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A REVIEW OF LITERATURE ON MENTAL HEALTH COURT GOALS, EFFECTIVENESS, AND FUTURE IMPLICATIONS

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Abstract: Mental health courts are designed to reduce criminal justice system involvement among those suffering from mental health disorders. These courts have proliferated across the United States in the last 30 years, growing to over 470 nationwide. Mental health courts incorporate multidisciplinary teams of criminal justice system practitioners and stakeholders to supervise and connect participants to treatment services. Mental health court evaluations generally show positive results when it comes to reducing recidivism and improving participant quality of life; however, limitations in research methodology reduce the validity of many studies. This article provides a review of literature on mental health courts, including court operations, effectiveness, and related issues.

Introduction

The criminal justice system has long recognized the prevalence of mental health issues in corrections populations. In a 2017 U.S. Bureau of Justice Statistics study, about 62% of jail inmates and 50% of prison inmates reported suffering from a mental health disorder at one time.[1] Mental health courts (MHCs) were designed to curb mental health disorders among justice-involved individuals. These problem-solving courts emphasize rehabilitation rather than punishment to promote desistance from criminal behavior (e.g., retributive justice).[2] MHCs maintain court dockets specifically for justice-involved individuals dealing with mental health disorders and include non-adversarial supervisory teams of criminal justice practitioners and clinical professionals, voluntary participation by defendants, and a goal of reducing incarceration.[3]

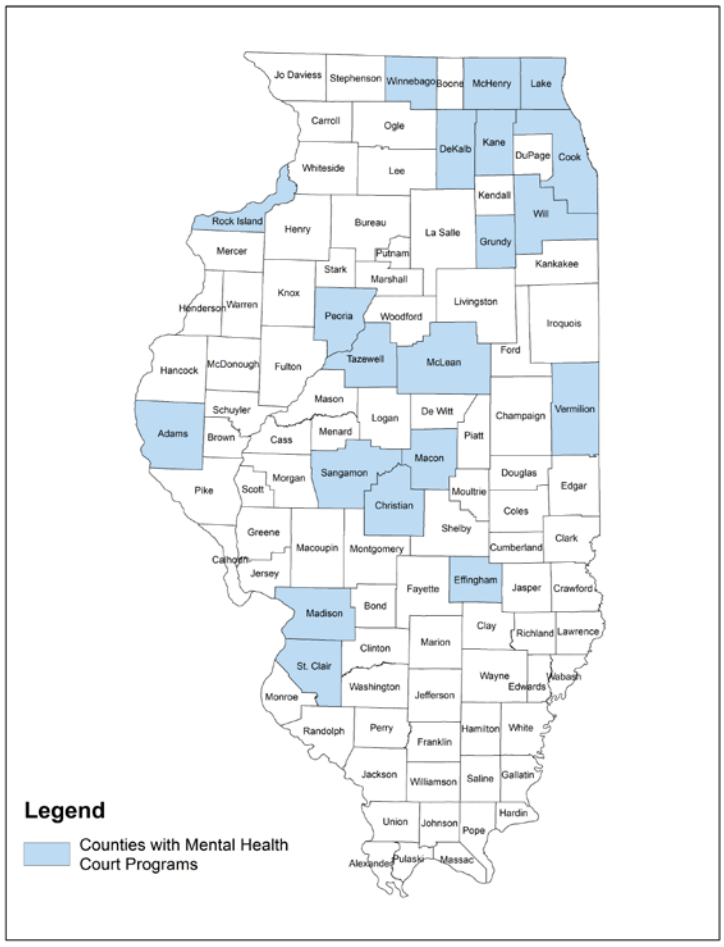
Though MHCs have become popular to reduce criminal justice system involvement among people suffering from mental health disorders, their efficacy is still up for debate. MHC evaluations tend to show positive results; however, inconsistencies in MHC programming from site to site and varying research methodologies have called into question the validity, reliability, and generalizability of those results. In this article, we explore MHC operations, effectiveness, and evaluation, as well as barriers to successful outcomes.

Background on Mental Health Courts

A growing recognition that the criminal justice system was becoming overwhelmed with individuals suffering from mental health disorders in the1980s led to a call for alternative approaches to incarceration.[4] The first problem-solving court for justice-involved individuals suffering from mental health disorders was established in Marion County, Ind., in 1980.[5] The court serviced individuals with serious mental health disorders who were facing non-violent misdemeanor or minor felony charges.[6] In 1983, the Los Angeles County Department of Mental Health established a forensic MHC diversion program that provided consultation to the courts on managing defendants with mental health disorders.[7]

The first MHC as they are now conceived and operated was established in Broward County, Fla., in 1997.[8] The Broward County MHC was borne out of a recognition that the county's drug court lacked the necessary mental health services required by participants with co-occurring mental health and substance use disorders.[9] While MHC programs vary from site to site, they borrow from the drug court model of phase progression culminating in program graduation.[10] The number of MHCs grew quickly in the early 2000s and now total more than 470 across the United States, including 25 in Illinois (Map 1).[11]

Map 1
Illinois Counties with Mental Health Court Programs



Source: SAMHSA Adult Mental Health Treatment Court Locator, accessed July 7/14/2020.

Goals and Components of MHCs

MHC components often include voluntary participation, diversion from incarceration to treatment, and multi-disciplinary court teams. Typically, teams are made up of treatment providers and criminal justice system practitioners with a judge at the center of the participant supervision process.[12]

The Council of State Governments Justice Center established 10 essential MHC elements that encourage best practices based on available research (Table 1).[13]

Table 1
Essential Elements of Mental Health Courts

Element	***Description***
Planning and Administration	Stakeholders representing the criminal justice system, mental health treatment practitioners, SUD treatment practitioners, and others guide the planning of the court.
Target Population	Eligibility criteria address public safety with the court's treatment capacity and each individual's relationship between mental health and criminality.
Timely Participation and Linkage to Services	Participants are identified, accepted, and diverted from incarceration as quickly as possible.
Terms of Participation	The terms of participation are clear, individualized, and correspond to each defendant's level of risk.
Informed Choice	Defendants must be fully aware of the conditions of participation and are provided legal counsel.
Treatment Supports and Services	Participants are connected to individualized treatment services.
Confidentiality	The participants' health and legal information gathered during treatment services should be protected.
Court Team	Training is provided to a team of criminal justice and mental health staff and treatment providers.
Monitoring Adherence to Court Requirements	Court staff collaborate in order to effectively monitor the participants and offer graduated incentives and sanctions.
Sustainability	Data are collected and analyzed to gauge the impact of the court, court processes are institutionalized, and community support is cultivated.

Source: Council of State Governments Justice Center

MHCs, and problem-solving courts more broadly, recognize the need for treatment coupled with rehabilitation among the justice-involved population and case managers serve as liaison between treatment providers and probation officers.[14] In this way, MHCs prioritize a more rehabilitative court setting with fewer punitive sanctions. Defining successful completion of participation in MHCs is more difficult, as overcoming a mental health disorder can differ greatly from person to person.[15] Common goals of MHCs include improving public safety, improving the quality of life of those suffering from mental health disorders, and reducing court and corrections costs by diverting people from incarceration.[16]

Some researchers argue that therapeutic jurisprudence is another common goal and an integral element of MHCs.[17] Therapeutic jurisprudence is a field of inquiry that focuses on the idea that legal rules, processes, and the behavior of legal actors may have therapeutic consequences for defendants.[18] MHCs practice therapeutic jurisprudence by minimizing punishment (e.g., antitherapeutic consequences) and expanding opportunity for empowerment and self-actualization (e.g., therapeutic consequences).[19]

While it is not a universally pervasive element of MHCs, the Risk-Need-Responsivity (RNR) model also tends to influence MHC operations.[20] The RNR model is based on the notion that it is unreasonable to assume individuals can effectively re-enter society after involvement with the justice system without addressing their underlying risk factors and criminogenic needs.[21] Criminogenic dynamic risk factors are risk factors that can be changed or improved, such as antisocial behavior or substance use disorders.[22] The third principle of the RNR model, responsivity, seeks to address criminogenic needs by providing appropriate and individualized treatment interventions and insulating the individual from future criminality.[23] Participant outcomes may be improved with the RNR model as a central MHC tenet.[24]

Effectiveness of MHCs

Despite the growing popularity of MHCs in the United States over the last two decades, they lack definitive evidence of their effectiveness. Generally, studies on the effectiveness of MHCs have found positive results, though there have also been some mixed findings potentially due to differences in outcome measurements and methodological rigorousness.[25] While much of the available research on MHC effectiveness relies on recidivism measures, some studies utilized more qualitative measures (e.g., perceived quality of life, program satisfaction) to analyze program efficacy.

Measuring Recidivism

Because the general goal of MHCs is to reduce criminality among people suffering from mental health disorders and increase general public safety, recidivism is the favored measure to gauge program effectiveness. Two meta-analyses found MHCs may reduce recidivism risk, but the effect might only be moderate.[26] One study of nine MHCs in Illinois found that 53% of MHC participants were arrested for a felony or misdemeanor within three years post-MHC enrollment.[27] MHC recidivism outcomes may be similar to those of standard probation. One study of Illinois probation participants found 54% were rearrested during or within four years of completing probation.[28] A Broward County, Fla., MHC evaluation revealed similar recidivism rates.[29] Researchers in that study found no statistically significant difference in first-year rearrest rates between regular probation participants and MHC participants.[30]

Studies comparing outcomes of MHC participants and those receiving standard probation revealed few differences. One study found while both groups experienced a decrease in annual rearrest rate, the decline among MHC participants was significantly greater.[31] Another study showed MHC participants recidivated and re-entered prison at about the same rate as those receiving standard probation.[32] Those researchers also found the MHC group had a greater

reduction in the average number of days spent in jail post-treatment, though the difference was insignificant.[33]

Characteristics and Recidivism

Research suggests MHC participants with certain criminal histories may be more prone to recidivism than others. For example, one study found participants with a history of committing varied types of offenses, prior violations of probation or parole, and a first arrest before the age of 18 were more likely to recidivate.[34] Additionally, some research suggests MHC participants referred for public order infractions, such as drug and alcohol, trespassing, and driving-related offenses, were more likely to recidivate than participants referred for violent offenses.[35] However, one study found that participants charged with violent offenses were less likely than those charged with non-violent offenses to recidivate.[36] Other characteristics related to successful outcomes include fewer prior arrests, MHC program completion, and prescription of psychiatric medication upon program release.[37]

MHC participants with co-occurring mental health and substance used disorders may be more at risk for recidivating. One study found that a majority of MHC participants who recidivated were arrested for offenses related to substance use.[38] Another study found that the most distinguishing characteristic between successful and unsuccessful program completion was the seriousness of the substance use disorder.[39] MHC participation in that study was found to be ineffective for those with serious substance use disorders and many participants had co-occurring mental health disorders and substance use disorders.[40] This finding may have resulted from a lack of available substance use disorder treatment, as some argue that substance use disorder treatment is essential for those suffering from co-occurring disorders.[41] Furthermore, research suggests MHCs that include substance use disorder treatment are more effective at reducing arrest and incarceration rates.[42] One study found participants with active substance use disorders were more likely to experience future involvement in the criminal justice system.[43]

Program Dosage and Completion

Treatment dosage is a common consideration in programs aiming to reduce recidivism and the relationship between MHC program completion and recidivism has been heavily researched.[44] Whether or not a participant completes an MHC program may portend a lower likelihood of recidivism.[45] An analysis of Michigan MHCs found successful program completion may help participants avoid committing new crimes.[46] The finding is supported by a study that found those who did not complete their MHC program were 3.7 times more likely to recidivate than those who did.[47] Similarly, other research suggests those who completed their MHC program had significantly lower odds of recidivism and a lower average criminal severity in cases of rearrest.[48] One study found those who completed the program had the lowest rate of recidivism (29%) compared to partial completers and non-starters and the differences in recidivism between partial completers and non-starters was statistically insignificant.[49] However, the researchers also found a significant decrease in assessed criminogenic needs and risk scores among program completers, while partial-completers and those who never participated in MHCs had little to no reduction in risk or criminogenic needs.[50] Factors that influence program completion may include criminogenic risk (i.e., participants with higher risk scores may be less likely to complete

the program) and mental health counseling (i.e., mental health services increase the likelihood of program completion). This suggests that recidivism may be reduced by increasing access to mental health disorder treatment services for participants with higher criminogenic risk.[51]

Additional Measures of Effectiveness

Some MHC outcome evaluations have examined holistic measures (e.g., program satisfaction and perceived quality of life) rather than traditional measures, such as recidivism or program completion.[52] Overall research has found high participant satisfaction and heightened perceived quality of life[53] and increased sense of personal responsibility, self-esteem, and hopefulness about the future.[54] In addition, some MHC participants reported successful diversion from incarceration and improvement in treatment accessibility.[55] Other research suggests when MHC participants perceive treatment as involuntary, treatment and service utilization do not affect quality of life.[56]

Issues in MHC Evaluation

While some MHCs have delivered promising results, more evaluation is needed to better assess their effectiveness. Some researchers argue the growth of MHCs has outpaced research efforts. Without demonstrable evidence of MHC effectiveness, growth will be unjustified.[57] In addition, methodological rigor of a study can drastically affect findings and account for variation in results regarding program effectiveness.[58] For example, one meta-analysis of MHCs found lower-quality studies tended to yield higher effect sizes, which suggests that high variance due to low study quality may influence findings.[59] MHC evaluation methodology has become more rigorous, resulting in more reliable, albeit, more modest, findings.[60] As these evaluations improve in methodological quality, a clearer understanding of their efficacy may emerge.

Evaluation Design

Study design is one of the most important considerations of research methodology. The gold standard for study design is true experimental design using a randomized control trial. In randomized control trials, subjects are randomly assigned to either an intervention or treatment group or a comparison groups and outcomes are observed.[61]

A lack of experimental design is common within existing MHC research.[62] Most MHC studies are quasi-experimental and lack random assignment.[63] In fact, an assessment of 15 MHC studies did not control for differences in relevant variables among those in the treatment and control groups, which would help to limit potential confounding factors and approximate randomized controlled research designs.[64] Some studies lacked a true comparison group, using pre- and post-testing, which limits the validity of findings because the study participants did not have equal likelihoods of being in the “control” or “treatment” groups.[65]

One MHC study that incorporated a randomized control trial found no significant difference in outcomes for MHC participants and standard probation participants.[66]

Data Collection

Data collection and analysis are key in program evaluation.[67] Researchers argue MHC data systems should be designed not only for tracking participant progress, but with evaluation in mind. [68] This includes keeping track of participant criminal history data, such as arrest and conviction records.[69] A successful data collection plan will include data elements, data sources, points of data entry, and where the data will be stored.[70] MHCs must establish proper data systems to ensure they are equipped for later program evaluation. Data for evaluation should include criminal justice outcomes (i.e., recidivism), mental health outcomes, and services.[71] In past MHC studies, researchers noted the lack of data on the type, quality, and appropriateness of treatment services provided was a limitation that may have impacted the validity of certain findings.[72]

Acquiring data for comparison groups is also an important consideration. Study validity is compromised without access to information on variables for both treatment and control groups. Research that does not adequately control for differences between treatment and comparison groups cannot reliably infer a causal relationship between MHC participation and participant outcomes.

It is important to consider contextual factors that may complicate data collection. For example, weaker collaborative relationships between criminal justice practitioners who operate the programs may inhibit data sharing.[73]

Focus on Recidivism

Maintaining and improving public safety through reduced criminality is perhaps the most common goal of MHCs. As such, many MHC evaluations measure participant success through recidivism avoidance.[74] However, more qualitative measures, such as participant satisfaction and quality of life, could offer a richer understanding of program effectiveness. Recidivism outcome studies do not capture the potential cognitive or social improvements developed during MHC participation.[75] One study found MHC participants who gave higher quality of life scores were less likely to recidivate than other probation participants.[76] This suggests efforts focusing on improving perceived quality of life may produce greater results in reducing recidivism. Research suggests the voluntary nature of the MHC program was enhanced with flexible treatment mandates.[77] Placing greater focus on how and to what extent MHCs discourage future criminal involvement may inform best practices for MHC programming.

Lack of Adherence to Uniformity

The lack of uniformity in MHC programming poses a challenge to the generalizability of research findings. As MHCs differ operationally from state to state and even county to county, program evaluations may not be generally applicable. The Administrative Office of the Illinois Courts standards for problem-solving court certification allow for local stakeholders to develop participant eligibility criteria, referral processes, and other program aspects.[78] Without specific guidelines for MHCs, it is difficult to generalize insight on their efficacy. While it is important

for MHCs to tailor programs to the needs of local participants and incorporate available resources, greater fidelity to best practices may help establish more uniform program guidelines.

Other Considerations

Other challenges to research on MHC effectiveness include samples that do not reflect the broader population, participant attrition or insufficient post-program follow-up periods, varying participant eligibility standards among different programs, and a lack of formal evaluation methods.[79] Additionally, because MHC program designs vary, they cannot be generalized; studies should seek to incorporate data from as many courts as possible to identify overall effects.[80]

The current body of research on racial disparities in MHCs also is lacking. The general focus on this aspect in evaluations is limited.[81] One study on differential experiences between Black and White MHC participants found that while Black participants reported higher levels of program satisfaction, they were still more likely to report negative experiences in the community and recidivate than their white counterparts.[82] More research is needed to determine how racial disparities may account for participant outcomes.

Barriers to Success and Future Considerations

While research on MHC effectiveness tentatively suggests participants see positive outcomes, many MHCs face barriers to success. Understanding program challenges and shortcomings can provide guidance for future operations.

Programmatic Shortcomings

Without a universal MHC model to follow, some MHCs employ programming that does not align with researcher recommendations on best practices, such as utilizing risk assessments, relying on incentives more than sanctions, and adhering to proper drug testing techniques. One Florida MHC study found that while participants had a greater likelihood of receiving mental health treatment, not all participants were linked to treatment.[83] Ensuring all participants are linked to treatment as intended should help to boost positive outcomes for participants.

Some MHCs do not adhere to the evidence-based RNR model when determining treatment needs.[84] One study found low- and medium-risk MHC participants were prescribed the same treatment services.[85] Over-prescribing services to participants has been shown to increase the risk of reoffending, as intensive services with excessive time requirements may impede on pre-existing protective factors, such as employment and social relationships.[86] Thus, providing appropriate levels of treatment to participants based on their risk level should increase positive outcomes.

Adherence to Punitive Programming

While MHCs are based on rehabilitation rather than retribution, MHCs still centrally incorporate punitive sanctions for noncompliance. Additionally, due to public safety concerns, some MHCs are wary of admitting individuals charged with more serious or violent offenses or may limit eligibility to those charged only with misdemeanors, denying MHC participation opportunities to those charged with felonies.[87] However, several studies suggest people charged with more serious offenses are less likely to recidivate and that increasing incentives to reinforce positive behavior may be more productive than imposing sanctions for negative behavior.[88] Thus, MHCs that adopt a less punitive approach may increase participant success rates.

Material Challenges for MHC Participants

People involved in the justice system tend to have low income, live in socially disadvantaged neighborhoods, and experience material disadvantages. In addition to finding that probation participants were more likely to live in disadvantaged neighborhoods than the general population, one study found that MHC participants were more likely than standard probation participants to live in disadvantaged neighborhoods.[89]

Additionally, research on people involved in community corrections indicates that many view structural barriers related to poverty (e.g., employment, housing, transportation) as bigger barriers to success than personal issues (e.g., substance use, mental health, negative peer association).[90] MHC professionals indicate they view systemic factors, such as stable housing and transportation, as important factors for successful participant outcomes.[91] While MHC programming and staff may be able to alleviate the structural barriers to participant success, these factors may be beyond the scope of MHC operations or budgeting. Regardless, it is important for MHC programming to address these issues wherever possible, and for researchers to keep these considerations in mind when evaluating MHCs.

Conclusion

The current body of research on MHCs indicates they yield generally positive results, both in terms of reducing recidivism and improving participants' perceived quality of life.[92] Still, concerns regarding data collection, study design, and programmatic shortcomings limit the usefulness of MHC evaluation findings. The lack of experimental study design in available MHC research is particularly problematic.[93] With a lack of important participant data (i.e., criminal or mental health histories), matching procedures needed to correct for non-random assignment may not be possible.[94] Failure to adequately control for differences between treatment and comparison group participants greatly compromises the validity of research findings. Without more methodologically rigorous research study designs, such as randomized control trials, knowledge of MHC effectiveness will continue to be insufficient. More rigorous research and data collection is needed to determine the efficacy of and improve upon MHCs.

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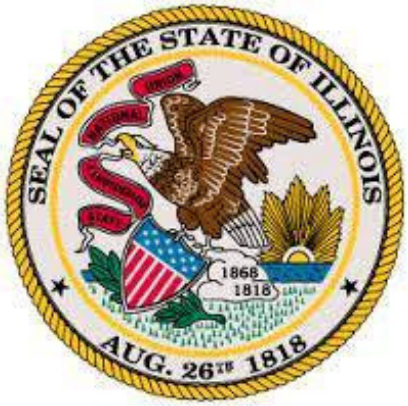

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