Mental Health Courts:
An Effective Criminal Diversion Alternative

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Abstract

This literature review examined the viability of Mental Health Courts (MHCs) as a legitimate diversion program, which originated as a response to the disproportionately high rates of individuals with mental illnesses involved in the criminal justice system. To do so, it evaluated the present body of research on this particular type of problem-solving courts, focusing mainly on the structure and organization of MHCs, the main (socio-demographic, clinical, and criminal) characteristics shared by their target population in order to identify factors that predict program completion, and their effectiveness in reducing recidivism rates among their participants when compared to defendants in regular court proceedings. Results showed that the manner in which MHCs are administered and structured varies widely across localities, which makes it more difficult to draw conclusions about their overall operation. Nevertheless, certain findings that apply across jurisdictions demonstrate that MHCs successfully diminish postexit jail days and rearrests among their participants, with program graduation being the most important factor in predicting lower recidivism rates. In conclusion, MHCs are a valid non-jail alternative for individuals with mental illnesses, given that they successfully reduce defendants’ criminal system involvement by linking participants to a wide range of public mental health and community services.
Mental Health Courts:

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Mental Health Courts (MHCs) are a relatively recent addition to the judicial system, created approximately 20 years ago as a way to better serve defendants with mental illnesses, a group of individuals whose criminal justice system involvement and incarceration rates are significantly higher than those of the general population (Burns, Hiday, & Ray, 2012).

As any comparatively new development, the actual effects of MHC interventions on its participants have not yet been fully empirically examined. However, the last several years have seen a rise in the interest paid to MHCs and their short-term and long-term consequences on crime reduction and recidivism among the population it offers its services to, which has resulted in an increasing number of studies and experimental interventions.

The primary focus of the following literature review is to demonstrate that MHCs are viable as a judicial intervention alternative to the traditional incarceration-based model. To do so, an analysis of the development and structure of these courts will be conducted. Moreover, this paper will focus on examining the main characteristics (socio-demographic, clinical, criminal) shared by those who become involved with these specialty courts, as well as factors that predict successful program graduation. In addition, this paper will examine whether or not MHCs have a significant effect in reducing recidivism among their participants, and who in their population can expect better results.

Mental Health Courts

Problem-Solving Courts

In the last couple of decades, the American judicial system has been influenced by a number of innovations that have shifted the practices and underlying assumptions about the role
and scope of the criminal justice system. One example of such innovations is the fast development of problem-solving courts.

Unlike traditional courts, problem-solving courts use a designated judicial, legal, and treatment team to divert individuals from the criminal justice system into community-based treatment in lieu of traditional case processing and sentencing. By the end of their involvement with the problem-solving court, most participants will have their criminal charges reduced or dismissed (Castellano & Anderson, 2012).

The most prominent of these courts have been the drug and alcohol courts that emerged in the mid 1990s, and have since then expanded around the country. In the late 1990s, and partly due to the perceived success of drug treatment courts, a new type of problem-solving courts emerged, known as Mental Health Courts (Dirks-Linhorst, Kondrat, Linhorst, & Morani, 2011). MHCs are problem-solving courts created in an attempt to divert persons with mental illness out of the cycle of arrest, incarceration, release, and rearrest, by motivating them to connect with treatment and services and to change their behaviors (Almquist & Dodd, 2009).

This initiative originated due to the large numbers of persons with a serious mental illness in the criminal justice system (Ray, Kubiak, Comartin, & Tillander, 2014), and the substantially higher arrest and incarceration rates of these individuals when compared to those of the general population (Burns, Hiday, & Ray, 2012).

**Mental Illness and the Judicial System**

People with untreated mental illnesses have a higher percentage of police contacts, given that they are more likely to participate in deviant behavior that exposes them to public scrutiny, thus increasing the likelihood of arrest (i.e., public drunkenness, disturbing the peace, and illegal lodging). This offender population is more likely to be overdetained, denied probation or parole,
and placed in isolation for protection against victimization or for disciplinary purposes (Earley, 2007).

According to Hiday and Burns (2009) most people with mental illnesses who come into contact with the criminal justice system belong to one of four groups: 1) individuals with mental illnesses arrested for nuisance behaviors (i.e., disturbing the peace or loitering); 2) individuals with mental illnesses arrested for survival behaviors (i.e., shoplifting or failure to pay for restaurant meals); 3) individuals with mental illnesses who also abuse alcohol and drugs, arrested for disruptive behavior connected to their addiction and the different ways they support their habit (i.e., prostitution, stealing, assault); 4) individuals with severe mental illnesses who are psychopathic or have a diagnosis of antisocial personality disorder (violent behavior driven by their personality disorders).

Castellano and Anderson (2012) reported that 16% of inmates confined to American jails and prisons have a serious mental health disorder. A different study conducted by McNeil, Binder, and Robinson (2005) presents very similar estimations, claiming that 18% of people entering jails in the United States have a severe mental disorder, such as schizophrenia, major depression, or bipolar disorder.

A special report by the Bureau of Justice Statistics conducted by James and Glaze (2006) found that 15% of a sample of inmates in state prisons and 24% of jail inmates reported at least one symptom of a psychotic disorder, understood as delusions or hallucinations that cause individuals to lose touch with reality (U.S. National Library of Medicine, 2013). Another recent study found that among jail inmates, 14.5% of men and 31% of women currently had a serious mental illness (Steadman, Osher, Robbins, Case, & Samuels, 2009), numbers that are four times higher for men and eight times higher for women in jails than for the general population.
Additionally, many people with mental illnesses do not adjust well to incarceration in jails and prisons. The stress and alienating effect of incarceration can often exacerbate psychiatric symptoms and create management difficulties (Dirks-Linhorst & Linhorst, 2010; Earley, 2007). People with mental illnesses who are incarcerated will on average spend more time in jail than non-ill defendants charged with similar crimes, they are more likely to cycle through the criminal justice system, the mental health system, and substance abuse treatment programs than others (McNeil et al., 2005), and their acts of re-offense happen at higher rates and more quickly after incarceration than offenders without mental illness (Cloyes et al., 2010).

**Therapeutic Jurisprudence and Therapeutic Rehabilitation**

The creation of MHCs finds its origin on a principle called “therapeutic jurisprudence”. This principle states that the law can have a positive psychological impact for offenders when the court uses its authority to encourage positive and meaningful changes (Ray et al., 2014; Wexler & Winick, 1991).

A second framework within which MHCs operate is that of “therapeutic rehabilitation”, which relies on the assumption that mental illness is causally connected to criminal acts. Thus, ameliorating symptoms of mental illness should lead to reduce criminal behavior (Johnston, 2012).

By aligning the criminal justice and mental health systems into a collaborative partnership, MHCs aim to improve the outcomes of participants in both realms. To this effect, MHCs are conceptualized as both a mental health intervention and a criminal justice diversion program. As a mental health intervention, MHCs seek to link individuals to community-based mental health treatment services, to motivate treatment engagement and compliance, and to improve their quality of life and functioning. And as a criminal justice diversion program,
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MHCs strive to reduce criminal recidivism among the mentally ill population, to relieve an already overburdened criminal justice and jail system (Hughes & Peak, 2013).

**Origin of MHCs**

The first MHC was created in 1997, when the Florida legislature allocated $1.5 million to establish a mental health court in Broward County (Castellano & Anderson, 2012; Hughes & Peak, 2013). This was the result of a recommendation advanced by a special task force that was studying the rising number of people with serious mental illnesses incarcerated for low-level offenses, the lack of in-custody psychiatric assessments, and the poor coordination of continued treatment in the community after release.

Fifteen years later, MHCs have appeared in jurisdictions all across the nation. The estimated numbers range from 90 to 150 (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006) to 250 (Hughes & Peak, 2013), to even over 300 (Goodale, Callahan, & Steadman, 2013).

**MHC Structure**

MHCs follow the drug treatment court model in structure. They have a separate docket, one or two dedicated judges who preside at regular status hearings, dedicated prosecution, a non-adversarial team approach involving consensus decisions by criminal justice and mental health professionals, voluntary participation of defendants, and dismissed charges or avoidance of incarceration (Hiday, Wales, & Ray, 2013).

MHCs are staffed by legal and social service professionals who are committed to addressing the problems in offenders’ lives that contribute to the cycle of arrests. By using judicial monitoring, case management, and other supportive services, they encourage defendants to follow prescribed treatment regimens and court mandates designed to alter the underlying problems associated with their criminal behavior, with the ultimate goal of integrating them back
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into their communities (Steadman, Davidson, & Brown, 2001). The MHC team develops
individually tailored plans for each defendant, which might include attending a treatment
program, meeting with a mental health professional, submitting to drug screenings, complying
with medication requirements, or offering some form of restitution (Ray et al., 2014).

Eligibility for MHC participation is typically determined by the criminal charge and a
psychiatric diagnosis of an Axis I mental illness (i.e., schizophrenia, major depression, and
bipolar disorder) that is considered primary to the defendant’s involvement in the criminal justice
system (Burns et al., 2012). However, participation in a MHC program is voluntary, and
defendants can decide to go back to the traditional criminal court model (TCC) at any time.
Most MHCs require participants to plead guilty to the criminal charge as a condition of program
acceptance. If an individual opts-in, they have to participate in community-based treatment
(decided by the MHC team) in place of traditional adjudication and sentencing for a designated
period of time, which can go from four months to over two years (Castellano & Anderson,
2012). They must also attend regular status hearings, during which the team evaluates treatment
compliance and progress.

The MHC judge (or judges) has a particularly important role during these periodic status
hearings. In fact, the judge tends to speak with defendants individually to encourage adherence
to treatment, offering praise for good behavior and warnings or sanctions for non-compliance
(Wales, Hiday, & Ray, 2010). If the participant is non-compliant, they can be terminated from
the program and sent back to traditional court (Ray et al., 2014). If they are compliant for a
predetermined period of time, the charges they pled guilty to are dismissed or reduced (Burns et
al., 2012). Participants graduate from the program when the court staff determines that they have
achieved emotional wellness, desisted from criminal activity, and demonstrated an ability to live independently (Castellano & Anderson, 2012).

It is important to emphasize that the high number of MHCs in existence also comes with a high degree of variation from court to court. MHCs can vary in the number of defendants they monitor, the type of offenses they accept (misdemeanor vs. felony), and the frequency of appearances before the judge, among other variables (Redlich et al., 2006).

**Selection Criteria**

**Eligibility**

As Castellano and Anderson (2012) reported, eligibility for MHC participation is normally determined by the criminal charge and a psychiatric diagnosis of an Axis I mental illness, such as schizophrenia, bipolar disorder, delusional disorder, psychotic disorder not otherwise specified, and depressive disorders (McNiel & Binder, 2007). In certain cases, exceptions may be made for individuals with developmental disabilities or severe borderline personality disorder.

Although a diagnosis of a substance-related disorder would not meet the eligibility criterion, individuals with co-occurring substance-related disorders could be eligible if there is a primary mental health diagnosis. In fact, half or more of MHC participants also present a co-occurring illicit substance use (Almquist & Dodd, 2009; Steadman & Redlich, 2006). A study by Hughes and Peak (2013) came to the conclusion that the typical MHC participant is likely to be a white male in his mid-thirties, with a dual diagnosis of a psychotic or mood disorder and substance use.

Studies have found that there might be gender and racial biases involved during the referral and admission processes. Steadman and Redlich (2006) found that men constituted an
average 60% of MHC referrals, although they represented 86 to 94% of jail and prison inmates in the country (Minton & Golinelli, 2014), which means women are disproportionately represented in MHCs relative to their general presence in the criminal justice system. In regards to race, Sarteschi, Vaughn, and Kim (2011) reported that although a majority of inmates in the U.S. are minorities, half or more of MHC participants are white.

While there is not enough research looking into the selection processes of each individual MHC, the above information would point to the presence of selection biases and creaming practices. The term “creaming practices” is used when referring to either intentional or unintentional selection by judges, attorneys, and case managers of the more promising cases (those individuals with fewer risk factors who are likely to be successful in the MHC program) (Hughes & Peak, 2013).

However, these biases continue even after participants have been accepted into the program, and it appears that racial prejudices held by court personnel may further influence participants’ success. A study by Redlich and colleagues (2010) that followed over 400 MHC participants across four courts discovered that nonwhite participants were perceived as less compliant (i.e., with judicial orders, community treatment appointments, and taking prescribed medications) than white participants.

Research on drug treatment court outcomes has found that African American and Hispanic participants tend to be less successful in the program than whites (Dannerbeck, Harris, Sundet, & Lloyd, 2006; Krebs, Lindquist, Koetse, & Lattimore, 2007). Although studies have yet to identify similar racial disparities in MHC outcomes, the evidence provided by the aforementioned studies does hint at racial biases in the entire process, from referral to completion.
Besides the different demographic and clinical characteristics described above, another participant selection criteria is the offense type for which individuals are arrested, considering misdemeanors (less severe crimes, punishable with incarceration for one year or less) and felonies (most serious type of offenses, punishable by prison sentences of more than one year) (18 U.S.C. § 3559) as the two main types of offense. The first mental health courts created were restricted to individuals charged with nonviolent misdemeanors (Griffin, Steadman & Petrila, 2002). However, in recent years a “second generation” of mental health courts has emerged, which do accept individuals charged with felonies and violent crimes. As of 2011, 40% of MHCs only accepted defendants with misdemeanor charges, 10% worked only with felony charges, and the remaining courts accepted defendants charged with either (Steadman et al., 2011). While data would suggest that MHCs are accepting individuals charged with felonies with increasing frequency, this new trend does beg the question of the impact this might have on court outcomes, as a felony-committing population has different characteristics than those who commit misdemeanors. More serious crimes would also demand closer court supervision and monitoring.

A study by McNiel and Binder (2007) evaluated whether or not courts that accept people with more serious charges could function without compromising public safety. They examined the outcomes of a San Francisco MHC, in which 2/3 of defendants were charged with felony offenses. Their sample consisted of 170 people who entered the San Francisco MHC program, whose recidivism rates were then compared to those of 8,067 other adults with mental disorders who were booked into an urban county jail after arrest. After controlling for possible confounding variables such as demographic characteristics, clinical variables, and criminal history, they found that mental health court participants showed a longer time without any new...
While MHCs do seem to reduce recidivism even in felony offenders, Ray and colleagues (2014) examined whether the defendant’s target arrest offense type (felony or misdemeanor) was a significant factor related to MHC completion and criminal justice outcomes. Their data came from eight MHCs in the same Midwestern state, and their study spanned over a three-year period (2009-2011). Among the full sample (which consisted of 234 participants), 41% of the defendants had a felony target arrest. The results showed that participants with a felony were significantly less likely to successfully complete the MHC process than those with a misdemeanor, and significantly more likely to recidivate post MHC exit.

**Women and the Judicial System**

The unique experiences of women have consistently been ignored across most scholarly disciplines, and criminology is no exception to this rule. The existing male bias in criminology makes it so that theories developed to explain delinquency and crime committed by males are simply applied to women as well, without considering how women’s and men’s different experiences may come into play (Liang & Long, 2013).

While males and females who engage in criminal activities do share some traits (they are disproportionately poor, less educated, and have more family problems), females also face certain challenges that are particular to women, such as sexual abuse, sexual assault, harassment, sexual exploitation, stalking, dating violence, and unplanned pregnancy, among others (Chesney-Lind & Pasko, 2004; Richie, Tsenin, & Widom, 2000).

Researchers have found that women are overwhelmingly incarcerated for non-violent offenses, mainly for the sale and possession of illegal drugs. It has been theorized that this
pattern of criminal behavior is gender related, as they call drug sales and other non-violent crimes “survival crimes” that women commit to make money, feed a drug habit, or escape partner victimization (Richie et al., 2000).

Gender is not only important in explaining the causes behind criminality, but also in explaining the way the criminal justice system responds to offenders (Chesney-Lind & Pasko, 2004), and the rapid surge in both the number and proportion of women involved with the system make this a topical concern. In fact, according to the Bureau of Justice Statistics, the female inmate population increased 10.9% between midyear 2010 and 2013. During the same period, the male inmate population declined 4.2% (Minton & Golinelli, 2014).

Despite this growth, women continue to comprise only a fraction of the total inmate population (14%, according to Minton and Golinelli [2014]), which is why it is easy to ignore them when programs are designed and resources are allocated. Female offenders have needs different from those of men, due in part to their disproportionate victimization and their responsibility for children. Additionally, women offenders are more likely than male offenders to be addicted to drugs and to suffer from mental illnesses (Morash, Bynum, & Koons, 1998).

**Gender and MHCs**

Statistics show that the female inmate population is not only increasing, but that the prevalence of psychiatric disorders among this population is on the rise as well, to the point that psychiatric disorders are disproportionately higher among women prisoners than their male counterparts (McPhail, Falvo, & Burker, 2012). Prevalence rates for severe mental illness are eight times higher for women in jails than for the general population, while they are only four times higher for men (James & Glaze, 2006).

James and Glaze (2006) found that 73% of women in state prisons and 75% women in
local jails presented symptoms of mental disorders. These rates are significantly higher than those of male inmates, who present mental health problems at a rate of 55% in state prisons and 63% in local jails.

Many of the psychiatric disorders that are prevalent among incarcerated women are associated with socioeconomically deprived backgrounds that include poverty and homelessness, as well as physical and sexual abuse, factors that are identified as relating to female criminality. Post traumatic stress disorder, borderline personality disorder, depression, and substance abuse are disorders prevalent in the female prison population (Logan, Walker, Jordan, & Leukefeld, 2006).

Research suggests that a gender responsive approach (which implies acknowledging and understanding experiences and challenges differ between men and women) is essential to improving the treatment outcomes in all criminal justice phases (Covington & Bloom, 2007). When applied to mental health, this type of approach would advocate for gender-specific treatment and interventions all throughout women’s involvement with the justice system.

Among the disorders associated with mental health court selection, major depression is the one most heavily associated with women, as it disproportionately affects them. Based on data collected during the 2012 National Survey on Drug Use and Health (SAMHSA, 2012), the National Institute of Mental Health claims that women are 70% more likely to experience depression during their lifetime than men.

Moreover, incarcerated women have higher rates of depression than community samples, incarcerated men, and women in the general population (Gunter, 2004). Particular attention should be paid to this situation, as a study on life-course recidivism identified depression as a positive predictor of recidivism that had a stronger effect for women than for men (Benda, 2005).
Another disorder linked to mental health court eligibility is borderline personality disorder. A study by Nee and Farman (2005) suggested that borderline personality disorder could be linked to criminality because of the impulsivity that is characteristic of the disorder. A different study conducted in 2007 that looked at a sample of 220 prisoners entering the Iowa prison system found that 29.5% of the prisoners met the requirements for a borderline personality disorder diagnosis, and that the percentage of women meeting criteria for borderline personality disorder was more than twice than that for men (Black et al., 2007).

Although by itself a substance abuse disorder does not mean automatic mental health court eligibility, it is not uncommon for mental health court participants to exhibit substance dependence as a co-occurring disorder. For instance, in a study conducted in the Tulsa County drug treatment court, 96% of the female clients reported mental health problems (Liang & Long, 2013).

These results coincide with Stefanis and Kokkevi’s (1986) findings that people often self-medicate alcohol and drugs to deal with mental health problems such as depression and bipolar disorder. This is particularly relevant in the case of women offenders, as substance abuse is the primary contributing factor to women being incarcerated, and it is a critical factor in their recidivism (Adams, Leukefeld, & Peden, 2008).

As previously mentioned, in relation to their general presence in the justice system, women are disproportionately represented in MHCs, making up about 40% of all referrals (Steadman & Redlich, 2006). A possible explanation for women’s overrepresentation in MHCs can be analyzed if viewed from a focal concerns perspective.

According to Steffensmeier, Ulmer, and Kramer (1998), decisions about defendants by court actors depend on three factors: the defendant’s blameworthiness, the need to protect the
community from dangerous offenders, and the practical constraints and consequences of the
legal decision. Given the information and time constraints to be found in a court setting, this
data is most often not available to court officials in its entirety. Thus, when it comes to making
decisions, court actors often rely on stereotypes associated with the offender’s demographic
characteristics, such as age, race, and gender. Since there is a common perception that the
criminal behavior of women is not a serious problem (Richie, Tsenin, & Widom, 2000) and
studies have found that adult female defendants are treated more leniently than adult male
defendants (Bickle and Peterson, 1991), it makes sense that women would be given the
opportunity to participate in MHCs’ diversion programs at higher rates than men, who are seen
as more dangerous and blameworthy.

Ray and Dollar (2013) found that at the time a new defendant is introduced to the docket,
the MHC team would spend more time discussing the reasons and consequences of
noncompliance for female than for male defendants. In the case of male defendants, the team
would decide whether they were suitable for the program based solely on their mental health
screening. No extra time was spent gathering additional information about the defendant at this
point in the process.

In the case of women, MHC personnel usually spent more time discussing their particular
situations at greater length and with more detail. Case managers introduced new female
defendants by contextualizing their arrests, giving information about their family and economic
situations, such as relationship status, number of children, and employment status. Thus, higher
rates of female participation in MHCs can be explained by the fact that decisions on male
acceptance into the programs tend to be based on stereotypes associated with their gender, while
decisions about females are made based on more detailed and factual information particular to each case (Ray & Dollar, 2013).

**Graduation, Nonparticipation, and Termination**

There have been several studies that have examined the factors that predict graduation from MHCs. In a 2014 study, Hiday, Ray, and Wales evaluated data from a large metropolitan MHC that accepted competent arrestees with severe mental illnesses charged with misdemeanors who have no pending violent felony charge and who have had no violent felony conviction in the past 5 years. Their sample consisted of all participants (N=408) in the first two years of the court’s operation (2007-2009).

They found that participant behaviors during MHC (persistent positive tests for illegal drugs, arrest, failure to appear for MHC hearings, and persistent noncompliance with court mandates) had the strongest impact on graduation, increasing the odds of failure to graduate. These variables had more of an impact on graduation likelihood than the characteristics with which participants entered the MHC, such as socio-demographics, recent criminal history, and use of an illicit drug.

Given that the study MHC graduated almost three-fifths of those who entered during its first two years of operation (the remaining participants were negatively terminated), these findings indicate that a significant proportion of participants was able to overcome the risk factors of their past and change their behavior with the structure and support of the MHC. These results are important to MHC screening processes, because they suggest that even people with mental illnesses with high risk factors are capable of changing their behavior patterns thanks to a well structured and resourced program, and thus they should not be denied admission to a MHC.

On the other side, Dirks-Linhorst et al. (2011) implemented a study that focused on
defendants who choose not to participate in MHC programs or who are negatively terminated from them. Their sample consisted of eight years of data from a suburban Midwestern MHC, with a total of 947 participants. Their results showed that substance abuse history and having multiple psychiatric diagnoses increased odds of nonparticipation. For those negatively terminated, being male, having racial minority status, multiple diagnoses, a charge of stealing, and committing a new crime while under the MHC supervision increased the odds of negative termination.

While studies in regards to gender and MHC completion are few and produce conflicting results, there does appear to be a difference in the way courts treat female defendants in their dockets. MHC teams’ tendency to spend more time contextualizing actions by women over those by men is not limited to the moment defendants are introduced to the docket. In fact, in the previously mentioned 2013 study, Ray and Dollar found that this particular pattern also applied to instances in which court personnel was determining compliance and considering program termination for a particular defendant.

Certain behaviors were overlooked or excused in the case of women, and were contextualized in a way that minimized their culpability. However, the same or very similar actions were deemed as noncompliant and in need of sanctioning in the case of male defendants. Personal and familial relationships, prior victimization, difficulty dealing with roommates, and time management issues with employment and school are examples of common and acceptable explanations for noncompliance for females but not for males. MHC personnel often reported feeling “concerned” for a female defendant’s personal circumstances, while this was less usual in the case of male defendants, which can hint at this situation being tied to paternalistic attitudes towards women (Ray & Dollar, 2013).
Liang and Long (2013) found that socioeconomic criteria (minority status, lower levels of education, and being unemployed) are important predictors of drug treatment court completion for women but not men. While more research needs to be conducted in the case of MHCs, the similarities between drug treatment courts and MHCs could hint at a similar pattern among the MHC population.

**Recidivism**

The main claim that supports the existence of MHCs is that they can successfully reduce recidivism among individuals who graduate from their programs. The following studies look into the factors and defendant characteristics related to criminal recidivism among MHC participants.

Dirks-Linhorst and Linhorst (2010) conducted a study focusing on criminal recidivism of defendants accepted by MHCs. To do so, they examined rearrest rates and factors associated with rearrests among defendants eligible for the St. Louis County Municipal Mental Health Court (MMHC), who were divided in three groups based on program completion status: successful completion, negative termination, and voluntary nonparticipation. The time frame considered was one year post court discharge. The St. Louis County MMHC hears ordinance violations only, that is, lower-level crimes that are similar to state misdemeanors in the type of offense and penalty.

This study looked to answer two main research questions. First, what is the rearrest rate of defendants who have successfully completed MMHC supervision, and how does that rate compare to MMHC participants who failed supervision and to defendants who were deemed eligible to participate but chose not to do so? Second, what factors are associated with rearrest for defendants eligible for the MMHC?
The results showed that the rearrest rate of defendants who successfully completed the program (N= 351) was 14.5%, while the rearrest rates of defendants negatively terminated from the program was 38% (N= 137), and those of defendants who chose not to participate was 25.8% (N= 89). These numbers show that individuals negatively terminated were 2.6 times more likely to be rearrested for any crime when compared to defendants who successfully completed the program. Further analysis of the factors associated with rearrest among the general sample revealed that being younger and being single increased the likelihood of rearrest. Researchers also found that being African-American increased the risk of rearrest among participants who successfully completed the program.

Another factor linked to rearrest among successful program completers is having a substance abuse problem. Among people with mental illness, substance abuse is a risk factor for reemergence of psychiatric symptoms, treatment noncompliance, dropping out of treatment programs, strained relationships among family and friends, aggressive and violent behavior, and housing instability; all behaviors that can have a negative effect on an individual’s ability to remain outside of the criminal justice system.

A study by Burns et al. (2012) followed participants of one MHC for two years, examining their criminal recidivism after they no longer receive the court’s services, supervision, and support. The researchers paid particular attention to the effect of type of court exit (graduation, opt-out, or termination) on recidivism. However, they also investigated participant socio-demographic characteristics (age, race, gender, employment, and homelessness), clinical characteristics (primary and co-occurring substance abuse diagnoses), criminal history (prior jail days), key arrest charge level (felony vs. misdemeanor), and process measures (jail days during
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MHC and MHC duration. Rearrest and time spent in jail post-program completion (postexit jail days) were used as measures of criminal recidivism.

The data was obtained from a Northern Georgia MMHC established in 2004. This particular court dealt with both misdemeanor and felony cases, which could involve violent or nonviolent charges. In order to be eligible for participation, defendants had to have a primary diagnosis of severe and persistent mental illness (psychotic and major mood disorders) or other Axis I disorders considered fundamental to the defendant’s criminal justice system involvement.

In total, there were 157 defendants in the 2005-2010 period, 99 of whom had complete data 2 years following MHC exit (last eligible defendant exited September 2, 2008). The program duration for this MHC averages 14 months for graduates, but it can range from less than 1 month to 35 months, depending on offense seriousness and compliance with treatment and behavioral court mandates. At any moment after a defendant enrolls in the MMHC program they may decide to opt-out, or they may be terminated by the MHC personnel and be sent back to TCC due to lack of compliance or failure to make court appearances.

The sample had more females than males, consistent with Steadman and Redlich’s (2006) findings. Consistent with Sarteschi et al. (2011), the sample in question had more Whites (66.7%) than any other race or ethnicity. Only about a third of defendants were employed, and 17% of defendants were homeless. Most defendants had a chronic mental illness and a co-occurring substance abuse diagnosis in addition to their primary diagnosis. More than three fourths of defendants admitted to MHC had felony charges. Almost all felony violent offenses (91.2%) involved cases of aggravated assault, battery, or obstruction. Most misdemeanor violent offenses were simple assaults or threats of violence.
The results showed that this MMHC graduated fewer than half of the defendants (43.4%) and terminated an equal amount. The remaining defendants chose to opt-out of the program and to voluntarily return to TCC for adjudication of their cases. More than three fourths of those terminated were noncompliant with treatment.

Overall, data showed that 39.4% of all 99 participants were not rearrested in the two years after their MMHC involvement. Moreover, only 24.6% of those who successfully completed the program were rearrested, while whereas 76.9% of opt-outs and 90.7% of terminated defendants were rearrested.

Successful graduates also demonstrated more positive outcomes on the other recidivism measure as well. In regards to postexit jail days, they averaged only 2.8 jail days, while opt-outs averaged 113.6 days, and terminated defendants averaged 202.3 days. Data also showed that defendants with a schizophrenia spectrum diagnosis averaged significantly more postexit jail days when compared to any other diagnostic group.

Results showed that the only significant predicting factors of graduation are co-occurring substance abuse diagnosis and prior jail days. Defendants with a co-occurring substance abuse diagnosis are 91% less likely to successfully graduate when compared to those without a substance abuse diagnosis. Defendants with more than 30 jail days prior to MMHC admission are 78% less likely to graduate when compared to defendants with 30 or fewer jail days. Furthermore, defendants with 7 or fewer jail days are approximately 6.5 times more likely to graduate when compared to those with more jail days. Researchers also discovered that MHC program duration reduces the likelihood of postexit rearrest, while amount of prior jail days increases the odds of rearrest. Graduates were found to be 88% less likely to be rearrested when compared to defendants who opted-out or were negatively terminated.
A different study by Hiday, Wales, and Ray (2013) evaluated the effectiveness of a short-term MHC in terms of recidivism. They posed three questions. First, determining whether or not MHCs do better than traditional criminal courts in reducing criminal recidivism beneath the recidivism level of defendants with mental illnesses who go through regular criminal adjudication. Second, they investigated whether it was mental health treatment or participation in MHC itself that made the difference. Are the mental health treatment and services integral to MHC (but that could be provided by other programs) the cause of the accounted reductions in recidivism? Or is whatever happens in a MHC (the legal procedures, monitoring, sanctions, and support) the main contributory cause? Finally, the researchers evaluated whether or not the positive effects of the MHC programs and services continue after the defendants exit the court and are no longer under its monitoring and supervision.

Hiday and colleagues (2013) looked at a large sample composed of defendants with mental illnesses in a misdemeanor MHC and comparable mentally ill defendants in the same jurisdiction. Both groups received the same supervision, case management, and services from the same agency and community providers. The only difference between the MHC sample and the traditional criminal court defendants was the added participation in MHC.

The MHC in question was located in the District of Columbia. It accepted competent severely mentally ill arrestees, charged with misdemeanors, who have no pending charge or conviction of a dangerous or violent felony in the prior 5 years. The court monitors participants for treatment and behavior compliance at required monthly status hearings. The study MHC is different from MHCs reported in the available literature because it has a relatively short period of court supervision (4 to 6 months) and a more limited court involvement in monitoring case managers and service providers. Another difference is that this study’s MHC has the benefit of a
mentally ill. This agency screens all arrestees for severe mental illness, and has a designated specialized supervision unit (SSU) that provides supervision and services (case management and linkage to mental health service agencies, and drug testing and treatment) to those screened positive, including MHC participants. SSU case managers are expected to refer MHC-eligible defendants to the court, who would then make a decision about whether or not they are accepted into the program.

The researchers compared one-year recidivism post court exit of MHC participants (N = 408) with that of other MHC-eligible defendants under SSU supervision (treatment-as-usual, N = 687) who received the same services and supervision by the same agency as the MHC participants. The results showed that one year after participants exited the court, the majority of both groups had not been rearrested. However, MHC participants were significantly less likely to be arrested in the follow-up year (27.5%) than SSU defendants with severe mental illnesses who had comparable services but who were processed in traditional criminal court (37.3%). Moreover, almost three-fourths of MHC participants had no rearrest, while only around three-fifths of SSU defendants had no rearrest. MHC participants also averaged fewer arrests and had a longer time to rearrest than the comparison group.

The graduation rate for this MHC was 58.3%. The study found that it was MHC graduates who mainly accounted for the recidivism differences between MHC participants and the SSU comparison group.

Criticisms

One of the major issues in evaluating MHCs as an overall intervention is the impossibility to generalize research results across the board. As previously mentioned, there is no unifying common model for the 350 or more MHCs that currently exist, mainly because there
is a lack of agreement as to what elements contribute to MHC effectiveness (Hughes & Peak, 2013).

To this end, in 2008 the Council of State Governments’ Justice Center published “Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court” (Thompson, Osher & Tomasini-Joshi, 2008), attempting to delineate the components of an ideal MHC. Nevertheless, while many of the elements included in this document are drawn from the experience of existing courts, the authors do clarify that they are not research based, they are not meant to be present in every single court, and if they are indeed present, they could manifest themselves differently across jurisdictions.

Nevertheless, the elaboration of this literary review did reveal certain trends when it comes to MHCs that are relevant when addressing the main criticisms to which this judicial intervention is subjected.

The first criticism directed at MHCs questions their actual performance and effectiveness in reducing the post-graduation justice system involvement of their graduates. As previously mentioned, the main claim behind the existence of MHCs is that they can successfully reduce recidivism among their target population. While the reported significance of success in reduction of recidivism varies from court to court, no study has found that MHC defendants are more likely to be arrested after involvement in MHC when compared to defendants in TCC (Ray et. al, 2014).

Critics have also raised concerns about MHCs coercing people into treatment. However, voluntariness is paramount for participation in any MHC program. Even if a defendant is identified as an appropriate candidate for MHC, he or she is in no way forced to accept the offer of participation if he or she has no desire to do so. Participation must be an informed decision on
the defendant’s part, and that responsibility falls on the court officials. For instance, the Queens Mental Health Court gives out a “Participant Handbook” to everyone considered for participation. In these handbooks, they clarify that all participants must be willing to participate in the program and that they have to be committed to the rigors of the treatment. In the following 13 pages, they clearly and punctually explain the details of the intervention, from the length of the program, to its goals, to the phases in which it is divided, so that the prospective participant is clearly aware of what joining the program entails (Queens Mental Health Court, 2014).

Furthermore, defendants are not forced to complete the MHC program. According to Thompson et al. (2008), mental health court participants should have the option to withdraw from the program at any point without having their participation and withdrawal reflect negatively on their criminal case. This should also address the criticism that MHCs require admission of guilt. Most of them do, but if the defendant chooses to go back to TCC that plea is withdrawn.

Another question surrounding MHCs is whether or not they are ultimately cost-effective. While research on this particular topic is limited and the results are inconclusive (Hughes & Peak, 2013), long-term cost savings are implied in the reduction in rearrest and jail days as supported by current evidence. In fact, Ridgely et al. (2007) conducted a cost-effectiveness analysis of the Allegheny County, and found no substantial increase in short-term costs when compared to traditional processing, and their results even suggested potential savings in the long-term.

Even if MHCs do not present themselves as an unequivocally less expensive alternative, it is important to emphasize that they do increase access to mental and behavioral health services
(Boothroyd, Poythress, McGaha, & Petrila, 2003) among at-risk populations that would not have the same possibility of access if limited to a traditional court proceeding.

**Conclusions and Future Studies**

In the relatively short time since the first MHC came to be, the number of MHCs across the country has increased exponentially. The rapid growth of this type of intervention reveals itself as a response to the disproportionately high rates of individuals with mental health disorders being detained, arrested, and incarcerated, and as an alternative that would attempt to break the cycle of re-offense in which many of these individuals find themselves after their first contact with the criminal justice system.

The research presented in this literature review would suggest that MHCs could be considered viable non-jail alternatives, since they do appear to lower recidivism among their participants. Even the less promising results found by current research have not found higher recidivism rates among MHC participants, the “worst case scenario” being that recidivism rates are not significantly lower than those in a comparison group.

Additionally, costs involved in MHCs have been found to be the same or even lower than those for traditional court proceedings. Consequently, a case for MHCs can be made on the grounds of these two facts. Seeing as costs and outcomes of traditional court proceedings and MHCs are comparable, MHCs have an additional advantage in that they provide their participants with access to mental health and other social services, as well as an entire support system comprised by the case managers, social workers, and other members of the MHC team. The criminal justice system can only benefit from working in coordination with the mental health system.
In terms of future studies, a more thorough evaluation of MHCs from the perspective of a mental health intervention emerges as a necessity. Most of the current body of research examines MHC as a legal intervention, using recidivism as performance measure. Given the implication that a defendant’s mental illness is causally related to his or her criminal acts, many see lower recidivism rates as confirmation that the mental health services have been clinically successful. That may or may not be the case, as there is not enough research to confirm either claim.

More specific information in regards to diagnosis could be helpful in determining new MHC policies. For instance, examining whether defendants with a certain type of diagnosed disorder tend to have higher recidivism rates even after successful graduation, and if so, what can be done to more properly address their specific service needs.
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