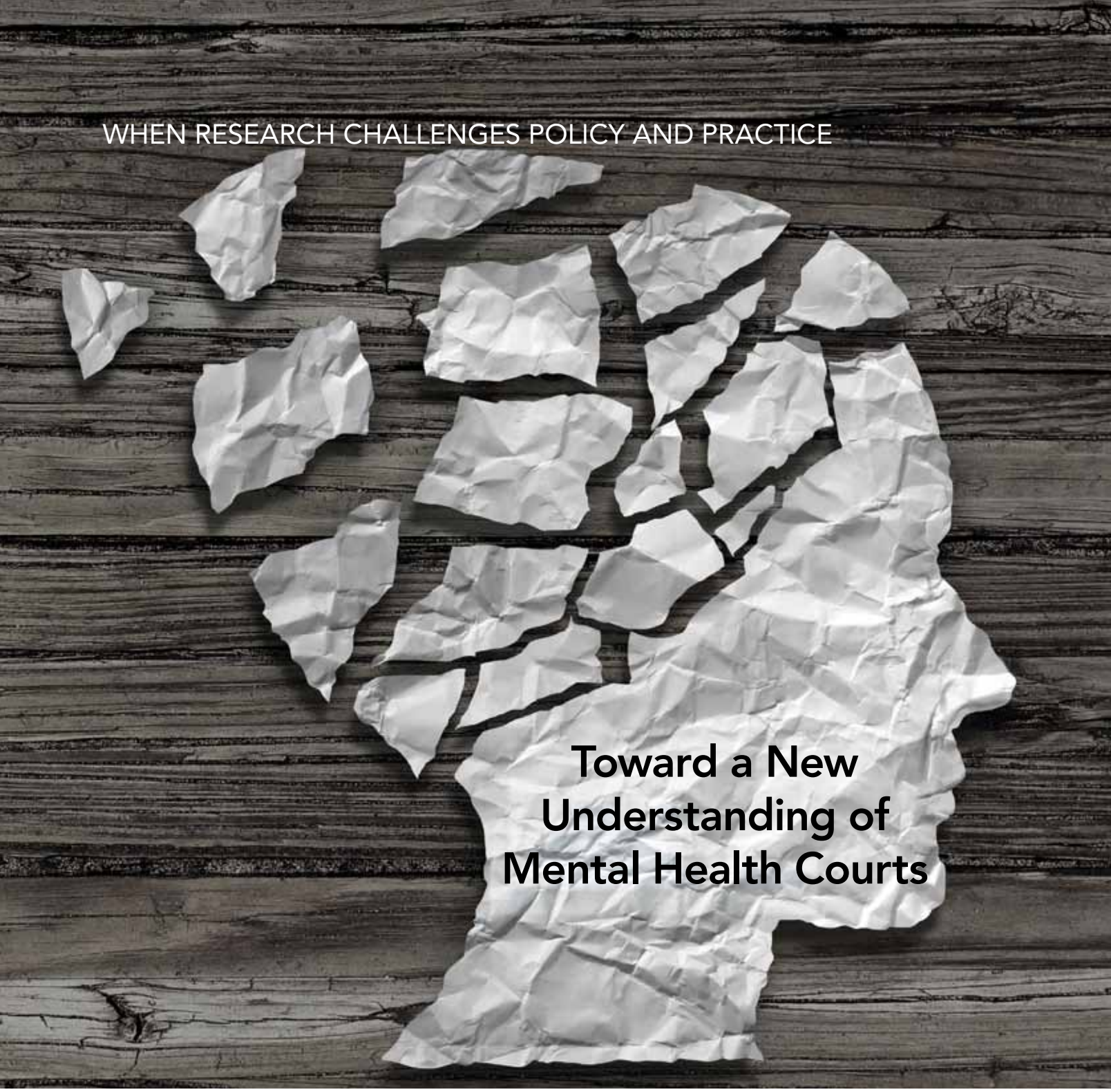

Toward a New Understanding of Mental Health Courts

By Carol Fisler

Mental health courts, like other innovations in justice, began as an experiment, testing the proposition that linking defendants with mental illnesses to court-supervised, community-based treatment as an alternative to incarceration would lead to improved mental health outcomes and reduced criminal justice involvement. A handful of mental health courts were launched in the late 1990s, a few dozen by 2003, and by 2010 approximately 300 were operating in more than 40 states, involving tens of thousands of defendants.

Jurisdictions were basing their decisions to open mental health courts, in part, on the success of drug courts. Research showed that participants in these courts had higher rates of treatment retention than addicts participating in treatment voluntarily and lower rates of recidivism than defendants in traditional courts.[1] Another reason for the blossoming of mental health courts was a belief by judges and other stakeholders in the logic underlying their design and operations. They assumed that (1) untreated, or inadequately treated, mental illness contributes to criminal behavior; (2) criminal

justice involvement can serve as an opportunity to connect people to appropriate treatment; (3) appropriate treatment can improve the symptoms of mental illnesses and reduce problematic behavior, especially when (4) judicial supervision, including the use of graduated incentives and sanctions, helps keep people in treatment; and, thus, (5) the combination of treatment and judicial supervision will reduce recidivism and improve public safety.

The growth in mental health courts preceded any significant research testing their underlying logic. By 2010, only a few studies of individual courts had provided evidence regarding the effectiveness of the program model. The pace of published mental health court research began to pick up in late 2010. Today, although a growing body of research shows consistent and promising results across a number of courts, it also squarely challenges the logic of the mental health court model. Participants in mental health courts do have lower rates of recidivism and spend fewer days incarcerated than similar people whose cases are handled in traditional courts. But these positive outcomes may have little to do with treatment or improvements in symptoms or functioning levels.

What does this mean? And what are the implications for the design and operations of mental health courts?

The Complexity and Variety of Mental Health Courts

Mental health courts, like the individuals who participate in them, are complex and heterogeneous. They are created through a collaborative planning process involving stakeholders across the criminal justice and mental health systems, as well as other community representatives, who may have a wide range of goals: improving public safety by reducing recidivism, reducing the criminalization of mental illness, reducing the number of people with mental illness in jail and prison, giving judges better tools for dealing with challenging defendants, improving the quality of life of people with mental illnesses, increasing treatment engagement, or using criminal justice and mental health resources more efficiently and effectively. As with other problem-solving courts, these goals go far beyond individual case proceedings.

Mental health courts typically handle cases involving defendants with serious psychiatric disorders like schizophrenia, bipolar disorder, and major depression. A high percentage of these individuals have co-occurring substance use disorders. Mental health courts vary widely, though, on whether they also accept individuals with developmental disabilities, personality disorders, traumatic brain injuries, dementia, and other cognitive and behavioral impairments.

Mental health courts also vary widely on key elements of program design: the range of eligible charges (violations, misdemeanors, nonviolent felonies, and felonies); the court stage at which cases are accepted (pre-plea, post-plea/pre-sentence, or post-sentence); the length of time that participants remain under court supervision (a few months to two or more years); whether monitoring and reporting are handled by treatment staff, probation officers, or a combination of justice and mental health personnel; the nature of the judge's responses to infractions (the degree to which jail is used as a sanction, for instance); requirements for successful completion of the court program (such as consistent attendance at treatment sessions, abstinence from drug use, accomplishment of educational and vocational goals, and payment of fees); and the disposition of the court case upon successful completion (dismissal or reduction of charges, conditional discharge, or early termination of probation).

Mental health courts rely on multidisciplinary teams that bring clinical resources into the court process. Behavioral health professionals conduct in-depth assessments and develop individualized treatment plans, which form the basis for defendants, prosecutors, and judges to decide whether participation is appropriate. Treatment plans represent another significant variation across mental health courts: The communities in which they operate differ in the availability of high-quality treatment and related supports for individual participants, including housing, educational and vocational services, and transportation.

Once a defendant enrolls in a mental health court, team members coordinate community-based services, monitor the participant's adherence to the treatment plan, and report back to the rest of the team—judge, prosecutor, defense counsel, and behavioral health partners—so that clinical and criminal justice responses to problems and progress in treatment can be coordinated. Participants appear regularly before the judge, who engages with them and responds with both rewards and sanctions to help motivate engagement in treatment and encourage law-abiding behavior. In focusing on outcomes as well as process, mental health courts emphasize accountability, holding participants accountable for adhering to treatment plans and providers for delivering appropriate services.

Research Findings

Research is crucial to helping us understand "what works" in bringing about desired goals, for individuals and communities, and decide how to allocate scarce resources to the most effective interventions. Research must ask more than whether a particular intervention is effective, however. It should help answer the questions: For whom is the intervention effective? Under what circumstances? And if a complex and multilayered intervention like a mental health court generates

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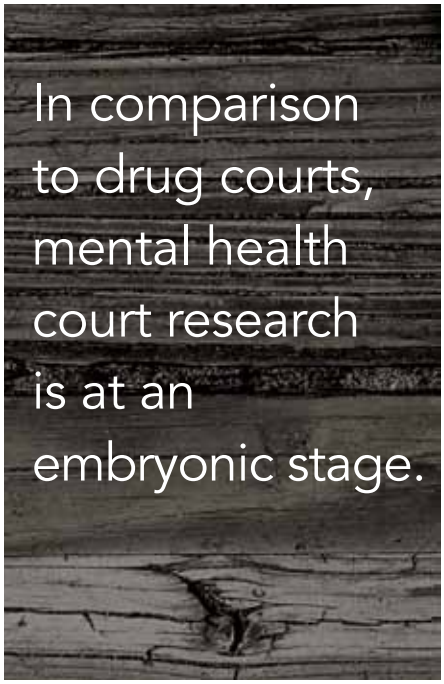
desired results, which aspects of the intervention are responsible?

In comparison to drug courts, mental health court research is at an embryonic stage. Drug court policymakers and practitioners have the benefit of hundreds of studies conducted over more than two decades. These have yielded very specific information on which aspects of court design and operations contribute to positive results, ranging from eligibility and exclusion criteria; assessment procedures; the interactions between the judge and the participants; the use of incentives, sanctions, and therapeutic adjustments; and treatment modalities.[2] By contrast, to date only about a dozen mental health courts have been subject to rigorous evaluations comparing participants with control groups in traditional courts.[3] Only a subset of the published studies has begun shedding light on which defendants are most likely to benefit from participation. No studies have yet evaluated the impact of specific policies and procedures on individual outcomes, nor have any addressed most of the system-level goals articulated by stakeholder planning teams.



Although the number of published mental health court studies is still fairly small and varies in the outcomes measured and the degree of statistical significance of their results, the outcomes have been generally consistent. Compared to defendants in traditional courts, mental health court defendants have lower rates of re-offending, longer times in the community before committing new offenses, and fewer days of incarceration. Studies that followed participants for a period of time after exiting the mental health court showed that positive effects can endure for a year or more. Mental health court participants also demonstrated greater engagement in community-based treatment than nonparticipants.[4] These research results appear, at least on the surface, to validate the assumptions underlying mental health court design and operations: The combination of treatment and judicial supervision will improve treatment engagement and public safety outcomes.

Intriguing results, however, have come from studies that have asked not only "are mental health courts effective?" but "for whom, and under what circumstances?" Across multiple mental health courts, the factors most predictive of rearrest were a higher number of prior arrests, a greater number of days spent in jail before mental health court participation, having a co-occurring substance use disorder, and younger age[5]—characteristics associated with recidivism generally, regardless of mental health status.[6]

Interestingly, the seriousness of charges, or of the most serious prior offense, was not associated with higher rates of re-offending. In fact, one court showed no significant difference between violent and nonviolent offenders on any recidivism outcome, and two courts showed lower rearrest rates among participants charged with violent felonies than those charged with drug and property crimes.[7] These findings challenge a common eligibility criterion that excludes defendants charged with violent offenses. Many jurisdictions fear that people charged with violent crimes present an unacceptable public safety risk, and a federal program that has funded dozens of mental health courts explicitly prohibits grant funds for programs handling violent offenses. But the research suggests that felony offenders and, more specifically, violent offenders with mental illness may be safely maintained in the community with appropriate supports.

More interesting still are the results related to mental illness and treatment engagement. A multisite study[8] found a few links between clinical factors and criminal justice outcomes. Specifically, people engaged in treatment in the six months before mental health court enrollment had lower rearrest rates than those not so engaged, and people with bipolar disorder had fewer days of incarceration post-enrollment than those with schizophrenia or major depression. But other clinical characteristics (history of psychiatric hospitalization, symptom severity at the time of enrollment or six months post-enrollment, or insight into mental illness), the type of treatment, and self-reported treatment engagement and adherence to medication regimen had no relationship to rates of recidivism or incarceration. The researchers summed it up bluntly: "We found no relationship between the type of treatment intervention received (or not) and whether the MHC enrollees were arrested or in jail following MHC enrollment."[9]

These findings certainly strike a blow at the logic model described at the beginning of this article. True, the significantly lower rates of re-offending and re-incarceration among mental health court participants compared to those in traditional criminal courts indicate that *something* positive is happening in mental health courts. But the research to date does not support the hypothesized links from treatment engagement to better mental health to improved public safety that have driven mental health court design and operations.

Does this mean that treatment is irrelevant? Not at all. First, there may be measurable benefits to individuals and communities from treatment engagement other than the criminal justice outcomes studied in these evaluations. Second, research might show a greater link between engagement in community-based services and criminal justice outcomes if mental health court participants have

access to all the services and related supports that policy experts consider useful, including evidence-based medication regimens, integrated treatment for co-occurring mental illnesses and substance use disorders, supported employment, illness management practices, trauma interventions, family education, cognitive behavioral therapies, and suitable and affordable housing.[10] Very few communities, though, are able to make a full array of services available to mental health court participants; far too many provide only minimal medication and counseling.

New Hypotheses

What, then, explains the good results in mental health courts? What aspects of current mental health court design and operations should be emphasized? And should new program elements be introduced in light of the research findings? Mental health court research has spurred new hypotheses but no clear answers.

The Risk-Needs-Responsivity Model

Because the factors most predictive of recidivism—prior criminal history and substance abuse—are common to both mental health court participants and the general criminal justice population, some have looked to criminology for understanding. The Council of State Governments Justice Center[11] has created a framework for people under criminal justice supervision that integrates Bonta and Andrews's "risk-needs-responsivity" or "RNR" model[12] with behavioral health factors. This framework has been embraced by federal mental health and criminal justice agencies and a growing number of mental health court practitioners.

The RNR framework has three prongs:

- *Risk principle: who to target*. Scarce criminal justice resources should focus on interventions for people at the highest risk of re-offending. Substantial research has identified "Central Eight" risk factors most predictive of criminal behavior: antisocial history, attitudes, friends and peers, and personality pattern; substance abuse; family discord; lack of success in education and employment; and lack of positive leisure activities.[13] Targeting individuals with a high number of these risk factors will produce the greatest reductions in recidivism; moreover, subjecting low-risk offenders to interventions intended to reduce criminal behavior can actually *increase* their likelihood of re-offending.[14]
- *Need principle: what to target*. High-risk individuals should receive interventions that target their particular criminogenic needs, which are best understood as dynamic risk factors that are potentially subject to change. Addressing more of an individual's criminogenic needs brings greater reductions in recidivism.
- *Responsivity principle: how to address criminogenic needs*. The ability to respond to an intervention depends on individual learning styles, motivation, culture, and abilities. Effective interventions require addressing responsivity factors, such as obstacles to learning.

Contrary to the assumptions underlying the development of mental health courts, mental illness is *not* considered a risk factor for criminal conduct.[15] Several recent studies of crimes committed by people with mental illnesses have found that mental disorders play a much smaller role than had previously been thought.[16] Relatively few crimes committed by people with mental illness, for instance, take place while someone is in an active psychotic or manic state. From an RNR perspective, which recognizes the prevalence of criminogenic risk factors among justice-involved people with mental illnesses, it appears that these individuals have more in common with other people in the criminal justice system than they do with non-justice-involved mentally ill individuals.

Mental illness still plays a role in the RNR framework, but as a *responsivity* factor that affects a person's ability to participate in and learn from interventions designed to address criminogenic needs. As Judge Stephanie Rhoades of the Anchorage Mental Health Court—one of the first in the nation—comments, "We believed mental illnesses basically were the direct cause of criminal justice involvement, and really it turns out that it's very few people for whom that's true. It appears now, from more recent research, that mental illness is a reason why people can't necessarily change as easily as other people."[17] In this context, treatment for mental illness remains crucial for mental health court participants, not because improvements in symptoms or functioning will have a direct impact on criminal behavior but because treatment will improve their ability to respond to interventions to change criminal behavior.

The RNR framework suggests several new guidelines for mental health courts: Courts should set their eligibility criteria to focus on defendants at high risk of re-offending; they should incorporate interventions to address criminogenic needs in the array of services offered to participants; and they should address participants' individual responsivity factors, including mental illness, to facilitate their engagement in criminogenic needs interventions.

A paradox remains: Because the mental health courts studied to date had not adopted these guidelines, how can the RNR framework explain their positive results? Some commentators have suggested that the courts' case management practices and judicial supervision have, perhaps unintentionally, addressed participants' criminogenic needs.[18] Mental health courts do, in fact, typically require participants to engage in constructive activities, including treatment, education, vocational programs, and employment; link those with co-occurring disorders to substance abuse treatment; and attempt to drive home the message that participants should avoid people, places, and things that will serve as triggers for drug cravings or influences toward risky behavior. But aren't there other things happening in mental health courts that might help explain the positive results?

Procedural Justice

Frequent status hearings and the use of graduated incentives and sanctions have been considered key components of mental health courts since their inception. In addition, judges' experiences and research from other contexts have shown that the quality of interaction between judges and participants and the tone of court proceedings are at least as important.

"Engagement with the judge is one of the reasons for our participants' success," says Judge Matthew D'Emic of the Brooklyn Mental Health Court.[19] Since it opened in 2002, this court has enrolled more than 1,000 participants, 45 percent of whom have been charged with violent felonies, and has consistently had graduation rates above 70 percent. "It's the same as with other relationships. If I engage with someone, and that person engages with me, we don't want to disappoint each other."

Tom Tyler of Yale Law School refers to this dynamic as *procedural justice*, or the perceived fairness of court procedures and interpersonal treatment.[20] This is quite different from distributive justice, or the perceived sense of the fairness of a final outcome (whether someone won or lost a case). Tyler and other researchers have demonstrated a strong connection between individuals' perceptions of procedural justice and their future attitudes and behavior. Individuals' sense of procedural fairness arises from having a *voice* in the proceedings; being treated by the judge and others in the courtroom with *respect*; feeling that the court process is *neutral* (unbiased and consistent across cases); and *understanding* the language used in court, their rights, and the decisions made. People who feel the legal system, and their own treatment within it, to be fair will internalize the values of the system, show greater compliance with court orders, and be less likely to re-offend.

Recent drug court research has highlighted the importance of procedural justice in motivating law-abiding behavior. In a study comparing defendants in 23 drug courts across the country to those in six traditional courts, a defendant's attitude toward the judge was the strongest predictor of reductions in new offenses, drug use, and violations of supervision. Similarly, when researchers conducted structured observations of interactions between judges and defendants, they found that drug courts whose judges were rated as more respectful, fair, attentive, caring, and knowledgeable had lower rates of recidivism than courts whose judges showed fewer of these attributes.[21]

Similar results have been documented in community courts, family courts, and domestic violence courts. Most significantly, a rigorous evaluation of a mental health court in Washington, D.C., which compared misdemeanor offenders who reported frequently over several months to a judge presiding over a specialized docket to similarly situated offenders who received identical case management and treatment services but limited judicial interaction, found that significantly fewer mental health court participants were rearrested and that they had significantly fewer total rearrests, even up to a year after exiting the court program; they also had a longer tenure in the community before being rearrested.[22] Research involving parolees and probationers with mental illnesses documents similar positive outcomes: individuals whose supervision officers treat them with trust, caring, fairness, and a nonpunitive stance are less likely to be remanded for technical violations or to re-offend than individuals whose supervision officers take an authoritarian and disrespectful stance.[23]

Engagement in Civic and Social Life

While procedural justice explains how individuals come to accept legal norms, mental health courts may well also be fostering connections to civic society and positive relationships with others.

Mental health policy and services have changed during the 15-year history of mental health courts from a medical orientation that emphasizes the biochemical aspect of brain disorders and the importance of pharmacological treatment to a recovery approach that emphasizes the importance of individuals leading a self-directed life and striving to reach their full potential across four dimensions: health, home, purpose, and community.[24] At first blush, it is easy for judges and other criminal justice practitioners to reject recovery principles as irrelevant for defendants subject to incarceration and continuing compliance with conditions of supervision. But if mental health courts seek to bring about long-term changes in people whose mental illnesses and poverty already marginalize them, then court practices that support connections in the community to families, peers, and institutions should be embraced.

"At first, I thought that having the participants come to court frequently made sense just for public safety," says Judge D'Emic. "But I started to realize that the courtroom itself is a de-stigmatized environment, where the participants can feel comfortable being themselves. They see the other participants and get to know them, and the courtroom becomes a community of participants. And they take that sense of acceptance and support with them back to their own communities."[25]

This attitude is a far cry from that of the judges who ask at conferences and training sessions, "What sanctions should I use to get the participants in my court to take their meds?" The appropriate answer is that medications may be necessary but far from sufficient for bringing about the changes in attitudes, thinking, relationships, and achievements that will help people with mental illnesses who have committed crimes lead purposeful—and law-abiding—lives in the community. A recovery orientation in the courtroom and in treatment dovetails entirely with principles of procedural justice and with RNR principles for reducing criminogenic risks.

Beyond Mental Health Courts

Many supporters of problem-solving courts are seeking ways to take them to scale and integrate some of their innovations into mainstream court practices. Detractors of problem-solving courts, in contrast, claim that they are an unwarranted drain on resources.[26] Both sides have reason to ask whether the positive results documented in evaluations of mental health courts could be replicated through other,

potentially less resource-intense case processing and sentencing approaches.

Some of the policy and practice proposals suggested by the research, such as targeting individuals with high criminogenic risks and seeking to change defendants' attitudes and behaviors by using courtroom communications practices grounded in procedural fairness, could certainly be implemented in traditional courts. Other hypotheses to explain the positive results seen in mental health courts, such as its de-stigmatizing courtroom experience, might only be applicable to other specialized courts.

Mental health court research is in its infancy, and its conclusions are still tentative. The research to date consistently supports the notion that mental health courts "work." Beyond this, more research will be needed to help us understand which aspects of mental health courts have the greatest impact on people's behavior, which individuals are most likely to benefit, and whether the positive attributes of mental health courts can be replicated and sustained in traditional court settings. ■

Endnotes

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5. Rossman et al., *supra* note 4; Steadman et al., *supra* note 4.

6. Mental health court research to date shows no relationship between race or gender and re-offending.

7. Anestis & Carbonell, *supra* note 4; Rossman et al., *supra* note 4.

8. Steadman et al., *supra* note 4; Keator et al., *supra* note 4.

9. Keator et al., *supra* note 4.

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