A SURVEY OF THE LITERATURE ON THE USE OF MENTAL HEALTH DIVERSIONARY COURTS ACROSS THE UNITED STATES

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Acknowledgement

The authors wish to thank Dr. Patricia Griffin, consultant to the Philadelphia Department of Behavioral Health and Mental Retardation Services, for the expertise that she provided in shaping the direction of our review.

What are Mental Health Courts?

Mental Health Courts were created in response to the increasing number of defendants with behavioral disorders in the criminal justice system (Griffin, Steadman & Petrila, 2002). As specialized courts, the purpose of mental health courts is to divert people with a history of serious mental illness from the traditional criminal justice system to treatment. Similar to drug courts, mental health courts spring from Therapeutic jurisprudence, a philosophy that views crime as an expression of an illness, and thus the focus is on an offender's rehabilitation (Geary, 2005; Odegaard, 2007). Upon successful treatment, mental health courts typically drop charges, or reduce sentences.

How they work

Mental health courts generally handle misdemeanors, although some courts consider felonies as well. Mental health courts are not designed to threaten the defendant with criminal sanctions in order to coerce compliance into mental health treatment. They focus on the defendant's choice to opt for a mental health treatment program that diverts the defendant from incarceration.

Mental health courts treat mental illness as the primary cause for criminal recidivism and attempt to assist in the offender's recovery process. A separate

docket is designed for mentally ill defendants. A judge presides at the initial hearing and subsequent monitoring sessions. Prosecution and defense counsel work with the judge in a non-adversarial team approach. Criminal justice and mental health professionals work in partnership to develop treatment plans. The offender must voluntarily participate in treatment that is monitored by the court with the promise to either dismiss charges upon completion of the treatment program or avoid incarceration (depending upon whether the court follows a pre or post adjudication model). Judge and counsel are less adversarial than in the traditional courts system. Treatment consists of intensive case management, medical treatment, individual and group counseling, all under the directive of a mental health court judge who regularly meets with the offender (Boothroyd, Mercado, Poythress, Christy & Petrila, 2005)**.**

Mental Illness and the Criminal Justice System

The prevalence of individuals with mental illnesses entering the criminal justice system is higher than in the general population. According to Mental Health America (2009), it is estimated that one in six inmates in jail is mentally ill. State prison inmates with mental conditions were more likely than other inmates to be incarcerated for a violent offense (53 percent compared to 46 percent); more likely to be under the influence of alcohol or drugs at the time of the current offense (59 percent compared to 51 percent); and more than twice as likely to have been homeless in the 12 months before their arrest (20 percent compared to 9 percent).

HISTORY OF MH COURTS

Mental health courts were inspired by drug treatment courts, due to the success of drug treatment courts in treating drug addiction as the illness that causes criminality among many drug abusers. Since the establishment of the first formal mental health court in Broward County, Florida in 1997, mental health courts have been created in several jurisdictions across the United States (Boothroyd et al, 2005). Congress promoted the development of mental-health courts with the passage of America's Law Enforcement and Mental Health Project Act in 2000, which provided funding for about 100 mental-health-court programs. Congress approved an annual appropriation of 10 million dollars through fiscal year 2004 to establish up to 100 mental-health-court programs (National Center for State Courts, 2003).

Mental health courts are located throughout the country. There were about 170 mental health courts operating in the United States as of the end of 2007. Seventy-eight percent of mental health courts were in non-rural regions, whereas only 22% of mental health courts were in rural regions. Thirty-seven percent of mental health courts were in the Western United States, 37% in the South, 15% in the Midwest, and 11% in the Northeast (Mental Health America, 2009).

“Three basic operational models”

Griffin et al (2005) and Steadman, Redlich, Griffin, Petrila & Monahan (2005) describe three points of intervention where the defendant is diverted from the traditional court system to mental health court.

1) Pre-adjudication model: In this model, a judge offers mental health court treatment as an option assigned to a treatment program. Criminal charges are suspended and dropped upon completion of the mental health treatment program.

2) Post-plea-based model: Adjudication occurs, but the sentence is suspended because the offender chooses to participate in a mental health treatment program as mandated by a mental health court.

3) Probation-based model: In this model, the offender is convicted and as a part of probation, the offender is obliged to enter a treatment program.

The second and third models are post-adjudication models. The convictions are in place, but sentences may or may not be imposed. The prosecutor often suspends charges as leverage- the suspension of charges in exchange for participation in for court-mandated treatment- to motivate the participant to comply with mental health treatment (Griffin et al, 2005).

The Literature

McNiel and Binder (2007) evaluated a mental health court in San Francisco. They examined whether mental health treatment, as mandated by a mental health court would reduce recidivism and violence by people with mental disorders who had been arrested. The researchers compared 170 offenders who entered the Mental Health Court after arrest to 8067 other adults with mental illness who entered the traditional court system.

Criminal Recidivism

The results indicate that after a year 48% of the Mental Health Court participants graduated, 26% were still in the program, and 26% left the program for other reasons (including voluntarily opting out, being removed from the program because of new changes, and non-compliance, and other reasons). 18 months after enrollment, the likelihood of Mental Health Court participants being charged with any new crimes were 26% lower than the offenders who entered the regular criminal justice system. Furthermore, mental health court participants were 55% less likely to get charged with a new violent crime. This appears to be a significant result.

Symptomatology:

McNiel and Binder focus on their assigned topic, the evaluation of criminal recidivism and the violence among participants in mental health court. However, they did not evaluate outcomes of any participants in traditional courts or mental health courts.

Moore and Hiday (2006) evaluated whether a mental health court can reduce the risk of recidivism and violence by people with mental disorders who have been arrested. They analyzed the mental health court in an anonymous town in the southeastern United States. They compared the 82 clients who were eligible and chosen for mental health court participation between September 2001 and August 2002 to 183 similar offenders whose cases were held in traditional courts. The traditional court sample was based on the judge's knowledge of community labeling and/or treatment history. This was not the

scientific method, but it was the same method for initial selection of the clients who entered mental health court.

Criminal Recidivism

Moore and Hiday (2006) found that defendants who completed the mental health court program had a re-arrest rate about 1/4th that of similar defendants in traditional court. There was also a significant reduction in the severity of re-arrest as compared to traditional court. However, Non-Completers showed no significant difference in re-arrest compared to Traditional Court defendants. A full dose of mental health court services appears to work, whereas there is no evidence that a partial dose works.

Boothroyd, Mercado, Poythress, Christy & Petrila (2005) examined the first mental health court, established in Broward County Florida. They compared 97 offenders from Broward County mental health court to 77 offenders from a traditional court in another Florida county.

The Brief Psychiatric Rating Scale-Anchored Version (BPRS) was utilized to assess the clinical status of defendants in the two courts. Trained research assistants clinically assessed and interviewed the same defendants for the duration of the study. The BPRS yields a global index of the severity of current psychopathology and four sub-scores associated with psychoticism, emotional withdrawal, hostility, and depression. Scores of the global index range from 18 to 126, with higher scores indicating greater severity.

No significant differences were found between defendants in the two courts in terms of gender, race or ethnicity, age, or overall level of

psychopathology, as measured by the BPRS. In fact, there were not any significant changes in defendants' clinical status, as measured by the BPRS, associated with receipt of treatment or participation in the mental health court.

There were no reductions in symptoms among defendants who received treatment in either court setting, which may reflect the chronic nature of their disorders. The results call attention to the quality of the public mental health system. It implies that there are not sufficient resources or enough support to provide adequate care. The researchers suggest a longer running study. There may be revealing data beyond the eight-month follow-up period of this study.

Broner, Mayrl & Landsberg (2005) conducted an evaluation study of NYC-LINK, a jail-based post-booking diversion program sponsored by the Department of Health and Mental Hygiene of New York City. According to the authors, jail-based diversion programs occur at any stage of the criminal justice process prior to sentencing. Using a quasi-experimental design, the study focuses on comparing the effects of two conditions in the diversion program—mandated vs. non-mandated diversion—on service access and use, recidivism, mental health stability, drug and alcohol use, and life satisfaction. Non-mandated diversion included those diverted and case managed from jail without specific court involvement or any mandated sanctions, whereas mandated diversion included those diverted though the court with diversion conditioned on treatment involvement, mandatory case management reporting, and with court sanctions for noncompliance. The study included 175 individuals with a history of serious

and persistent mental illness and substance abuse. Both felony and misdemeanor charges were eligible for the study, with exception of murder.

Recidivism

Findings show that mandated diversion clients were more likely to be linked to residential and outpatient treatment programs, to spend more time in treatment, and to spend more time in the community (as opposed to incarcerated or in a hospital) than were non-mandated clients. In addition, mandated diversion clients were more likely to decrease drug use, the number of days spent in incarceration, and recidivism during the course of a year than were non-mandated clients. According to the study findings, mandated diversion may more effective than non-mandated diversion in reducing number of days of incarceration, increasing number of days spent in the community, and reducing drug use as well as in effectively creating treatment linkages.

Symptomatology:

With the exception of medications, treatment had no significant effect on mental health and quality of life outcomes. Greater medication compliance was associated with a decrease in length of incarceration, risk of violence, and acute psychiatric symptoms during the course of a year.

Cosden, Ellens, Schnell, Yamini-Diouf, Wolfe (2003) evaluated whether mental health treatment court with assertive community treatment has better outcomes than treatment as usual kind of courts.

The assertive community treatment group was defined by services such as intensive case management. Subjects were sent to a special court with non-

adversarial court proceedings. The “treatment as usual” group was given a regular courtroom with adversarial court proceedings. The subject was offered mental health services in the jail setting or if put on probation expected to find services with a community mental health treatment agency.

The criteria for the study consisted of the following:

- adults charged with either a felony or misdemeanor
- had at least one prior booking
- were diagnosed with a serious and pervasive mental illness
- were residents of Santa Barbara county, California

Offenders could enter the program either pre-plea or post-adjudication. Pre-plea participants could have no prior offenses that involved serious acts of violence. Post conviction participants could have some violence in their past, if they were seen as no longer posing a threat of danger to others as determined by the District Attorney and other MHTC team members.

According to the authors, diagnosis was determined by a psychiatrist or psychologist working with county inmates, developed using a clinical interview and observations. Inmates who were already part of the county mental health care system were re-evaluated for the purpose of this program to ascertain whether they still met the diagnostic criteria. In addition, substance abuse problems were assessed via administration of the Addiction Severity Index (ASI; McLellan, Kushner, Metzger, & Peters, 1992). The study population consisted of 235 adults who were diagnosed with “serious mental illness” and all participants volunteered for the study.

The authors found that those persons with a substance use history or a history with the criminal justice system are good predictors of future involvement in the criminal justice system for individuals with mental health diagnoses.

- An addiction treatment component must be integrated with ICM programs. Results show those Intensive Case Management with a substance abuse component had lower recidivism rates.
- Services need to be intensive and comprehensive, including housing, psychiatric, vocational and addiction treatment services.
- Coordination of the mental health system and the courts or correctional agencies needs to take place. However, the authors suggest that there needs to be a clear distinction between the clinical role of case managers and the monitoring and court role of probation and parole officers.
- Effective jail diversion programs used early engagement strategies while consumers were in jail, prison or forensic hospitals.

Recidivism

M. Cosden et al (2003) concluded that the court system should coordinate with correctional agencies and the mental health court system. Furthermore, an addiction treatment component needs integration with Intensive Case Management programs. Intensive Case Management intervention is an essential component of a jail diversion initiative but is not sufficient to keep individuals away from future arrest and incarcerations.

Offenders with an Intensive Case Management that addressed substance abuse issues had lower recidivism rates. Treatment plans need to include housing, psychiatric, vocational and addiction treatment services. The authors concluded that Intensive Case Management intervention is an essential component of a jail diversion initiative but is not sufficient to keep individuals away from future arrest and incarcerations.

According to **Ruddell (2008)**, each jail developed its own intervention programs based on its unique conditions, such as size of mental health population, jail size, and the availability of resources within jail and the community. Overall, both admission screening forms and suicide risk forms were widely used in most jails, and most administrators reported them as being the most effective approach in identifying the needs of inmates with mental illness. In regard to programs that diverted mentally ill individuals from jails, including mental health courts, jail administrators generally perceived them as being less effective than other approaches such as mental health units in jails, jail-based case management, and providing training to jail officers. One reason for low confidence in diversion programs seemed to be the lack of strong mental health services in the community for forensic individuals. As Ruddell (2008: 127) states: “Although interventions such as drug or mental health courts are intended to work with special-needs populations, the absence of comprehensive mental health services and community resources makes the success of referrals less likely.”

Although the perceptions of jail administrators provide an important insider's glimpse into what approaches may effectively work for jail inmates with mental illness, the results of this study need to be interpreted with caution, precisely because they are based on biased perceptions rather than on empirical evidence. In any case, the study underscores a very important point: the effectiveness of any jail diversion program depends on the availability of community resources and strong linkages to specialized resources.

Summary

The effect on criminal recidivism and clinical outcomes are mixed. McNiel and Binder found a dramatic reduction in criminal recidivism at the mental health treatment court in San Francisco. In fact, 18 months after enrollment, the likelihood of Mental Health Court participants being charged with any new crimes was 26% lower than the offenders who entered the regular criminal justice system. Furthermore, mental health court participants were 55% less likely to get charged with a new violent crime. The study of a mental health court in a Southeastern town by Moore and Hiday (2006) found that defendants who completed the mental health court program had a re-arrest rate about 1/4th that of similar defendants in traditional court. There was also a significant reduction in the severity of re-arrest as compared to traditional court.

M. Cosden et al (2003) discovered offenders with an Intensive Case Management that addressed substance abuse issues had lower recidivism rates than those who entered traditional courts. Treatment plans must include housing, psychiatric, vocational and addiction treatment services.

Broner et al (2005) found that court mandated diversion may be more effective than non-mandated diversion in reducing number of days of incarceration, increasing number of days spent in the community, and reducing drug use as well as in effectively creating treatment linkages. Interestingly, treatment had no significant effect on mental health and quality of life outcomes. Greater medication compliance was associated with a decrease in length of incarceration, risk of violence, and acute psychiatric symptoms during the course of a year. Boothroyd et al (2005) found no reductions in symptoms among defendants who received treatment in either traditional court or mental health treatment court settings.

Discussion

Mental health court outcomes are inconclusive. Some research (Moore and Hiday, 2006) suggest that a “full dose” of mental health treatment effectively reduces the re-arrest rate of offenders. There was also a significant reduction in the severity of re-arrest as compared to traditional court. However, Non-Completers showed no significant difference in re-arrest compared to Traditional Court defendants. There is no evidence that a partial dose of mental health treatment works.

Researchers compared offenders from Broward County mental health court to offenders from a traditional court in another similar county in Florida (Boothroyd et al, 2005). Interestingly, offenders of both traditional courts and mental health treatment courts actually showed an increase in the severity of mental health symptoms over 8 months after beginning treatment.

Broner et al (2005) found that only medical compliance was associated with a decrease in length of incarceration, risk of violence, and acute psychiatric symptoms. The rest of the treatment plan was ineffective.

Cosden et al (2003) concluded that the court system should coordinate with correctional agencies and the mental health court system. Furthermore, an addiction treatment component needs integration with Intensive Case Management programs.

Results show that Intensive Case Management with a substance abuse component had lower recidivism rates. Services need to include housing, psychiatric, vocational and addiction treatment services.

Aside from criminal recidivism and mental health Symptomatology issues, there are also ethical questions. Mental health courts can potentially misapply their power. Law enforcement may target mentally ill people in the community for “petty crimes” that would otherwise be ignored (ie. Loitering, public intoxication, etc). The mental health court system may wish to help the offender recover. However, these offenders may not opt for mental health treatment, may not complete their treatment, or may have adverse reactions to court mandated treatment. Offenders who are unable to comply with the designated mental health court treatment may be directed to jail. Thus, even more people with mental illness may be brought into mental health courts with the intent to treat their mental illness, but in actuality, they are punished for their mental illness. This population may otherwise be ignored by the justice system without a mental health court system.

Mental health courts may contradict the recovery model. With the exception of court mandated probationary mental health treatment, mentally ill offenders usually filter into mental health courts between time of arrest and before sentencing. Offenders with mental illness can agree to enter the mental health court or return to the traditional court system. However, leverage- the suspension of charges in exchange for participation in for court mandated treatment- raises questions regarding the free volition to enter treatment (Griffin et al, 2005). Can the justice system really offer mentally ill people recovery-oriented choices in treatment when treatment is viewed as a better option than another punishment?

The Recovery Model views recovery as journey of healing and transforming a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. It is a personal journey of empowerment, self-determination, self-realization, supportive relationships, and social inclusion.

Previous models, which institutionalized mentally ill people, failed to socially include them in society. Furthermore, they had little say in their own treatment plans. Mental health courts risk becoming an updated version a mental health institution. The stigma of criminality and the scars of incarceration can be detrimental to the mentally ill. However, are programs that are monitored by a judge, and implemented by case managers, therapists, and peer-support counselors, effective at empowering mentally ill people?

Therapeutic jurisprudence views crime as an expression of mental illness. However, that philosophical perspective is not without flaws. Some mentally ill individuals want to engage in criminal behavior. It is true that many mentally ill people engage in criminal activity because of a lack of resources or supports. That loitering, public urination, aggressive panhandling, etc., would not exist if the individuals could achieve their goals without breaking the law. However, some criminal behavior is inhibited by mental illness. An individual's mental illness might produce cognitive difficulties that get in the way of properly committing a crime. As a result of treatment, he/she may reduce or even eliminate the symptoms of mental illness only to return to committing crimes. However, this time he/she can engage in criminal behavior without making the mistakes that resulted in incarceration and/or arrest in the first place. In other words, the individual becomes more capable of carrying out deviant/criminal behavior while avoiding arrest.

It is uncertain whether compliance to mental health treatment causes a reduction in criminal recidivism or a reduction in severity of subsequent crime. It is possible that offenders who successfully complete their court-mandated treatment are already motivated to change their conduct. Therefore, they are more likely to successfully finish any diversionary program.

It is questionable whether mental health treatments such as individual and group therapy help the offender in his/her recovery process. Perhaps structured activities combined with a designated residence where the client can live, albeit temporarily, does more to transform the individual.

Each mental health court system has its own idiosyncrasies possibly based on cultural, social, and economic factors within a region. It is difficult at this stage to parse out strategies that work effectively, make little difference, or are detrimental to the individual. While there are snapshots of success throughout the nation, much more research is necessary before coming to a valid conclusion.

Regarding programs that diverted mental health individuals from jails, including mental health courts, jail administrators generally perceived them as being less effective than other approaches such as mental health units in jails, jail-based case management, and providing training to jail officers (Ruddell, 2008). One reason for low confidence in diversion programs seemed to be the lack of strong mental health services in the community for forensic individuals. As Ruddell (2008: 127) states: “Although interventions such as drug or mental health courts are intended to work with special-needs populations, the absence of comprehensive mental health services and community resources makes the success of referrals less likely.”

Suggestions and recommendations for future research.

The literature suggests that mental health treatment courts show some promise in reducing criminal recidivism and the severity of follow up crime. However, there is little evidence to prove that court mandated mental health treatment helps clients recover. Although mental health courts provide an

important gateway to treatment, these courts have little influence or control over the type and quality of services that defendants receive.

Researchers should to collect longitudinal data consisting of years instead of months in order to measure how mental health courts affect participants' criminal recidivism and recovery outcome. One of Recovery's principles is non-linearity. Recovery is not linear, rather it is based on continual growth, occasional setbacks, and learning from experiences to move forward. It takes years to measure the effect of court mandated treatment programs. However, there is reason to feel hopeful that criminal recidivism is reduced by treatment assigned by mental health treatment courts.

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