What Can We Say About Mental Health Courts Today?

Gregg Goodale, M.S.
Lisa Callahan, Ph.D.
Henry J. Steadman, Ph.D.

Mental health courts (MHCs) are a popular type of problem-solving court, and there is ample evidence that they reduce recidivism and increase participation in community-based treatment. The authors summarize evidence for the effectiveness of MHCs and present findings from a study in which they identified and characterized 346 adult and 51 juvenile MHCs currently operating in the United States. The continued growth of MHCs will be based in large part on funding for services. The Affordable Care Act will have major consequences for services provided to this population, and its implementation may therefore affect the future of MHCs. The authors note that it is preferable that people with mental illness not become involved in the criminal justice system in the first place. Despite the success of MHCs, they are not a substitute for an adequate mental health system. (*Psychiatric Services* 64: 298–300, 2013; doi: 10.1176/appi.ps.201300049)

A dozen years ago in this journal, a Law & Psychiatry column titled "Mental Health Courts: Their Promise and Unanswered Questions" (1) examined a new type of treatment court. Has the promise of mental health courts (MHCs) been achieved? Have the core questions about their effectiveness been answered? Over the intervening years, mental health courts have remained popular and continued to proliferate. In contrast to their early years of growth, however, there is now ample evidence demonstrating that MHCs reduce recidivism and that after enrollment in the program, MHC participants receive more community-based treatment than their counterparts whose cases are tried in regular courts. MHCs are an increasingly popular option for responding to the large number of people with mental illness in the criminal justice system.

In this column, we summarize evidence on the effectiveness of MHCs, present findings from a study in which we identified MHCs operating in the United States, and discuss the future of MHCs.

The authors are affiliated with Policy Research Associates, Inc., 345 Delaware Ave., Delmar, New York 12054. Send correspondence to Dr. Callahan (e-mail: lcallahan@prainc.com). Paul S. Appelbaum M.D., is editor of this column.

Background

MHCs are a type of problem-solving courts, which have three main characteristics: a problem-solving orientation, interdisciplinary collaboration, and a focus on accountability (2). Although there are similarities among MHCs, their practices vary across jurisdictions. MHCs can seek to divert defendants before trial or to provide posttrial treatment-oriented dispositions as alternatives to incarceration. In general, MHCs share the goal of reducing "recycling" through the justice system of persons with mental illness who can safely be supervised and treated in the community. Early MHCs often targeted only defendants charged with misdemeanors, but over time, although most MHCs continue to exclude certain classes of offenders, more courts are open to defendants facing many categories of felony charges (3).

Potential MHC clients are referred by jail personnel, defense attorneys, and others with whom they come into contact (4). If they meet eligibility criteria and choose to participate in the MHC, the court will set the prerequisites for acceptance, which typically include a guilty plea, conditions to which clients must adhere in the community (for example, no drug or alcohol use), periodic hearings before a judge, and participation in treatment. Most MHCs use a combination of incentives and sanctions to gain compliance with court orders. Occasionally, a jail term is ordered for violations of conditions or failure to comply with treatment, but for most courts that is a last resort (5).

The earliest specialty docket devoted to mental health cases was in Marion County (Indianapolis), Indiana, in 1980, and it has been operating ever since, with a hiatus from 1992 to 1996. The first highly visible MHC was established in Broward County, Florida, in 1996. Like drug treatment courts, MHCs are usually initiated by judges who become frustrated by how ineffectively the justice system processes offenders with mental disorders. Judges often have the leverage to create MHCs, and they have the "power of the gavel" over both the treatment court clients and treatment providers that is needed to make the courts work.

Effectiveness of MHCs

Our knowledge about MHCs has increased significantly in the past 12

years. Most research has involved single-site case studies, either comparing MHC participants before and after their MHC enrollment or comparing participants with similar nonparticipants. Most, though not all, single-site studies find that MHC participants have better criminal justice outcomes after enrollment or compared with "treatment-as-usual" defendants. McNiel and Binder (6), for example, found a reduction in new charges for violent crimes and a longer period before new charges were filed among San Francisco Behavioral Health Court graduates, compared with treatment-as-usual jail detainees. In a Clark County (Portland), Oregon, study, a diagnosis of schizophrenia and being an MHC graduate were associated with less postenrollment recidivism than observed for nongraduates (7). Findings from the King County (Seattle) MHC showed a reduction in recidivism and jail days among MHC participants compared with defendants who opted out of the MHC (8).

In the MacArthur Mental Health Court Study—the only multisite study to date that included prepost data and a comparison group—we examined the two main goals of MHCs: reduced recidivism and improved treatment engagement. The sites involved—San Francisco County and Santa Clara County, California; Hennepin County, Minnesota; and Marion County, Indiana—were selected on the basis of several factors, including caseload, duration of operation, and program eligibility criteria. Newly enrolled MHC participants and similar jail detainees with mental disorders were invited to participate in the study. All who gave consent were interviewed at baseline, and 70% were reinterviewed at six months. We also obtained permission to access their mental health and criminal justice records.

We found that both of the primary MHC goals—reduced criminal justice involvement and increased community treatment—were met. Looking at criminal justice outcomes, we found that MHC participants had significantly lower arrest rates after enrollment than before enrollment and lower postenrollment arrest rates than the comparison group; the MHC participants also had significantly fewer postenrollment jail days than the comparison group (9). When the reduced recidivism rate in this and other MHC studies was compared with the most recent results from drug court research, MHCs were more successful at reducing recidivism—recidivism rates of 25% versus 10%–15% (9,10).

As for the goal of increasing engagement in community treatment, MHC participants accessed community treatment more quickly than the comparison sample and also had more intensive and therapeutic treatment episodes (11). Like other researchers, however, we found no relationship between the type of treatment and whether the MHC participants were rearrested. Treatment may decrease symptoms and improve quality of life, but it appears not to have a direct effect on reducing recidivism. The "active ingredient" that lowers recidivism has not been identified in either mental health or drug court research, although it may involve some combination of intensive monitoring and supportive relationships with MHC staff.

One reason that many state and local leaders endorse MHCs and other treatment courts is the assumption that they save money. However, research on MHC costs is equivocal. Single-site studies conducted in Pittsburgh (12) and San Francisco (13) suggested that cost savings occur, particularly in the second year of supervision. The MacArthur Mental Health Court Study did not support this conclusion across the board. Instead, we found that it is important to examine participant subgroups, because some individuals are high users of services both before and during their MHC participation. This underscores the need for MHCs to identify high-risk–high-need participants and engage them in appropriate evidence-based practices along with close court-ordered community supervision.

Growth in the number of MHCs

Given the absence of a central registry of MHCs, we undertook a project to identify and characterize the existing adult and juvenile MHCs in the United States. We began by examining lists compiled by such organizations as the National Center for State Courts and then turned to each state government Web site (for example, ".gov" and ".state.us"), where MHCs were often listed. As needed, we contacted an individual at the state court administrator's office to obtain additional information. It is possible that despite these efforts, we did not locate every MHC that is currently operating, but we believe that we came close to this goal.

Our study identified 346 adult MHCs and 51 juvenile MHCs currently operating in the United States. (More than 2,700 adult and juvenile drug courts are currently in operation, according to the National Association of Drug Court Professionals [www.nadcp.org]). As recently as 2003, there were fewer than 75 adult MHCs, which illustrates the decadelong growth of these specialty dockets and courts. Nearly all states have at least one adult MHC, and some states—for example, California, Florida, New York, and Ohio—have many. Of interest, these four states are also among the jurisdictions with the highest number of drug courts. Six states have no MHCs—Arkansas, Connecticut, Nebraska, New Jersey, Rhode Island, and Wyoming; however, all six of these states have drug courts. Some states provide guidelines and technical assistance for treatment courts, including MHCs. Ohio has recently adopted standards for certification of its MHCs, a requirement for continued state-level assistance. Although MHCs tend to coexist with drug courts, they lack the diverse funding stream of most drug courts, which are supported by a combination of federal, state, local, and grant monies. MHCs may receive some state funds in larger states, such as California and Ohio, but most are funded through court budgets, local agencies, or grants. [A complete list of the 346 adult and 51 juvenile MHCs can be found on the GAINS Center Web site (gainscenter.samhsa.gov). No information could be located for MHCs in the nine U.S. Territories.]

Looking forward: policy implications

MHCs are not without their critics. One complaint is that the courts were created to compensate for the criminal justice system's unfair treatment of people with mental illness and the public mental health system's failures. Thus some critics argue that MHCs signal an acceptance of the rates at which people with serious mental illnesses reenter the criminal justice system, making it more difficult to generate political will to address the root of the problem. Other challenges focus on the court's legitimacy in depriving defendants of the discretion to accept or reject mental health treatment merely because they were convicted of a criminal offense. It may be that the adoption of MHCs in some jurisdictions has been slowed by concern over these issues.

Another policy question is the extent to which the MHC model will be adapted to deal with juveniles with mental disorders or other discrete groups, such as veterans. Even in the absence of empirical data on the effectiveness of juvenile MHCs, there are approximately 51 such courts nationwide, with more than half concentrated in three states (Ohio, California, and Texas) (14). In addition, veterans' treatment courts have expanded widely in the five years since the creation of the first such court in Buffalo in 2008. Today, according to the National Association of Drug Court Professionals (www.nadcp.org), there are approximately 110 veterans' treatment courts. In many respects, these new types of treatment courts are expanding in much the same way as adult MHCs, moving forward with little empirical data about their success. Although MHCs have ultimately been shown to be effective, a more rational approach for juveniles, veterans, and other groups would be to establish effectiveness before promoting proliferation of the model.

Whether MHCs improve justice and treatment outcomes for people with mental disorders who are involved in the criminal justice system appears to be settled: they do. If that were the sole basis for expanding MHCs to other jurisdictions across the United States, it would be simple to recommend such an expansion. However, we should proceed with caution. Communities must have the fiscal resources to support MHC programs, and they must have the evidence-based practices in place for the potential clients of their courts.

The extent to which MHCs will see continued growth will likely be based in large part on the availability of funding for such services. The Affordable Care Act (ACA) could have major consequences for provision of services to persons with both mental illness and substance use disorders who become involved with the criminal justice system. The ACA requires that both types of treatment be included in all health plans, including Medicaid, and does not exclude justice-involved individuals from this requirement. Therefore, MHCs and drug treatment courts could mandate treatment and expect that insurance would cover appropriate services. Numerous evidence-based practices are available for individuals involved in the justice system, including interventions for persons with mental illness, substance use disorders, co-occurring disorders, and trauma. Whether the ACA will help to expand services to the target population of MHCs remains to be seen.

Conclusions

Even with the evidence for the effectiveness of MHCs, almost all experts would agree that it is preferable that people with mental illness not become involved in the criminal justice system in the first place. Insofar as expansion of insurance to the uninsured and creation of treatment programs that meet their needs improve both health and public safety outcomes, communities would be wise to facilitate enrollment and early engagement of persons at risk for becoming involved with the criminal justice system. MHCs are not a substitute for an adequate mental health system.

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