Mental Health Courts: A Judicial Innovation with Clinical and Public Safety Implications

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ABSTRACT

- *Objective:* To describe the characteristics of mental health courts and review the available research on their impact.
- *Methods:* Review of the literature.
- *Results:* The number of people with mental illnesses entering the criminal justice system, and the complexity of their needs, has become a major social policy issue in multiple jurisdictions. There have been a variety of efforts to divert people into treatment, with the hope that better service access and reduced criminal recidivism will result. Mental health courts are one part of these larger diversion efforts. This paper describes mental health courts in the broader context of diversion, discusses their core characteristics, and reviews the current research on the success of the courts in their primary goals of rapidly identifying and diverting eligible defendants into treatment, creating court processes that defendants experience as less coercive than traditional criminal court, increasing access to services and reducing recidivism, and doing so in a cost-efficient manner.
- *Conclusion:* Accumulating research suggests that mental health courts have been generally successful at meeting their goals compared with outcomes achieved by traditional criminal courts, but there is still room for improvement.

CASE VIGNETTE

Joseph Woek is a 42-year-old male who has just been arrested for public urination and trespass at a local convenience store. This is Mr. Woek's 3rd arrest in the last 2 months, all for minor charges, and his 13th arrest in the last 2 years. He has been booked into the local jail, where he has stayed in a jail cell for the last 6 days. He is disheveled, talks to himself quietly, and is unclear when asked whether he has been taking medication for any physical or mental illnesses. A contract psychiatrist comes to the jail once a week to check on inmates, but Woek was arrested on Wednesday, and the psychiatrist will not be able to see him until the following week. However, Woek's public defender, who just met him, expects that by then Woek will be released for time already served when he pleads no contest to the charge. When asked what she thinks will happen to Woek after release, the public defender replies, "I assume he'll get arrested again unless he decompensates so badly in the next few weeks that he's civilly committed. However, arresting him again will not do him or the public any good because he'll be released after a few hours and there aren't adequate community services for any of his needs. At some point I know we'll see him here again. I just don't see any way this cycle will change absent some fundamental alterations in how we handle these cases. I used to represent psychiatric patients and we talked about 'revolving door' patients. Well, the 'revolving door' still exists, but it's the courthouse door, not the hospital door."

Mr. Woek is the face of one of the most complex social policy and health-related issues facing local and state governments. Frequently arrested, mentally ill, and in and out of jail and psychiatric emergency rooms, Mr. Woek has found little prospect from the traditional criminal justice system and local treatment systems beyond simply repeating the cycle. One increasingly popular strategy to meet the needs of Mr. Woek and others like him is the mental health court, a criminal court with an explicitly therapeutic orientation. This article discusses mental health courts, their purpose, and available research on their impact.

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MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM

Mental illnesses can have a devastating impact on the individual, family members, and society in general. The World Health Organization (WHO) estimates that mental health and behavioral health disorders affect more than 25% of all people at some point during their lives, and that about 10% of the population has such a disorder at any point in time [1]. WHO also suggests that depression alone accounts for approximately 4.5% of the global burden of disease, and nearly 12% of total years lived with disability [2]. The US Surgeon General in a 1999 report [3] concluded that approximately 20% of the US population is affected by mental disorders during a given year, and that 9% of US adults experienced significant functional impairment as a result. While mental illnesses affect all classes of people, prevalence rates vary among some cohorts. For example, mental disorders are overrepresented among people in lower socioeconomic strata [4,5].

Mental illnesses have multiple effects on individuals and their families. However, such illnesses can also have a major effect on human services systems, particularly those such as the educational and criminal justice systems whose primary functions do not include the identification and treatment of major mental illness. In recent years, the impact of mental illnesses on the criminal justice system has become a major policy issue because of the growing numbers of individuals entering that system with a major mental illness. A recent study of the prevalence of serious mental illnesses in 2 Maryland and 3 New York jails found that 14.5% of males and 31.0% of females had current symptoms for serious mental illness, defined as major depressive disorder, depressive disorder not otherwise specified, bipolar disorder, schizophrenia, and other psychotic disorders [6]. The study's authors concluded that if these estimates were generally true for all arrestees in the United States, then more than 2 million of the approximately 13 million individuals booked into jail in 2007 had a serious mental illness.

This study confirmed what many judges, law enforcement officials, and prosecuting and defense attorneys already knew: mental illnesses are swamping the criminal justice system. The issue is not confined to the United States. In Canada, the percentage of prisoners with a mental illness is increasing 5% to 10% per year [7], and many European countries are struggling to create strategies to prevent people with mental illnesses from entering growing prison populations [8].

DIVERSION STRATEGIES

While the volume of people entering the criminal justice system with serious mental illnesses is increasing, the criminal justice system is ill-equipped to address the issues they present. For example, in some jurisdictions, arrestees with mental illnesses stay in jail 3 to 4 times longer than arrestees without mental illness [9]. Police, usually the first responders to threatening behavior, are often not trained in identifying signs that the behaviors they encounter may be related to mental illness. Judges, faced with adjudicating large caseloads that make it difficult to spend much time on an individual case, are often unfamiliar with their community's mental health treatment resources; those more familiar with these resources are often frustrated by a perception that treatment is sporadic, focused on system alleviation rather than recovery, and of little long-term benefit.

As a result, multiple jurisdictions have searched for strategies to divert those individuals into treatment. In 1992, approximately 52 jails in the United States had a diversion program; by 2005, there were more than 300 programs, and the number continues to grow in the United States and internationally [10,11].

Diversion programs fall into 2 general categories: prebooking and postbooking. Prebooking diversion is police-based, with law enforcement officials attempting to link the potential arrestee to treatment services rather than arrest them. At least 3 specialized strategies have been adopted [11,12]. The first focuses on training police to respond to psychiatric crises. The most widely used approach is the Crisis Intervention Team program, pioneered in Memphis and now used across the country. Officers are provided with intensive training about mental illness as well as community mental health resources, and there is some evidence that officers trained in this approach are more likely to divert individuals to treatment [13]. The second approach places mental health professionals directly with police responders, to provide assistance at the point of intervention. The third uses mental health crisis teams, based in the local mental health system, to work closely with law enforcement in responding to situations where a mental health issue might be presented. There is evidence suggesting that prebooking diversion programs can be effective, particularly in placing people into treatment and in some instances reducing future recidivism [14], though the research base requires more development. In addition, at least 1 study has concluded that a triage center created to enable police to

quickly drop off individuals who otherwise might have been arrested achieved modest cost savings compared with booking those individuals into the local jail [15].

Postbooking diversion occurs after the person has been arrested, either pre- or post-arraignment (the arraignment of a criminal defendant is a procedure in which a judge or magistrate provides the accused with a reading of the criminal charge, followed by the defendant's plea to the charge). Diversion may be staged in the jail or by a court. For example, a jail-based program may involve a jail-based case worker who does outreach to the mental health system to permit placement in care [16]. Court-based initiatives include mental health courts, discussed in more detail below. As with prebooking diversion, there is evidence to suggest that postbooking diversion can have a positive impact on individual access to care, frequency of arrest, and days in jail [17]. Mental health courts are an example of postbooking diversion and are the focus of the rest of this article.

SPECIAL JURISDICTION COURTS

The judicial system has long relied on special jurisdiction courts to adjudicate particular types of claims and disputes [18]. For example, many countries use business courts to resolve commercial disputes. Probate courts address issues arising from the distribution of a decedent's goods. Family courts consolidate claims involving families, and juvenile courts for more than 100 years have adjudicated cases involving youth. These courts are designed to create efficiencies in the administration of justice by grouping categories of cases before a particular judge; in addition, the fact that the presiding judge hears a particular type of case is supposed to create coherence in the application of the relevant branch of law.

Another type of specialty court has emerged in the last 25 years. Often called therapeutic courts, these courts have an explicitly rehabilitative focus and are designed to address a broader range of issues than traditional courts. In some ways, the juvenile court was the forerunner of therapeutic courts, with its emphasis on rehabilitating juveniles rather than relegating them to the adult criminal justice system. However, the prevalence of mental and substance use disorders in the criminal justice system has given the therapeutic court movement enormous momentum, momentum that shows little sign of abating.

Drug courts were the first therapeutic courts of the modern era. Miami–Dade County, Florida, created the first drug court in 1989. Drug courts were established in response to the massive influx into the criminal justice system of first-time drug offenders caused by changes in drug offense and sentencing laws in the early 1980s [19]. Drug courts were designed to reduce recidivism and substance abuse among nonviolent substance use offenders through early, continuous, and intense treatment supervised by the court, mandatory drug testing, and the use of a mix of sanctions, services, and awards to achieve compliance [20].

By 2010, there were 2633 drug courts in the United States, operating in every state and territory [21]. The federal government provided significant funding for their development [22] and as a result, drug courts, while not all identical, assumed certain common characteristics. The US Department of Justice, which administers federal funding for the courts, published a guide to the 10 "key components" of drug courts in 1997 [23]. The components include an explicit commitment to integrating treatment in the processing of criminal cases; an emphasis on early identification and placement of eligible defendants into treatment; on-going oversight by the judge through status hearings; monitoring through drug testing and coordinated strategies to address non-compliance and relapse; and creation of a nonadversarial court process in contrast to reliance on the traditional adversarial court process.

There has been extensive research into the efficacy of drug courts, and there is substantial evidence that they are meeting program goals. A meta-analysis of studies conducted by the US Government Accountability Office [24] in 2005 concluded that there were significant reductions in criminal recidivism among drug court clients, but results were mixed on the reduction of drug relapses. There was also evidence that while drug court case processing was more expensive than traditional court processing, net savings accrued from reduced criminal offending.

A more recent multi-site, longitudinal study funded by the Department of Justice included process, impact, and cost evaluations of 29 drug courts. This study found that drug courts reduced criminal recidivism and drug use among participants when compared to a matched comparison group of non-drug court probationers. The study also concluded that drug courts appear to have a positive (though statistically insignificant) effect on employment, education, family dynamics, and income [25].

MENTAL HEALTH COURTS

The first mental health court in the United States was created in Broward County, Florida, in 1997, though

in the early 1980s a court in Marion County, Indiana, had begun focusing exclusively on mental health issues at a state psychiatric hospital in Indianapolis. While the federal government did not provide funding for mental health courts comparable to that provided drug courts, mental health courts have experienced rapid growth. Today there are more than 250 mental health courts for adults, and in the last few years, approximately 40 juvenile mental health courts have been created [26].

Mental health courts have important similarities to drug courts. For example, like drug courts, mental health courts attempt to divert eligible defendants into treatment without sacrificing public safety. However, there are also significant differences between the 2 types of courts. The primary difference is that drug use is a criminal offense, while having a mental illness is not. Therefore the focus of drug courts and mental health courts is quite different: drug courts focus on drug-related offenses, while mental health courts focus on mentally ill individuals whose criminal offending may be incidental to their illness. Monitoring also relies on different strategies. In drug court, urinalysis provides a uniform monitoring tool that reliably detects many violations of the court-ordered condition to abstain from drugs. However, there is not an equivalent measure to monitor compliance with mental health treatment. Finally, drug courts often have treatment services that operate under the court's auspice, while mental health courts typically negotiate for access to local mental health providers.

While mental health courts vary, they typically have several common characteristics [27]. These include:

- A specialized docket for defendants with mental illnesses that meet the court's eligibility criteria;
- A voluntary decision by the defendant to enter the court;
- A non-adversarial court process, where traditional lawyering is minimized and the defendant's active participation in the court proceeding is encouraged;
- A treatment plan developed jointly by court personnel and mental health professionals who may be assigned to the court;
- Continuing oversight of the individual's progress with and adherence to treatment and other court conditions by the judge and treatment staff;
- The use of incentives and sanctions to reward treatment adherence and punish noncompliance;
- "Graduation" from the court, based on predetermined criteria marking success.

Early mental health courts focused primarily on individuals charged with misdemeanors (ie, offenses generally punishable by no more than 1 year of incarceration). However, in recent years, mental health courts have begun handling felony cases, either exclusively or as part of a docket in which misdemeanor cases are also permitted. Unlike drug courts, where a defendant is required to plead guilty to the charge as a condition of entering the court, some mental health courts accept a case without requiring a plea, while other courts require a plea. In either event, mechanisms are generally in place for the charge to be dismissed if the person successfully completes the requirements of the court.

Caseloads of different mental health courts vary dramatically, from as few as 15 active cases to several hundred. As is typically the case with diversion programs, individuals referred for admission to mental health courts on average are older, more likely to be female, and more likely to be white than the overall cohort of individuals involved in the criminal justice system [28]. Mental health courts also vary in their use of punishment for noncompliance, with some courts using jail with some frequency while other courts rarely if ever using it. This is another contrast with drug court, where the use of jail as a sanction is routine [29]. The variation among mental health courts may reflect ambivalence about punishing mental illness–related behavior, in contrast to drug courts, where the punishment is typically for noncompliant behavior that is criminal, for example, a relapse into illegal drug use.

MENTAL HEALTH COURT OUTCOMES

The evidence base for the effectiveness of mental health courts is still modest, compared to that for drug courts. However, studies have begun to accumulate that in the aggregate suggest that mental health courts are meeting many of their primary goals. Research has focused on 5 primary issues: rapid case identification and entry to the court; process questions such as fairness and procedural justice; access to services; reductions in recidivism; and cost.

Early Screening and Admission to the Court

An important goal of diversion programs is to identify and place individuals in services quickly to minimize time in the criminal justice system, particularly time

in jail. A study of 34 diversion programs that did *not* include mental health courts found that the median time from arrest to enrollment in the diversion program was 11 days [30]. However, a recent study of 3 mental health courts (in San Francisco; Hennepin County, Minnesota; and Marion County, Indiana; a fourth court, Santa Clara, California, was excluded because of data retrieval issues) found considerably more time elapsed between arrest and admission to the court than was the case in the study of non-court-based diversion. For the mental health courts, the median length of time from arrest to entry to the mental health court was 70 days. In contrast, for a matched sample of defendants with mental illness *not* referred to mental health court, the median length of time from arrest to case disposition was 37 days [31].

The authors of this study found it encouraging that the elapsed time from referral to disposition for individuals referred to mental health court was several days shorter than the national average for case processing of criminal cases (70 compared to 76). However, it is also clear that to the degree that diversion is supposed to be swift, the process in these courts took twice as long as traditional processing of the matched sample, and nearly 7 times as long as diversion in non-court-based programs (11 days). Therefore, it is difficult to place at least these courts in the same context as other diversion programs if the metric is rapid referral and disposition.

On the other hand, as the discussion below illustrates, a growing body of evidence suggests that mental health courts are much more successful in meeting other important goals.

Court Process and Procedural Justice Outcomes

Criminal court rests on an adversarial system in which the defendant's interests are represented by a lawyer but in which the defendant rarely speaks for herself. The law acts upon defendants for the most part and attempts to attain outcomes (deterrence of future crimes, punishment) unlikely to be endorsed by a defendant. In contrast, a number of legal scholars believe that adherence to treatment and other outcomes sought by mental health courts are more likely to be achieved if the defendant voluntarily endorses the law's decisions; this approach has been labeled "procedural justice" [32]. Procedural justice posits the importance of 2 components: the quality of the legal decision making and the quality of the interpersonal treatment of the individual defendant. In addition, many judges have been influenced by "therapeutic jurisprudence," a school of legal thought that emphasizes that legal actors should continually assess the positive or negative effects of the law on the individual's mental health [33].

Mental health court judges typically attempt to create a courtroom environment consistent with the theoretical constructs of procedural justice and therapeutic jurisprudence. Great care is taken to address the defendant respectfully, to permit the defendant to speak freely, and to create a nonadversarial environment in the courtroom. Efforts are also taken to assure that the defendant perceives that the process is fundamentally fair and noncoercive. The individual's subjective view as to the degree she experiences something as coercive is often referred to as "perceived coercion" [34].

While mental health court studies have only infrequently focused on questions of procedural justice and perceived coercion, those that have done so report that defendants believe that they have been treated fairly and had choice in decision making, particularly compared to defendants in traditional criminal courts [34,35]. As Poythress and colleagues reported regarding the Broward County mental health court (MHC) [34],

> The MHC has made a number of procedural adaptations in its effort to have the court experience be one that potentially reduces stigma and contributes as an 'active therapeutic agent in the recovery process.' Our findings suggest that these adaptations have resulted in the kinds of procedural justice enhancements that theory suggests might ultimately be beneficial to therapeutic outcomes…As has been found in procedural justice studies in other legal contexts, voice and respectful treatment by authority emerged as significant determinants of outcome satisfaction...

These mental health courts appear to do well in creating a judicial environment in which defendants believe that they are treated fairly and have voice. At this point, whether this is an independent factor in improving adherence with court conditions and treatment is an unanswered question. But given long-standing concerns by observers of the criminal justice system that the criminal process only furthers alienation and cynicism among defendants [36], the fact that mental health court defendants appear to have a positive view of their experiences in mental health court may be important independently of its potential effect on treatment compliance.

Access to Care Outcomes

Another primary goal of mental health courts is to increase access to services. The underlying assumption is that access to services will improve mental health status and functioning, which in turn will play a role in reducing criminal reoffending.

Available evidence suggests that mental health courts *do* increase service access for court clients, particularly when compared to service access by defendants whose cases are processed in traditional criminal court. For example, clients of the Broward County mental health court had significant increases in treatment services after enrollment in the court, as the mean number of behavioral health services received by individuals in the mental health court rose 61.6% while those for defendants in the traditional court declined by 18.3% [37]. In Clark County, Washington, service access also increased, with court clients typically enrolled in services within 3 to 10 days of admission to the court; court clients received more hours of case management, medication management, and days of outpatient services after court admission, while crisis services and inpatient treatment days declined [38]. In a study in Santa Barbara, California, one of the few mental health court studies to use random assignment found that mental health clients were more likely to be engaged in services post admission to the court than individuals in the treatment as usual condition, and that mental health court clients engaged in more treatment activities [39]. Clients of the San Francisco behavioral health court also had a greater number of ambulatory mental health and substance abuse services in the 6 to 12 months after entry to the court than did a comparison group of individuals who met court eligibility criteria but were neither referred to or rejected from the court [40].

While these studies are not definitive, they each report that mental health court defendants have improved access to services after court admission. This does not mean that the services are adequate either in terms of quantity or quality, but given the significant disjointedness of past treatment for many mental health court clients, improved service access can be viewed presumptively as a positive factor.

Reduced Recidivism/Public Safety Outcomes

A primary goal of the criminal justice system is to assure public safety, and even therapeutically oriented courts, such as mental health courts, must consider public safety in attempting to divert people into treatment. Policy makers and the public are unlikely to approve a trade-off in which service access is increased but public safety is reduced. Available evidence, while somewhat mixed, suggests that to date, mental health court clients generally have fared no worse and in some cases better on re-offending than matched samples of traditional criminal court defendants.

In the first multi-site mental health court study (San Francisco County, Santa Clara County, Hennepin County [MN], and Marion County [IN]), Steadman and colleagues used a prospective, longitudinal, quasi-experimental design to examine this issue [41]. A treatment group was selected comprising 447 newly enrolled clients from the 4 courts. A comparison group (treatment as usual) was selected from individuals who met eligibility criteria for one of the courts but who had not been referred or rejected by a mental health court. Random assignment was not used. Data was analyzed for a pre 18- and post 18-month period from enrollment in the court.

The major finding was that mental health court participants had fewer arrests and fewer days of incarceration in the 18-month period after court enrollment than the matched control individuals. In fact, days incarcerated *increased* slightly for mental health court participants after enrollment in the court (by 9 days) but the control group was incarcerated on average 78 days longer in the 18-month post period. The authors conclude that their findings suggest that mental health courts can accomplish their goal of reducing recidivism and days in jail compared to non-court-enrolled individuals.

While this was the first multi-site study of mental health courts, several single-site studies have reached similar conclusions. Clients of the Broward County mental health court did not have significantly fewer arrests than a comparison cohort whose cases were adjudicated by a traditional criminal court, but spent significantly fewer days in jail than the comparison group after entry into the court, and longer periods of time between arrests. They accounted for fewer acts of violence than the comparison group at an 8-month follow-up [42]. Similar results have been reported from courts in Alaska [43], San Francisco [40], and St. Louis [44]. In the Santa Barbara study [39], mental health and non-mental health court clients had no significant differences in arrests and convictions, while in Seattle [45], mental health court clients had more arrest arrests and days in jail than the comparison group. In a study reporting on a 2-year ef-

fect, Hiday and Ray found that a North Carolina mental health court also reduced arrests and time to arrest 2 years out, suggesting a more lasting effect from the court's intervention [46].

These data are not conclusive, of course, and many of the studies have methodological limitations [47]. However, a recent review of the literature on diversion, after discussing limitations in various studies, still characterized the overall findings on recidivism and mental health courts as "evidence of a high degree of effectiveness in reducing recidivism" [47]. It may be that the evidence falls somewhat short of that standard, but at the same time there is nothing in the evidence to date that would suggest that public safety concerns should stand as a major barrier to the further development of mental health courts.

Cost

Most mental health courts have small caseloads compared with traditional criminal courts and at some level operate as boutique courts. The judiciary in many states has suffered severe budget cuts [48], as have publicly funded mental health treatment providers [49]. Therefore, the impact of mental health courts on cost is an important though understudied question.

The RAND Corporation has conducted the only comprehensive evaluation of cost issues, in the Allegheny County, Pennsylvania, mental health court [50]. Investigators examined service utilization and costs for individuals served by the court using a 1-year pre/post design, with a 2-year analysis of a subgroup of individuals. The investigators concluded that treatment costs for mental health court participants increased in the first year after enrollment in the court. This is not surprising, since mental health courts are designed to expand access to services for their clients. At the same time, decreased jail time resulted in lower jail expenditures, which largely offset treatment service costs. Over 2 years, treatment costs returned to pre- mental health court levels, while jail costs decreased significantly in the second year. Again, the reduction in jail costs offset treatment costs.

Total cost savings for the full 2-year period were not statistically significant, but in the last 2 quarters of the second year, mental health court program-related costs were statistically significantly lower, and subgroups of defendants with evidence of more distress (felony charges, psychotic disorders, high levels of psychiatric acuity and low functioning) accrued even larger cost savings. The study concludes that the Allegheny court did not raise costs significantly in the short term compared with ordinary court processing. The study also notes that cost savings may accrue *over time* because mental health court involvement was associated with reduced criminal offending and utilization of the most expensive forms of treatment, primarily hospitalization. One study is not definitive, but the RAND study suggests that mental health courts can operate in ways that accomplish treatment access while reducing recidivism, without significant increases in overall costs.

SUMMARY

Mental health courts emerged as part of a larger set of strategies designed to divert people with serious mental illnesses away from the criminal justice system into treatment. Like drug courts, mental health courts have expanded rapidly and in every part of the United States, suggesting that the problems they attempt to address cut across state and local lines. Whether they work, and if so, for whom and why, are critical questions that research has begun to address in an accumulating number of studies. The evidence to date is not definitive, but each of the single-site studies and the 1 multi-site study that have been done report findings that all point in the same direction: mental health courts appear to have success in improving access to services, and do not increase and in a number of instances reduce recidivism, compared with the experiences of defendants whose cases are processed by traditional criminal courts. In addition, the courts appear to be embraced by defendants as providing choice and voice far beyond that experienced in traditional criminal court. Whether this is associated with better outcomes is a separate issue, but mental health courts appear to be a rare example of a judicial process that does not increase defendant alienation. The one area where courts appear to diverge from the goals of diversion is in the timely processing of cases, where other types of diversion programs appear to identify and process cases more rapidly.

As is nearly always the case with innovative strategies that attempt to address complex, multi-dimensional social and health problems, more research is needed. However, the research to date, conducted in a number of disparate jurisdictions across the United States, appears to support the continued expansion of mental health courts as an alternative to the traditional criminal justice system for at least some of the individuals with serious

mental illnesses who cycle in and out of community jails and emergency rooms.

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