AOC Literature Review

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MENTAL HEALTH COURTS

An Overview

An overview of the literature on mental health diversion programs and mental health courts.

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AOC Literature Review

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INTRODUCTION

Mental illness is a considerable problem within jails and prisons and juvenile detention facilities. A large amount of research argues that adult jails and prisons and juvenile detention centers are the new asylums for mentally ill adults and juveniles and that correctional institutions are now the primary providers of services (Cohen & Pfeifer, 2008; Lamb, Weinberger, & Reston-Parham, 1996; Moore & Hiday, 2006; Robison, 2005). A recent report by the California Judicial Council's Task Force for Criminal Justice Collaboration on Mental Health Issues discussed the role of courts in addressing the needs of offenders with mental illness (Administrative Office of the Courts [AOC], 2011). One strategy for addressing the issues and challenges of both adult and juvenile offenders with mental illness is through a *mental health court*, a criminal or delinquency court that has a dedicated calendar and judge for offenders with mental illness. Mental health courts, a form of mental health diversion, allow eligible offenders to avoid detention by obtaining community treatment under court supervision.

This document will review the literature on adult and juvenile mental health courts and other mental health diversion programs, including the models they use, any evidence related to recidivism and treatment utilization among offenders with mental illness, and whether they are cost beneficial. Most of the research in the area of mental health courts has focused on the adult population because far more adult mental health courts are in operation. However, an increasing number of juvenile mental health courts are being established, and more research is being conducted on the population served by these courts.

BACKGROUND

James and Glaze of the Bureau of Justice Statistics (2006) reported that 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates had a mental health diagnosis or symptoms of mental health problems in the 12 months before their being interviewed for the study. In juvenile detention facilities, an estimated 65 to 75 percent of juvenile offenders have a diagnosable mental health disorder (Wasserman, Ko, & McReynolds, 2004). Despite this prevalence, only about half of state prisons provide 24-hour mental health care (Beck & Maruschak, 2001), and only about three-quarters of juvenile detention facilities provide mental health care. In fact, researchers estimate that two-thirds of juveniles are housed in detention facilities while they wait for community mental health services (U.S. House of Representatives, 2004).

The most common mental health problems in jails and prisons include major depression, bipolar disorder, schizophrenia, and other psychoses (James & Glaze, 2006; Lurigio, Rollins, & Fallon, 2004). The prevalence of these illnesses in incarcerated adults is approximately three to four times higher than that in the general public (Ditton, 1999). In addition, Ditton estimated that 1 in 10 adult inmates takes psychotropic medication and only 1 in 8 receives mental health counseling.

The most common mental health problems in juvenile detention facilities are substance abuse disorder, anxiety disorder (including high rates of posttraumatic stress disorder, or PTSD), and affective disorders such as depression and bipolar disorder (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Researchers have estimated that rates of mental health disorders among youth in the juvenile justice system are at least twice as high as those in the general population (Cocozza & Skowyra, 2000; Teplin et al., 2002). No studies indicate the extent to which juveniles take psychotropic medications; however, some researchers suggest that youth in out-of-home placement are often prescribed multiple psychotropic medications, including antipsychotic and mood-stabilizing drugs, without a clear medical rationale or proper monitoring (as cited in Moses, 2008).

DEFINITION OF MENTAL HEALTH DIVERSION PROGRAMS AND MENTAL HEALTH COURTS

Mental health diversion programs aim to divert people with mental illness from the criminal or juvenile justice system to appropriate mental health treatment. These programs are in place at various points: at the point of arrest the police can divert an offender to a mental health facility rather than to jail, or attorneys and judges can divert offenders at arraignment or while awaiting trial. Diversion programs can be informal or formal. Under informal diversion, an offender receives a reduced sentence or punishment in exchange for participating in mental health treatment as a condition of probation (Lamb et al., 1996). Under formal diversion, including mental health court, an offender must adhere to a list of conditions that the court sets, such as attending psychiatric treatment. If the offender completes all of the conditions, the court dismisses the charges.

Mental health courts apply collaborative justice principles to combine judicial supervision with intensive social and treatment services to offenders in lieu of jail or prison or juvenile detention. These collaborative justice principles include a multidisciplinary, nonadversarial team approach with involvement from justice system representatives, mental health providers, and other support systems in the community. Offenders with mental illness are screened for inclusion in mental health courts, with screening and referral occurring as soon as possible after arrest. Each offender who consents to participate receives case management that includes supervision focused on accountability and treatment monitoring.

Mental health diversion programs and mental health courts were designed to keep people with mental illness out of the jail and prison population. However, some have argued that the criminal and juvenile justice systems are not the appropriate front door to access to mental health care (Seltzer, 2005). Although there is consensus that a preventive public mental health system would limit the number of people with mental illness from entering the justice system, mental health courts have been highlighted as an outcomes-based effort to connect people with mental health problems to evidence-based practices (Berkeley Center for Criminal Justice, 2010).

All mental health courts follow a general drug court model, which involves offender assessment, judicial interaction, monitoring and supervision, graduated sanctions and incentives, and treatment services. All courts are also encouraged to follow the 10 essential elements of mental

health court design and implementation (Bureau of Justice Assistance, 2007), which were the result of a consensus among practitioners, policymakers, researchers, and others about what a mental health court is and what it should be. However, courts have various criteria for eligibility and use different processes, such as when and how to incorporate sanctions and incentives. This variation in process has generated some concern among academics because of courts' dependence on local influences and relationship dynamics (Bozza, 2007; Wolff & Pogorzelski, 2005). They noted that the variation and environmental factors could limit the validity of effectiveness findings. Another concern that some academics have with the general drug court model is the lack of traditional adversarial principles, which some claim could impede due process (Bozza; Stefan & Winick, 2005).

The first identifiable mental health court was established in 1980 in Indiana but was suspended in 1992 and reopened as a diversion program in 1996 (Steadman, Davidson, & Brown, 2001). The court more widely considered to be the nation's first adult mental health court opened in 1997 in Broward County, Florida. The first juvenile mental health court began in Santa Clara County, California, in 2001. The country now has more than 200 mental health courts, and California has more than 30 adult and more than 10 juvenile mental health courts in 25 counties.* Across the country and in California, evaluations have been conducted on mental health courts and mental health diversion programs to determine their outcomes and cost-effectiveness. A nonexhaustive list of relevant studies and their results is illustrated in the Appendix.

* Data related to the number of collaborative courts in California have been voluntarily provided by the courts. These numbers may fluctuate in response to changes in funding or legislation. The number of mental health courts in California is accurate to the best of the author's knowledge at the time of writing.

EVALUATION OF MENTAL HEALTH DIVERSION PROGRAMS AND MENTAL HEALTH COURTS

Only a few years after the opening and expansion of mental health diversion programs and mental health courts, researchers began examining whether these programs reduce recidivism among their participants. An additional factor in evaluations is whether these programs save money for the jurisdictions in which they are located. There continues to be a dearth of research on both adult and juvenile programs, however. Few rigorous evaluations have been conducted on adult programs; even fewer studies have focused on juvenile programs.

Some authors have noted that evaluating collaborative justice courts such as mental health courts has inherent challenges. Wolff and Pogorzelski (2005) identified five such challenges: defining the nature of the therapeutic intervention, finding an appropriate control group, selecting a representative sample, ensuring appropriate and consistent dosage of treatment, and measuring effects at appropriate follow-up intervals. They also noted that population and environmental differences should be controlled in evaluations.

Despite these challenges, researchers continue to evaluate mental health courts using rigorous methods. All of the studies that have been conducted have shown promising results in three primary outcomes: increased utilization of treatment services, reduced recidivism, and cost savings. Below is a description of results of these three outcomes.

Utilization of Treatment Services

Steadman and Naples (2005) found that mentally ill offenders who were in a mental health diversion program were significantly more likely than nonparticipants to report receiving three or more counseling sessions and taking prescribed medications. An early study conducted on Seattle's mental health court, started in 1999, also showed that the mental health court is effectively linking mentally ill offenders with necessary treatment services and that mental health court participants have a greater likelihood of treatment success and access to housing and critical supports than mentally ill offenders in traditional court (Trupin, Richards, Wertheimer, & Bruschi, 2001). Another evaluation—of the Broward County, Florida, court—also showed that participation in the mental health court increases the likelihood of participants' engaging in treatment (Boothroyd, Poythress, McGaha, & Petrila, 2003).

Juvenile mental health court participants also have access to services that they otherwise may not have access to. In a study of Alameda County's juvenile mental health court, the National Center for Youth Law (2011) found that once youth were enrolled they had access to more inpatient, outpatient, and day treatment than before enrolling. In addition to mental health treatment, the youth and their families were able to more easily access resources such as disability benefits, special education services, and health insurance. They also had less frequent psychiatric crises than before entering the program. However, the researchers found that treatment utilization decreased after the youth left the mental health court program.

Recidivism

Several evaluations have illustrated the impact of mental health courts on reducing recidivism. In one early study, researchers found that one year after sentencing, misdemeanants who were court mandated to complete judicially monitored mental health treatment had significantly better outcomes than misdemeanants who were referred to mental health treatment but declined (Lamb et al., 1996). *Significantly better outcomes* were defined as avoiding hospitalizations, rearrests, violence against others, and homelessness. Other researchers found similar outcomes for mental health courts. In the evaluation of Seattle's mental health court, Trupin et al. (2001) found that participants' arrests significantly decreased—by nearly half—between the time they entered the program and a year after they entered the program. Herinckx, Swart, Ama, Dolezal, and King (2005) also found a significant reduction in the number of arrests of mental health court participants between the 12 months before enrolling and the 12 months after enrolling. In the 12 months after enrollment, there was also a significant reduction in probation violations.

In an evaluation of the Broward County, Florida, court, Christy, Poythress, Boothroyd, Petrila, and Mehra (2005) found that participants' average number of arrests significantly decreased between one year before participating and one year after entering the mental health court program. When compared to arrest rates of those who went through traditional case processing, however, there were no significant differences. Christy et al. did find, though, that mental health court participants spent significantly fewer days in jail compared to the comparison group. The researchers concluded that both groups had reduced arrest activity but noted the nonequivalence in groups and drew more confidence in the pre-post analysis.

More recently, Moore and Hiday (2006) found that mental health court participants in another Southeastern state were rearrested significantly less often than were those in a comparison group of traditional criminal court defendants; the mental health court participants had a rearrest rate of about half that of the comparison group. The researchers also found that a "full dose" of mental health court, or completion, had a significant effect on recidivism. In a follow-up study, Hiday and Ray (2009) followed mental health court graduates for two years and found that their proportion and number of arrests continued to be significantly lower than in the two years before entering the mental health court. In addition, those who completed the mental health court program had fewer arrests and a longer time to rearrest than did those who failed to complete the program.

In California, Cosden, Ellens, Shnell, and Yamini-Diouf (2005) compared mental health court participants to a "treatment as usual" comparison group two years after participants entered the program. They found that participants and those in the comparison group had a significant decrease in the number of jail days in the two-year period, although those with a dual diagnosis were less affected by treatment than were others. The researchers concluded that judicial training and changes in community practice affected both participants in the program and those who were receiving "treatment as usual." A more recent study in California also showed the effectiveness of mental health courts on recidivism. McNeil and Binder (2007) compared mental health court participants to defendants in traditional court who also had a mental illness in San Francisco and found that mental health court participants were 26 percent less likely to be charged with new crimes and 55 percent less likely to be charged with violent crimes than were those in the comparison group. In addition, the researchers found that after 18 months, the risk of being charged with a new violent crime among mental health court graduates was about half of that of the comparison group.

In another recent study of four mental health courts—two in California, one in Minnesota, and one in Indiana—researchers found that mental health court participants had a lower rearrest rate and fewer incarceration days than did a "treatment as usual" group (Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2010). In addition, those who graduated from a mental health court program had lower rearrest rates than those whose participation was terminated before graduation. The researchers noted that "the appropriate question for mental health courts is

not 'do they work?' but 'for whom, and under what circumstances do they work?'" (Steadman et al., 2010, p. E5). They found that a diagnosis of schizophrenia or depression rather than bipolar disorder and illegal use of drugs within the previous 30 days was associated with more incarceration days during the follow-up period. They also found that longer exposure to the mental health court program is associated with improvement after leaving the program.

In a study of Santa Clara County's juvenile mental health court program, Behnken, Arredondo, and Packman (2009) found significant reductions in recidivism among program participants for violent, aggressive, and property crimes in the 23 months after entering the program compared to the recidivism rates in the 18 months before entering the program. The researchers found that 99 percent of program graduates had recidivated at least one time before entering the mental health court program while under traditional probation supervision, which they attributed to at least partial failure of prior judicial or mental health involvement.

Researchers have found reduced recidivism among juveniles in mental health diversion programs as well. Cuellar, McReynolds, and Wasserman (2006) found that youth who participated in a juvenile mental health diversion program in Texas were significantly less likely to be rearrested than a comparison group. Other researchers found that in New York, a mental health juvenile diversion program was successful in reducing both out-of-community placement and recidivism among mentally ill youth who participated (Sullivan, Veysey, Hamilton, & Grillo, 2007).

Cost-Effectiveness

Researchers have also looked at the cost-effectiveness of mental health courts. In a study of four mental health diversion programs in different states, Steadman and Naples (2005) found that in general, mental health diversion programs have lower criminal justice costs and greater treatment costs than traditional case processing. In the short term, the treatment costs are greater than the criminal justice savings. In another report, however, Ridgely et al. (2007) examined the fiscal impact of a mental health court and found that the mental health court did *not* result in substantial short-term costs over traditional case processing. However, Ridgely et al. suggested that substantial long-term savings could result from reductions in recidivism as well as reductions in using expensive, intensive treatment such as hospitalization.

CONCLUSION

Evidence shows that adult jails and prisons and juvenile detention facilities have become the new institutions for the mentally ill. With such a large proportion of adult and juvenile offenders with a mental illness, the AOC's Task Force for Criminal Justice Collaboration on Mental Health Issues detailed recommendations for changing the paradigm for persons with mental illness in the criminal justice system. The recommendations include increasing services in several areas, including diversion programs.

Mental health diversion programs and mental health courts have become useful tools in providing the appropriate treatment to these offenders. Numerous evaluations in the past decade have shown promising results for these programs in several areas, including participants' utilization of services, reduced recidivism, and cost savings to counties and states. Some authors have identified challenges to studying the effectiveness of courts that follow a general drug court model, such as nuances in their operations (Wolff & Pogorzelski, 2005). This difficulty also makes generalizing findings challenging (Bozza, 2007).

Despite the promising results shown thus far, continued research with strong and rigorous designs on the effectiveness of mental health courts is recommended. Further research should include studies with equivalent comparison groups, extended follow-up to determine how long a mental health court's effect lasts, and large sample sizes.

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Appendix: Nonexhaustive List of Relevant Studies and Their Findings

Author (Year)	Study	Findings
Boothroyd, Poythress, McGaha, & Petrila (2003)	The Broward mental health court: Process, outcomes, and service utilization	Participation in mental health court increases the likelihood of participants' engaging in treatment.
Christy, Poythress, Boothroyd, Petrila, & Mehra (2005)	Evaluating the efficiency and community safety goals of the Broward County mental health court	Mental health court participants spent fewer days in jail for the index arrest than did a comparison group. Rearrests did not differ up to one year after enrollment between participants and comparison group. Participants reported fewer acts of violence than did the comparison group at 8 months.
Cosden, Ellens, Shnell, & Yamini-Diouf (2005)	Efficacy of a mental health treatment court with assertive community treatment	Recidivism declined and psychosocial functioning improved for mental health court participants compared to a treatment-as-usual group. Mental health court was less effective for participants with serious drug and alcohol problems or dual diagnoses.
Cuellar, McReynolds, & Wasserman (2006)	A cure for crime: Can mental health treatment diversion reduce crime among youth?	Youth who participated in a juvenile mental health diversion program were significantly less likely to be rearrested than a comparison group.
Herinckx, Swart, Ama, Dolezal, & King (2005)	Rearrest and linkage to mental health services among clients of the Clark County mental health court program	The number of arrests for mental health court participants declined significantly between 12 months before enrolling and 12 months after enrolling. In the 12 months after enrollment, probation violations also significantly declined.
Hiday & Ray (2009)	Arrests after exiting mental health court	The proportion and number of arrests of mental health court graduates continued to be significantly lower two years after the graduates entered the mental health court than in the time before participating in the program. In addition, those who completed the mental health court program had fewer arrests and a longer time to rearrest than did those who failed to complete the program.

McNeil & Binder (2007)	Effectiveness of a mental health court in reducing criminal recidivism and violence	At 18 months, the likelihood of mental health court participants' being charged with any new crimes was 26% lower than for individuals receiving treatment as usual, and graduates of mental health court maintained reduced recidivism after they were no longer under court supervision.
Moore & Hiday (2006)	Mental health court outcomes: A comparison of rearrest and rearrest severity between mental health court and traditional court participants	Mental health court participants had a rearrest rate of about half that of a comparison group. Also, a "full dose" of mental health court, or completion, had a significant effect on recidivism.
Ridgely, Engberg, Greenberg, Turner, DeMartini, & Dembosky (2007)	Justice, treatment, and cost: An evaluation of the fiscal impact of Allegheny County Mental Health Court	Fiscal impact analyses showed that entry into the mental health court program leads to an increase in the use of treatment services in the first year as well as a decrease in jail time for program participants during both the first and second years after entry. The decrease in jail expenditures mostly offsets the cost of the treatment services.
Steadman & Naples (2005)	Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders	Mentally ill offenders who were in a mental health diversion program were significantly more likely than nonparticipants to report receiving three or more counseling sessions and taking prescribed medications. Authors conclude that mental health diversion reduces time spent in jail without increasing risk to public safety.
Sullivan, Veysey, Hamilton, & Grillo (2007)	Reducing out-of-community placement and recidivism: Diversion of delinquent youth with mental health and substance use problems from the justice system	A juvenile mental health diversion program significantly reduced recidivism among participants 120 days after referral to the program. Recidivism continued to decrease during the two-year study period. Participants also had a decreased rate of out-of-community placement.
Trupin, Richards, Wertheimer, & Bruschi (2001)	City of Seattle mental health court evaluation report	Mental health court participants' arrest rates significantly decreased between the time they entered the program and a year after they entered the program. The mental health court also effectively links mentally ill offenders with services.

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