent defendants in criminal matters.
- You work or have worked within a jurisdiction that has a mental health court, *whether you have practiced in the mental health court or not.*

The survey is brief and should only take about 10 minutes to complete. Participation is **voluntary** and you are free to exit the survey at any time.

To protect your confidentiality and anonymity, no personal identifying information will be gathered from you at any time during the survey.

After you complete the survey, you will have the opportunity to click to an incentive page where you can provide an email address to receive a **\$10 Amazon gift card** and be entered in a drawing to win an **Apple iPad**. The email address you enter will *never* be linked to your survey responses, and you may choose to decline the incentives and not provide an email address.

If you are eligible and wish to participate in this study, please click the link below (or copy the link to your browser)

<https://www.surveymonkey.com/r/5RCW6M9>

If you have colleagues who you believe are eligible to participate in this important research, please forward this request for participation.

Thank you for your time. If you have questions or concerns regarding this study, please do not hesitate to contact me.

Andrea Marber, Esq.
ALM Candidate
Harvard University Extension School
Cambridge, MA 02138
aam845@g.harvard.edu

Appendix II.

Notification of Initial Study Exemption Determination



HARVARD
Human Research Protection Program

Harvard University-Area
Committee on the Use of Human Subjects
1414 Massachusetts Avenue, 2nd Floor
Cambridge, MA 02138
IRB Registration - IRB00000109
Federal Wide Assurance - FWA00004837

Notification of Initial Study Exemption Determination

November 29, 2016

Andrea Marber
marbermom@aol.com

Protocol Title: Defense attorney attitudes toward clients with mental disorders: Does mental health court practice reduce stigma?
Principal Investigator: Andrea Marber
Protocol #: IRB16-1697
IRB Review Date: 11/29/2016
IRB Effective Date: 11/29/2016
IRB Review Action: Exempt

This Initial Study submission meets the criteria for exemption per the regulations found at 45 CFR 46.101(b)(2). As such, additional IRB review is not required. For international research, the Principal Investigator is required to comply with any applicable local laws, legislation, regulations, and/or policies. Additionally, if local IRB/ethics review is required, it must be obtained before any human subjects research activities are conducted in the field. If assistance with applicable local requirements is needed, please contact the Harvard University-Area IRB office.

The documents that were finalized for this submission may be accessed through the IRB electronic submission management system at the following link: [IRB16-1697](#).

The determination that your research is exempt does not expire, and you will not file annual renewals. If changes to the research are proposed that would alter the IRB's original exemption determination, they should be submitted in ESTR by selecting the Create Modification activity. If unsure, contact the Harvard University-Area IRB office.

The IRB made the following determinations:

- Research Information Security Level: The research is classified, using Harvard's Data Security Policy, as Level 2 Data.

Please contact me at (617) 495-1775 or meghan_pronovost@harvard.edu with any questions.



HARVARD

Human Research Protection Program

Sincerely,

Meghan F. Pronovost
IRB Administrator

University Area IRB <http://cuhs.harvard.edu>
Longwood Medical Area IRB <http://www.hsph.harvard.edu/ohra/>

Appendix III.

Online Survey “Defense Attorney Attitudes Toward Clients with mental Disorders”

Defense Attorney Attitudes Toward Clients with Mental Disorders

1. Introduction to the Study, Eligibility and Consent

You are being invited to participate in a research study about defense attorney attitudes toward clients with mental disorders because you have been identified as an attorney who has represented indigent defendants in criminal matters within a jurisdiction that has established a mental health court, whether or not you have ever represented a client in a mental health court.

The researcher for this study is Andrea Marber, JD, ALM Candidate at Harvard Extension School, Harvard University, Cambridge, Massachusetts. The faculty sponsor is Ronald Schouten, MD, JD, Harvard University, Cambridge Massachusetts. The researcher can be reached at aam845@g.harvard.edu with any questions, concerns, or complaints.

The study questionnaire should take approximately 10 minutes to complete. It is your choice whether or not to participate in the study. If you choose to participate, you may change your mind and leave the study at any time. You may decline to answer any particular question or questions you do not wish to answer for any reason.

The study questionnaire is anonymous and no one will be able to link your answers back to you. SurveyMonkey.com's privacy policy may be found online at <http://www.surveymonkey.com/mp/policy/privacy-policy/>.

This research has been reviewed by the Committee on the Use of Human Subjects in Research at Harvard University. They can be reached at 617-496-2847 or cuhs@fas.harvard.edu if your questions, concerns, or complaints are not being answered by the researcher, if you cannot reach the researcher, if you want to talk to someone besides the researcher, or if you have questions about your rights as a research participant.

If you choose to participate in this study, you are eligible to receive a \$10 Amazon gift certificate and be entered in a drawing to win an Apple iPad. Upon submission of the study questionnaire you will have the option of clicking to a new SurveyMonkey page, where you will be prompted to enter an email address to receive the \$10 Amazon gift certificate and be entered in a drawing to win an Apple iPad. Your email address will not be linked to your questionnaire answers, and will not be used for any purpose other than delivery of incentives. You may decline the offered incentives if you do not wish to supply an email address.

Please confirm your eligibility by clicking the “Eligibility Confirmed” button below. Please note that you are still eligible for participation if you have represented indigent defendants in criminal matters within a jurisdiction that has established a mental health court whether or not you have ever represented a client in such a court.

* 1. I am an attorney licensed to practice law in the United States who has represented indigent defendants in criminal matters within a jurisdiction that has established a mental health court.

- Eligibility confirmed
- Eligibility not confirmed

2. Participation Consent

* 2. If you wish to participate in this study, click the "I agree" button below. By clicking the "I agree" button below, you are voluntarily agreeing to participate.

I agree

I do not agree

3. Demographic and Participant Background

This portion of the Survey collects general demographic and background information from participants.

3. What is your gender?

- Male
- Female
- Other
- Choose not to answer

4. What is your age?

- 25-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- 66 years and above
- Choose not to answer

5. How long have you been practicing criminal defense law?

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26 years and above
- Choose not to answer

6. How long have you been employed in your current job?

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 25 years and above
- Choose not to answer

7. To your belief or knowledge, approximately what percentage of the total number of your current or former criminal clients have a diagnosed mental disorder or illness (other than or in addition to substance use/abuse disorders)?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- More than 80%
- Choose not to answer

* 8. Have you ever represented a client in a mental health court?

- Yes
- No

4. Demographic and Participant Background

9. If YES, approximately how many cases have you handled in a mental health court?

- 1-10
- 11-20
- 21-30
- 31-40
- 41-50
- More than 50
- Choose not to answer

5. Demographic and Participant Background

10. If NO, did you

- Have an opportunity to practice in mental health court but chose not to
- Not have an opportunity
- Choose not to answer

6. Demographic and Participant Background

11. Which of the following best describes the jurisdiction in which you are employed?

- Rural
- Suburban
- Large urban
- Choose not to answer

12. Have you received special education or training in mental health?

- Yes
- No

7. Demographic and Participant Background

13. If yes, indicate all education or training in mental health that apply

- Undergraduate courses
- Graduate or professional courses
- Continuing legal education courses
- Seminars or workshops
- Prior employment in the mental health field
- Employer-sponsored training
- Choose not to answer

14. To your belief or knowledge, have any of the following received a mental health diagnosis (other than or in addition to substance use/abuse disorders)

- Self
- Family member
- Friend
- Colleague
- Choose not to answer

15. To your belief or knowledge, have any of the following used mental health services of any kind

- Self
- Family member
- Friend
- Colleague
- Choose not to answer

Defense Attorney Attitudes Toward Clients with Mental Disorders

8. Attitudes Toward People with Mental Disorders

This portion of the Survey contains statements that express various opinions about people with mental disorders.

In this portion of the Survey, the phrase "people with mental disorders" refers to people who receive or need mental health care but who are capable of living independently outside of a psychiatric hospital.

Please indicate the response which most accurately describes your reaction to each statement. It is your first reaction which is important. Do not be concerned if some statements seem similar to ones you have previously answered. Please note that it is requested but not mandatory for you to answer all questions.

16. As soon as a person shows a sign of a mental disorder, they should be hospitalized.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

17. More tax money should be spent on the care and treatment of people with mental disorders.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

18. People with mental disorders should be isolated from the rest of the community.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

19. The best therapy for many people with mental disorders is to be part of a larger community.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

20. A mental disorder is an illness like any other.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

21. People with mental disorders are a burden on society.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

22. People with mental disorders are far less of a danger than most people suppose.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

23. Locating mental health facilities in a residential area downgrades the neighborhood.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

24. There is something about people with mental disorders that makes it easy to tell them from people without mental disorders.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

25. People with mental disorders have for too long been the subject of ridicule.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

26. A person would be foolish to marry someone who has suffered from a mental disorder, even though they seem fully recovered.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

27. As far as possible mental health services should be provided through community-based facilities.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

28. Less emphasis should be placed on protecting the public from people with mental disorders.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

29. Increased spending on mental health services is a waste of tax dollars.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

30. No one has the right to exclude people with mental disorders from their neighborhood.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

31. Having people with mental disorders living within residential neighborhoods might be good therapy, but the risks to residents are too great.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

32. People with mental disorders need the same kind of control and discipline as a young child.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

33. We need to adopt a far more tolerant attitude toward people with mental disorders in our society.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

34. I would not want to live next door to someone who has had a mental disorder.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

35. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

36. People with mental disorders should not be treated as outcasts of society.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

37. There are sufficient existing services for people with mental disorders.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

38. People with mental disorders should be encouraged to assume the responsibilities of independent life.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

39. Local residents have good reason to resist the location of mental health services in their neighborhood.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

40. The best way to handle people with mental disorder is to keep them behind locked doors.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

41. Our psychiatric hospitals seems more like prisons than like places where people with mental disorders can be cared for.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

42. Anyone with a history of mental disorders should be excluded from taking public office.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

43. Locating mental health services in residential neighborhoods does not endanger local residents.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

44. Psychiatric hospitals are an outdated means of treating people with mental disorders.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

45. People with mental disorders do not deserve our sympathy.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

46. People with mental disorders should not be denied their individual rights.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

47. Mental health facilities should be kept out of residential neighborhoods.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

48. One of the main causes of mental disorders is a lack of self discipline and will power.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

49. We have the responsibility to provide the best possible care for people with mental disorders.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

50. People with mental disorders should not be given any responsibility.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

51. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

52. Virtually anyone can develop a mental disorder.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

53. It is best to avoid anyone who has a mental disorder.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

54. Most people who were once patients in a psychiatric hospital can be trusted as childcare providers.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

55. It is frightening to think of people with mental disorder living in residential neighborhoods.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

9. End of the Survey

Thank you for participating in the survey!

Please click "Done" to complete the survey and access thank you gift options.

Appendix IV.
Online Survey “Incentives”

Defense Attorney Attitudes Toward Clients with Mental Disorders-Incentive Survey

* 1. If you wish to receive a \$10 Amazon gift card and be entered into a drawing for an Apple iPad, please click 'Accept Gifts' and enter your preferred email address for receipt of the thank you gift(s).

2. Your email address will be kept private and used for gift delivery only. It will never be connected with your responses to the Survey.

3. If you do not wish to enter an email address please click 'Decline Gifts'.

Accept Gifts

Decline Gifts

Defense Attorney Attitudes Toward Clients with Mental Disorders-Incentive Survey

* 2. Please enter your preferred email address

Appendix V.

Community Attitudes Towards The Mentally Ill Scale

The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please circle the response which most accurately describes your reaction to each statement. It's your first reaction which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

- a. As soon as a person shows signs of mental disturbance, he should be hospitalized.

SA A N D SD

- b. More tax money should be spent on the care and treatment of the mentally ill.

SA A N D SD

- c. The mentally ill should be isolated from the rest of the community.

SA A N D SD

- d. The best therapy for many mental patients is to be part of a normal community.

SA A N D SD

- e. Mental illness is an illness like any other.

SA A N D SD

- f. The mentally ill are a burden on society.

SA A N D SD

- g. The mentally ill are far less of a danger than most people suppose.

SA A N D SD

- h. Locating mental health facilities in a residential area downgrades the neighbourhood.

SA A N D SD

- i. There is something about the mentally ill that makes it easy to tell them from normal people.

SA A N D SD

- j. The mentally ill have for too long been the subject of ridicule.

SA A N D SD

- k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

SA A N D SD

- l. As far as possible mental health services should be provided through community-based facilities.

SA A N D SD

SA=Strongly Agree	A=Agree	N=Neutral	D=Disagree	SD=Strongly Disagree
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m. Less emphasis should be placed on protecting the public from the mentally ill.

SA A N D SD

n. Increased spending on mental health services is a waste of tax dollars.

SA A N D SD

o. No one has the right to exclude the mentally ill from their neighbourhood.

SA A N D SD

p. Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

SA A N D SD

q. Mental patients need the same kind of control and discipline as a young child.

SA A N D SD

r. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

SA A N D SD

s. I would not want to live next door to someone who has been mentally ill.

SA A N D SD

t. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.

SA A N D SD

u. The mentally ill should not be treated as outcasts of society.

SA A N D SD

v. There are sufficient existing services for the mentally ill.

SA A N D SD

w. Mental patients should be encouraged to assume the responsibilities of normal life.

SA A N D SD

x. Local residents have good reason to resist the location of mental health services in their neighbourhood.

SA A N D SD

y. The best way to handle the mentally ill is to keep them behind locked doors.

SA A N D SD

z. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

SA A N D SD

SA=Strongly Agree	A=Agree	N=Neutral	D=Disagree	SD=Strongly Disagree
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COMMUNITY ATTITUDES TOWARDS THE MENTALLY ILL

- | | |
|--|--|
| <p>aa. Anyone with a history of mental problems should be excluded from taking public office.</p> <p style="text-align: center;">SA A N D SD</p> | <p>hh. We have the responsibility to provide the best possible care for the mentally ill.</p> <p style="text-align: center;">SA A N D SD</p> |
| <p>bb. Locating mental health services in residential neighbourhoods does not endanger local residents.</p> <p style="text-align: center;">SA A N D SD</p> | <p>ii. The mentally ill should not be given any responsibility.</p> <p style="text-align: center;">SA A N D SD</p> |
| <p>cc. Mental hospitals are an outdated means of treating the mentally ill.</p> <p style="text-align: center;">SA A N D SD</p> | <p>jj. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.</p> <p style="text-align: center;">SA A N D SD</p> |
| <p>dd. The mentally ill do not deserve our sympathy.</p> <p style="text-align: center;">SA A N D SD</p> | <p>kk. Virtually anyone can become mentally ill.</p> <p style="text-align: center;">SA A N D SD</p> |
| <p>ee. The mentally ill should not be denied their individual rights.</p> <p style="text-align: center;">SA A N D SD</p> | <p>ll. It is best to avoid anyone who has mental problems.</p> <p style="text-align: center;">SA A N D SD</p> |
| <p>ff. Mental health facilities should be kept out of residential neighbourhoods.</p> <p style="text-align: center;">SA A N D SD</p> | <p>mm. Most women who were once patients in a mental hospital can be trusted as baby sitters.</p> <p style="text-align: center;">SA A N D SD</p> |
| <p>gg. One of the main causes of mental illness is a lack of self-discipline and will power.</p> <p style="text-align: center;">SA A N D SD</p> | <p>nn. It is frightening to think of people with mental problems living in residential neighbourhoods.</p> <p style="text-align: center;">SA A N D SD</p> |

SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree
--

Community Attitudes Toward The Mentally Ill

Key to Items			Scoring		
	SA	A	N	D	SD
Authoritarianism					
Pro: a, i, q, y, gg	5	4	3	2	1
Anti: e, m, u, cc, kk	1	2	3	4	5
 Benevolence					
Pro: b, j, r, z, hh	5	4	3	2	1
Anti: f, n, v, dd, ll	1	2	3	4	5
 Social Restrictiveness					
Pro: c, k, s, aa, ii	5	4	3	2	1
Anti: g, o, w, ee, mm	1	2	3	4	5
 Community Mental Health Ideology					
Pro: d, l, t, bb, jj	5	4	3	2	1
Anti: h, p, x, ff, nn	1	2	3	4	5

Appendix VI.

Permission to Use CAMI Scale

From: Natalia Gartley-ONC <oncsec@uvic.ca>
To: marbermom <marbermom@aol.com>
Cc: Martin Taylor <smt@uvic.ca>; Natalia Gartley-ONC <oncsec@uvic.ca>
Subject: Re: permission to use copyrighted material
Date: Thu, Mar 24, 2016 5:55 pm
Attachments: CAMI Questionnaire Page 1[1][1].pdf (18K), CAMI Questionnaire Page 2[1][2].pdf (15K), CAMI Keys[1][1].pdf (10K), Taylor and Dear SB 1981[1][1].pdf (1476K)

Dear Andrea,

Thank you for your inquiry. Dr. Taylor has reviewed your message and is pleased to provide his permission to use the CAMI instrument in your research. Attached are the documents including 2 pages of CAMI Questionnaire and the marking keys. Also included for your reference is a paper published in Schizophrenia Bulletin (1981) which documents psychometric properties for the CAMI scales.

Do not hesitate to contact us if we can be of any further assistance.

Kind Regards,

Natalia Gartley

on behalf of
S. Martin Taylor, PhD
Professor Emeritus
University of Victoria
Adjunct Professor McMaster University and University of Waterloo



Natalia Gartley | Executive Assistant

Ocean Networks Canada | T 250 721 7231 | M 250 532 0155 | oceannetworks.ca
University of Victoria PO Box 1700 STN CSC 2300 McKenzie Avenue Victoria, BC V8W 2Y2

From: Michael Dear <m.dear@berkeley.edu>
To: Andrea Marber <marbermom@aol.com>
Subject: Re: Request for permission to use copyrighted material
Date: Wed, Mar 23, 2016 9:45 pm

Dear Andrea Marber - Permission granted for the CAMI use that you describe. Good luck! - Michael Dear

On Tue, Mar 22, 2016 at 9:52 AM, Andrea Marber <marbermom@aol.com> wrote:

Dear Dr. Dear:

I am a Master of Liberal Arts candidate at Harvard University Extension School. My thesis project, tentatively titled *Defense Attorney Attitudes Toward Clients with Mental Illness: Does Mental Health Court Practice Reduce Stigma?*, seeks to measure attitudes of criminal defense attorneys toward people with mental illness.

I hereby request your permission to use the Community Attitudes Towards the Mentally Ill scale (Copyright 1979; Department of Geography, McMaster University, Hamilton, Ontario, Canada: Taylor, S. M., & Dear, M. J.) ("CAMI") in my research study. I will use the CAMI only for my research study and will not sell or use it with any compensated activities. I will include the copyright statement on all copies of the instrument.

If you agree to allow use of CAMI for my research, please indicate so by return e-mail at marbermom@aol.com.

Thank you in advance for your attention.

Sincerely,

Andrea Marber

138 Marlborough Street #1
Boston, MA 02116
[917-453-9720](tel:917-453-9720)
marbermom@aol.com