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Recent Developments In Mental Health Courts: What Have We Learned?

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Mental health courts (MHCs) are problem-solving courts that attempt to redirect individuals with mental illness into treatment rather than incarceration (Wolff, 2003). The primary purpose of this article is to provide a narrative review of recent evidence on the empirical status of MHCs and suggest directions for future social work research. Such a review is critical given the existence of 300 MHCs in the United States (Council of State Governments Justice Center, 2011) with more in development. Four major questions guided our review: (a) How do they work? (b) Does a theoretical basis exist to explain how they work? (c) What is the nature of the evidence? and (d) What are the characteristics of the mentally ill who choose not to participate in MHC programs and of those who are negatively terminated? Though studies have shown reductions in assessed outcomes, a lack of methodologically strong evaluations significantly limits the strength of those results. There exists a need for additional, methodologically rigorous studies to better understand the effectiveness of MHCs.

Mental health courts (MHCs) were developed to divert individuals with mental illnesses from incarceration and into treatment. MHCs have largely been in existence since the passing of America's Law Enforcement and Mental Health Project Act in 2000 (Bazelon Center for Mental Health Law, 2003). Currently, there are over 300 MHCs in the United States (Council of State

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Governments Justice Center, 2011) and the number is rapidly increasing. It is critical to periodically review the latest scientific knowledge concerning the evidence of this model of diversion. The primary purpose of this article is to provide a narrative review of recent evidence on the empirical status of MHCs and suggest directions for future social work research. Four major questions guide our review: (a) How do they work? (b) Does a theoretical basis exist to explain how they work? (c) What is the nature of the current the evidence? and (d) What are the characteristics of the mentally ill who choose not to participate in MHC programs and of those who are negatively terminated?

HOW DO MHCs WORK?

Set Up and Design

The Department of Justice (DOJ) offers general recommendations and requirements for the establishment of an MHC, but specific arrangements are devised by local jurisdictions and law enforcement (Cosden, Ellens, Schnell, Yamini-Dioff, & Wolfe, 2003; Reed, 2002; Tyuse & Linhorst, 2005). For this reason, the program has been criticized for not having a standardized national model (Cosden et al., 2003; Tyuse & Lindorst, 2005). According to the Criminal Justice/Mental Health Consensus Project website, the Council of State Governments has compiled a set of 10 "essential elements." The recommendations serve as a guide for the development of MHCs. The 10 elements include planning and administration, identifying a target population, timely participant identification and linkage to services, development of terms of participation, ensured informed choice among participants, connecting participants with the appropriate treatments and supports, ensuring confidentiality, a court team comprised of criminal justice and mental health staff, the monitoring of court requirements, and evidence of demonstrated stability and sustainability of a MHC (Thompson, Osher, & Tomasinin-Joshi, 2007).

Selection Process

MHC participants are typically referred by defense or prosecuting attorneys, judges, law enforcement professionals, (Castellano, 2011a) and in some cases family members. Wolff, Fabrikant, and Belenko analyzed six MHCs to determine how clients were identified, screened, recruited, excluded, and included for participation in their respective court programs. It was determined that MHC processes could be characterized by three stages: initial screening, assessment screening and evaluation screening. The initial screening stage, they observed, essentially served as a "clearinghouse function" (Wolff et al., 2011, p. 405). Individuals were screened for eligibility to determine their

appropriateness for the court. Those determinations included both formal (i.e. formal screening protocols) and informal eligibility criteria (i.e. subjective "suitability" assessments by clinical staff; Wolff et al., 2011, p. 406).

Wolff et al. (2011) described the second stage of evaluation and screening for MHC participation as being more in-depth than the first stage. At Stage 2, a defendant's eligibility status was considered relative to diagnosis, current charges, criminal history, and problems such as substance abuse or axis II personality disorders. Wolff et al. (2011) noted seven reasons for rejection at this stage including not having an axis I diagnosis, not needing intensive case management services, unavailability of treatment services in the community, no evident connection between mental illness and criminal behavior, defendant deemed not treatable, considered too violent, or not deemed suitable for participation by clinical staff. Wolff and colleagues (2011) also observed that the majority of the judges in their study deferred to and accepted the recommendations of the treatment staff. Stage 3 of the eligibility screening process involved two key players: the judge and client. Judges, in some cases, requested meeting with the client. In those cases, the judge made the final determination regarding whether or not the client would ultimately be admitted into the court program (Wolff et al., 2011).

Frailing (2011) conducted one of the more recent studies concerning the MHC inclusion and exclusion processes. Her study examined 1,220 participants in a Nevada MHC. Over half the referrals were rejected ($n = 678$). The most common reasons for rejection included ineligibility to participate in the court, time served or having to go to prison. The second most common reason for rejection was not having a severe mental illness or a treatment history that made one eligible for court participation. The third most common reason for rejection concerned the nature of a defendant's crime. For instance, individuals whose crimes included violence against others, manslaughter, assault with a deadly weapon, rape, or robbery were often excluded.

In that same study, individuals with mental retardation, thought disorders, mood disorders, nonviolent felony charges, anxiety disorders, misdemeanors, or gross misdemeanors were more likely to be accepted into the MHC, when compared to individuals without those characteristics. Frailing (2011) also reported that she has identified only two previous studies (Luskin, 2001; Steadman, Redlich, Griffin, Petrila, & Monahan, 2005) that focused on court referrals. Luskin (2001) found that people who had a history of felony convictions, had been charged with having committed a crime against a person, being male, and being a young rather than an older female decreased a person's chances of being diverted to a court-monitored treatment program. Steadman et al. (2005) studied 285 people referred to seven MHCs over the course of 3 months. They looked at both who was referred and who was ultimately accepted in to a MHC program. Individuals most likely to be referred to a MHC where were older (over 35), White, and female, a finding they believe "is consistent enough to warrant further investigation" (p.224).

The most consist reason for rejection, was that a potential participant did not have a mental health disorder. Individuals with schizophrenia and bipolar disorder were more likely to be accepted than those without these disorders. Age, race, and gender did not significantly factor into whether or not a participant was accepted into a MHC.

Rewards and Sanctions

MHCs stipulate that participants are to comply with all court orders. Common rewards for compliance include verbal praise from the judge (Fisler, 2005; Frailing, 2010), ending court supervision, reducing or dropping criminal charges, or modifying the treatment plan to decrease the number of requirements (Linhorst et al., 2009; Wolff, Fabrikant, & Belenko, 2011). If an individual does not comply with the stipulations imposed by the court, he or she may be reprimanded by the judge (Redlich, 2005) or sent to jail or prison. Other sanctions that may be imposed, as in the case of Washoe County in Nevada, include community service or observing other defendants' court sessions (Frailing, 2010). When adherence to treatment is a condition of probation, this becomes leverage that is used to facilitate and ensure a participant's acceptance of treatment. In this way, MHCs are thought to be influential in facilitating treatment among its' participants, who may not otherwise have accepted or received treatment, thereby decreasing their chances of reincarceration.

MHC Treatment Team and Defendant-Judge Interactions

Within the literature, several articles describe the nature of MHC treatment team interactions, the court environment, and the interactions between judges and defendants. In traditional court settings the judge, attorney, and other criminal justice officials typically have adversarial or formal relationships with defendants (Goldcamp, 1999). MHC staffs have nontraditional relationships with defendants that are geared toward rehabilitation instead of punishment. For instance, Frailing (2010) described the atmosphere of the Washoe County Nevada MHC as being nonadversarial. Often graduates had their photographs taken with MHC personnel, judges included. Applause was given when an individual successfully completed the MHC program. Pallone (2011) described a similar nonadversarial atmosphere in her examination of the Allegheny County MHC in Pittsburgh, Pennsylvania. All members of the treatment team were geared toward the rehabilitation of the defendant. Offenders were praised for their efforts and often given more discretion and latitude than would typically be given to defendants involved in traditional court settings.

Many believe that the judge plays a particularly important role in the success of MHC participants. Judges often acted more like case managers than traditional judges. Ferguson, Hornby, and Zeller (2008) described the

role of the judge as being a team leader. Pallone (2011) described the judges as being the most important team member. She described the judge as being a team player who was always willing to work with each defendant. Participants of the court, when surveyed, said they felt that the judge had listened to them. A similar observation was made by Ray, Brooks Dollar, and Thames (2010). They observed that the direct interaction between judges and defendants facilitated a feeling of respect among defendants. Frailing (2010) believed that the personalized care and interaction offered by the judge is associated with positive outcomes. Likewise, Wales, Hiday, and Ray (2010) argued that many of the reductions in recidivism among MHC participants were in large part due to the role of the judge, who provided three essential functions: treating defendants with dignity and respect, holding both participants and service providers accountable, and ensuring transparency through an open negotiation process.

The Interworkings of MHC Teams

Although many believe that the judge is of primary importance in MHC settings, Castellano (2011b) argued that case managers effectively function as the "lynchpins" (Castellano, 2011b, p. 510). She arrived at this conclusion after an in-depth, 16-month, ethnographic study of four Midwest MHCs, which included the direct observation of court proceedings and agency meetings, interviewing 17 case managers and reviewing archival materials. She observed that case managers are "riding the fence" between the world of social work and criminal justice and in doing so essentially act as "double agents" (Castellano, 2011b, p. 510). Castellano suggested that case managers are acting effectively as "boundary spanners," a concept described by Steadman (1992). Though the judge does not adhere to every recommendation put forth by case management professionals, Castellanos' observations revealed that they are deeply involved in the outcomes of the court proceedings. In her opinion, case management professionals are the "new court authority" and in many ways are "the architects of the courts' routine practices and protocols for facilitating client compliance" (Castellano, 2011b, p. 510).

Gallagher, Skubby, Bonfire, Munetz, and Teller (2011) studied the team dynamics of 11 MHCs by conducting face-to-face interviews with 59 mental health and criminal justice personnel. Ultimately, two main themes emerged: MHC team members understood their own roles on the team as well as those of their colleagues and all team members were focused on the common goal of meeting the needs of the client. In some cases, team members were personally involved in assisting clients to reach their goal. The group seemed to work well together. They respected each other's fields of expertise and deferred to each other when the occasion necessitated. It was also noted by the researchers that many of the individuals who are part of collaborative teams, self-selected their positions. The authors speculated that perhaps the

teams worked so well together because individuals who were self-selected were both committed to serving that population and endorsed a multidisciplinary, nonadversarial approach that is seemingly characteristic of MHCs.

Potential Drawbacks of MHCs

Sarteschi, Vaughn, and Kim (2011) outlined some of the potential problems with MHCs. One of the main disadvantages of MHCs is that individuals are not receiving mental health assistance until after they have already committed a crime. This is not to suggest that this is the fault of any MHC program. After all, MHCs might only exist because the public mental health system has failed to meet the needs of people with severe mental illnesses (Bureau of Justice Assistance, 2000) A more effective approach would be to create programs that minimize or prevent individuals with mental illnesses from becoming involved in the criminal justice system. Two legal concerns associated with MHCs include the fact that individuals may not be competent to agree to participate and thus are not entering voluntarily (Redlich, 2005; Redlich, Hoover, Summers, & Steadman, 2010; Seltzer, 2005) and the fact that to participate in the MHC, an individual may have to plead guilty (Seltzer, 2005). Another potential problem associated with MHCs is that there may be a gender or race bias associated with who is ultimately admitted into these programs (Sarteschi et al., 2011). Finally, there is a concern that MHCs may only be accepting less serious offenders or those individuals who are more likely to have successful outcomes, a practice sometimes referred to as "cherry picking" (Moore & Hiday 2006; Redlich, Hoover, et al., 2010; Sarteschi et al., 2011; Burns, Hiday, & Ray, 2013). Further research is needed to better understand how those aforementioned issues may be impacting MHCs.

DOES A THEORETICAL BASIS EXIST FOR HOW MHCs WORK?

A review of the early MHC literature regarding the theoretical basis for "why" the courts are effective reveals that the majority of studies rely on empirical generalizations. Instead of operating under a well-specified a priori theoretical framework, MHCs seem to be functioning generally under the guiding principle of therapeutic jurisprudence (TJ; Rottman & Casey, 1999). The concept first appeared in a 1987 lecture by psychology and law professor David B. Wexler delivered to the National Institute of Mental Health (Madden & Wayne, 2003). TJ is the "study of the therapeutic and anti-therapeutic study of the law" and how laws impact an individual's "emotional and psychological well-being" (Wexler, 2000, p. 125). TJ recognizes that although laws are designed to help people, sometimes they are detrimental in practice (Wexler, 2008). Adhering to a TJ framework means that the courts will attempt to ensure that laws, to the extent possible, foster positive therapeutic outcomes

(Casey & Rottman, 2000), and simultaneously respect due process and other constitutional measures (Madden & Wayne, 2003). The goal of TJ is to produce the most constructive therapeutic outcome for client, the client's family, the community, and society at large. TJ is truly interdisciplinary because it requires professionals from legal and social science disciplines—including psychiatry, psychology, criminology, and social work—to collaborate and be sensitive to the possible outcomes of legal procedures and decisions (Madden & Wayne, 2003; Wexler, 2008).

Only seven MHC studies contain even short discussions of a theoretical basis that would predict the appropriateness and efficacy of the MHC program (Boothroyd, Poythress, McGaha, & Petrila, 2003; Boothroyd, Calkins Mercado, Poythress, Christy, & Petrila, 2005; Cosden, Ellens, Schnell, & Ellens, J. K., Schnell J. L., & Yamini-Dioff, 2003; Herinckx et al., 2005; Trupin & Richards, 2003; Neiwsender, 2005; Sneed, Koch, Estes, & Quinn, 2006). Several studies (Boothroyd et al., 2003; Cosden at al., 2005; Neiwsender, 2005) include a discussion specifically related to therapeutic jurisprudence, although most of these studies offer only a brief mention of a theoretical paradigm. Neiwsender, in his 2005 dissertation, offered a relatively extensive discussion of therapeutic jurisprudence and how it applies to MHCs. Trupin and Richards (2003) discussed the ecological jurisprudence perspective defined as "the context and situation in which the individual interacts … including family setting, neighborhood and access to resources," and how it relates to MHCs (Trupin & Richards, 2003, p. 35). Sneed et al. (2006) provided a summary of the philosophy behind the operation of MHCs but like most other studies, it is brief and not comprehensive. Palermo (2010) identified TJ as being the underlying theoretical basis for Nevada MHCs.

Johnston (2011) offered a critique of the TJ framework and suggests that social learning theories related to rehabilitation or criminological theories of deterrence, may provide a more accurate justification of MHCs. Johnston's primary critique of TJ is that it is based upon the incorrect and narrow assumption, in her view, that untreated mental illness symptoms are the sole driving force behind recidivism, also known elsewhere as the criminalization hypothesis. The theoretical basis of MHCs should be broadened, she believed, to include theories that conceptualize crime as being the result of other criminogenic risk factors that motivate offending including poverty, homelessness, substance abuse, procriminal attitudes, and associates. Johnston did not expand upon which specific social learning theories of criminality were preferable over TJ but noted that the key component of these theories is based upon the premise that "criminal behavior is largely learned through early modeling and reinforcement patterns" (p. 51). She further criticized MHCs by suggesting that they encourage and incentivize individuals to commit crimes in exchange for treatment services. She also argued that individuals with mental illnesses who are ambivalent about treatment may purposefully choose to commit crimes to ensure the acquisition of

treatment services, offered to participants of MHCs. In some cases, Johnston believes that individuals may feign a mental health condition to participate in a MHC program and receive the benefit of otherwise scant social services (e.g., housing, transportation, travel vouchers, etc).

Some communities in Pennsylvania and Ohio have adopted the Sequential Intercept Model. The Sequential Intercept Model provides a 5-point conceptual framework that can be used by communities when interfacing with mental health and criminal justice systems (Munetz & Griffin, 2006). Munetz and Griffin explain that the model was specifically designed to reduce the number of mentally ill individuals that would reenter the criminal justice system. The five points of "interception" include (a) law enforcement and emergency services, (b) jails and courts (MHCs included), (c) jail and prison reentry, (d) community corrections, and lastly, (e) community support. Each point of interception, Munetz and Griffin explained, is designed to highlight actionable interventions that may prevent individuals from returning to the criminal justice system, and to link them to community treatments. Early reports show such interventions to be helpful, but at this time only a small number of communities have adopted this model. Future research is needed to explore whether such a model can assist MHCs in ensuring that their clients do not recidivate and are connected to appropriate treatment services.

Castellano (2011a) recently observed that MHCs may be operating under a model of problem-solving jurisprudence. Essentially, problem-solving jurisprudence focuses on helping individuals in alternative court settings that are better able to address both personal and community problems. Finally, Dirks-Linhorst, Kondrat, Linhorst, & Morani (2011) have recommended that MHCs adopt the Transtheoretical Model of Change (TTM) as well as motivational interviewing techniques. They observed that although individuals who were re-arrested, during their participation in a St. Louis County MHC program, had an increased likelihood of being negatively terminated, over half of the defendants who gained new criminal charges ultimately had a positive termination from the court. Both TTM and motivational interviewing use the concept of stages of change. Characteristic of both approaches is the recognition that individuals are at various stages of readiness to change and that setbacks are expected. Ultimately, the authors persuasively argue that both approaches have a great deal of potential positive therapeutic benefit for MHCs.

WHAT IS THE NATURE OF THE CURRENT MHC EVIDENCE?

Recidivism

Published studies of MHCs typically report two main types of outcomes: recidivism and the improvement of psychosocial symptoms. As shown in

Table 1, the majority of published MHC evaluations assessed the outcomes of recidivism. Herinckx, Swart, Ama, Dolezal, and King (2005) compared rates of arrest in the 12-month period prior to MHC enrollment and 12 months after entry. MHC graduates were nearly four times less likely to reoffend than those who did not graduate. Similarly, Moore and Hiday (2006) found that during a 12-month follow-up, traditional court defendants were re-arrested significantly more often than MHC participants. A 2007 study of a San Francisco MHC by McNeil and Binder compared time to arrest on new charges among two groups: participants of a MHC and jail inmates with a mental illness. It found that MHC participants went longer without being charged with a new crime, including violent crimes, when compared to individuals who received treatment as usual (TAU).

Methodological Quality of MHC Studies

Table 1 summarizes the design details of published MHC evaluations. The majority of studies are nonexperimental. The only published study that used a randomized controlled design (Cosden et al., 2005) had a treatment group who received assertive community treatment (ACT) in addition to being in a MHC. A more pure test of the effectiveness would have excluded ACT. In addition, many of the studies in Table 1 vary considerably with regard to staffing, funding, eligibility requirements, type of offenses (misdemeanor vs. felony), follow-up periods, and diagnosed mental illness. Those variations mirror a similar set of limitations experienced by early drug court evaluations (Wolff & Pogorzelski, 2005). Also contributing to variation between MHCs are the number of community resources available, the availability of mental health and substance abuse services, public opinion, and the broader criminal court systems (Wolff & Pogorzelski, 2005).

Two of the methodologically stronger MHC studies of those presented in this article were conducted by Steadman, Redlich, Callahan, Clark Robbins, and Vesselinov (2011) and Keator, Callahan, Steadman, and Vesselinov (2013). Both studies used a prospective, longitudinal, quasi-experimental design and included a diverse set of misdemeanor and felony MHCs in four locations: San Francisco County, California; Santa Clara County, California; Hennepin County, Minnesota; and Marion County, Indiana. In the earlier study, participants were interviewed and followed for up to 18 months at each site location. Among key public safety outcomes (including subsequent arrest rates, number of subsequent arrests, reduction in pre- to post-MHC arrests, number of subsequent incarceration days, and change in pre-to post-MHC subsequent incarceration days), results indicated that the MHC group did significantly better than the TAU group. Post-18 month examinations of the two groups found that the MHC group was significantly less likely to be arrested then the TAU (49% vs. 58%), respectively. Additional analyses of which individuals in MHCs do better or worse found that the absence of

TABLE 1 Summary of Published Mental Health Court (MHC) Evaluations

Study	Study design	Design details	Main outcomes	Main findings
Boothroyd, et al., 2005	Quasi-experimental	MHC defendants matched with sample from traditional misdemeanor court	Psychosocial	No significant differences found between groups; MHC participation was associated with reduced psychiatric symptoms, substance use and improved quality of life
Christy et al., 2005	Quasi-experimental	MHC defendants matched with sample of persons with mental illness from traditional misdemeanor court; posttest only group design	Recidivism Psychosocial	Time spent in jail significantly lower for MHC; difference in arrest rates favored MHC but not statistically significant; fewer arrest pre than post enrollment in MHC; MHC group not significantly more aggressive or violent than than comparison group
Cosden et al., 2005	Experimental	Randomized to either MHC or TAU; MHC utilized ACT approach to case management	Psychosocial Recidivism	Both groups improved but MHC group had more significant reduction in psychological distress, drug problems and had greater improvement in QOL and global functioning; recidivism outcomes only partially supported
Dirks-Linhorst & Linhorst, 2010	Quasi-experimental	Post-test only comparison group design; comparing re-arrest and crime severity rates among three groups: MHC successful graduates, those negatively terminated and those eligible but chose not to participate	Recidivism	MHC successful graduates had significantly lower re-arrest rates for any type of crime when compared to other two groups
Burns, Hiday, & Ray, 2013	Observational	Pre-post analysis of MHC participants; two years pre-MHC and two years post-exit	Recidivism	Majority of MHC graduates were not rearrested though overall rearrest rate for sample was 60%; MHC graduates showed the greatest improvement when compared to opt-outs and those terminated
Frailing, 2010	Quasi-experimental	MHC defendants and graduates where compared to those referred to MHC who had another disposition in their case (i.e. sentenced to jail or opted not to participate)	Psychosocial Recidivism	MHC defendants and graduates had a significantly fewer number of days in jail and psychiatric hospitalization days than the control group in the year after entering the MHC program; majority of drug use seen in first 4 months and nearing end of MHC program participation

(*Continued*)

TABLE 1 Continued

Study	Study design	Design details	Main outcomes	Main findings
Heninckx et al., 2005	Observational	Secondary data analysis, single group pretest-posttest design	Psychosocial Recidivism	After enrollment, MHC clients linked to more case and medication management, and had more outpatient services; they also had fewer hours of crisis service use and fewer inpatient treatment stays; statistically significant reduction in average number of arrests from pre to post enrollment
Hiday & Ray, 2009	Observational	Pre-post analysis of MHC participants; two years pre-MHC and two years post program exit	Recidivism	MHC participants were arrested significantly less in the two years after program completion when compared to the two years before entry; MHC program completers had fewest arrests in contrast with those who were ejected or who who opted not to participate
Keator et al., 2013	Quasi-experimental	4-site prospective, longitudinal study of MHC participants matched with jail detainees identified as having a mental illness	Recidivism Psychosocial	MHC participants received significantly treatment services both before and after involvement in the court; MHC graduates utilized less treatment intensive services than while in the program; no significant relationship between receipt of treatment services and subsequent arrest rates
McNeil & Binder, 2007	Quasi-experimental	Non-random assignment with propensity score weighting; compared individuals in MHC with individuals in local jail with mental health disorder	Recidivism	MHC group had longer time without new charges, new violent charges, or new charges for violent crimes than comparison group; successful completion of MHC program associated with continued reduction in outcomes after graduation
Moore & Hiday, 2005	Quasi-experimental	MHC defendants matched with similar offenders in traditional criminal court who were not self-selected	Recidivism	TCC re-arrested significantly more than MHC group during 12-month follow-up; MHC group arrested about half as much as TCC group; MHC program completers had much lower re-arrest rate than TCC group
Steadman et al., 2011	Quasi-experimental	4-site prospective, longitudinal study of MHC participants matched with jail detainees identified as	Recidivism	MHC has significantly lower arrest rates, number of subsequent arrests, reductions in pre- to- post arrests, number of subsequent incarcerations, and change in pre- to post-MHC
Trupin & Richards, 2003	Quasi-experimental	Analysis of two MHCs; Pretest-posttest design; also compared those who opted to participate in MHC to those who opted out	Recidivism Psychosocial	Statistically significant evidence showed MHCs reduced crime among its participants and led to an increase in appropriate treatment services

TAU = treatment as usual; ACT = assertive community treatment; QOL = quality of life; TCC = traditional criminal court offenders.

treatment at baseline, having a diagnosis of schizophrenia or depression, and having used illegal drugs in the past 30 days were significantly associated with more incarceration days.

In Study 2, 296 MHC participants were compared to a 386-person TAU group (Keator et al., 2013). MHC participants receive significantly more treatment services both before and after their involvement in the court. MHC graduates used less treatment intensive services than when they were participating in the MHC program. Keator et al. (2013) also determined that there was no significant relationship between acquiring treatment services and a decrease in subsequent arrest rates, a surprising finding they noted because of the presumed assumption that participation in mental health treatment would ultimately reduce recidivism. Though most MHC studies have shown reductions in recidivism and improvements in psychosocial functioning among MHC participants, a lack of methodologically strong evaluations significantly limits the strength of those results. In the absence of rigorous, methodologically strong studies, the question of whether MHCs work cannot be definitely answered at this time.

What Are the Characteristics of the Mentally Ill Who Choose Not to Participate in MHC Programs and of Those Who Are Negatively Terminated?

Because the completion of a MHC program (graduation) has been shown to be one of the most significant predictors of the reduction of recidivism (Burns et al., 2013; Dirks-Linhorst & Linhorst, 2012; Herinckx et al., 2005; Hiday & Ray, 2010; McNiel & Binder, 2007; Moore & Hiday, 2006), it important to explore the characteristics of who chooses not to participate or who are terminated from MHC programs. Currently, little is known this population (Dirks-Linhorst et al., 2011; Sarteschi et al., 2011). Neiswender (2005) reported that the main reason why some MHC participants chose not to participate is because they did not believe that treatment was necessary. Herinckx and colleagues (2005) found that of the 368 study participants, approximately 60% were terminated for noncompliance, chose not to participate, or were ultimately transferred to another court program. Approximately one third of the MHC participants in the Moore and Hiday (2006) study were returned to a traditional court setting due to noncompliance. Statistical analyses could not identify a significant difference in the demographic or criminal history variables between those who completed the MHC program and those who did not.

McNeil and Binder (2010) interviewed 43 key MHC personnel regarding their perceptions of the court. A variety of themes emerged but of particular importance were their opinions of why individuals were removed from the program. The two most common reasons cited for program removal included committing new crimes and not adhering to their treatment plans. The respondents observed that as some participants began to experience symptom

improvement, they erroneously believed that they no longer needed their medication and subsequently decompensated. It was the belief of many respondents that the commission of new crimes was a result of decompensation. In addition, many of those surveyed believed that substance abuse was a particularly significant problem for many of the participants.

To address the gap in the literature, Dirks-Linhorst and colleagues (2011) conducted one of the most comprehensive studies to date that identifies factors associated with nonparticipation in a MHC and negative termination. Analyses were conducted on two groups: (a) defendants who were deemed eligible for the MHC program but chose not to participate, and (b) those who were negatively terminated. In the first group ($n = 141$; approximately 15%), factors that increased the odds that a defendant would not participate included having a history of substance abuse and having multiple diagnoses. Among that same group, factors that decreased the odds of nonparticipation included having a diagnosis of bipolar disorder and being referred by a social service agency, probation or parole officer, community maintenance department, or a private attorney. Study authors noted that no specific type of crime was associated with nonparticipation.

Analyzing the negatively terminated group ($n = 195$; approximately 30%), it was found that being male, being African American, having multiple mental health diagnoses, and being referred to the MHC by Crisis Intervention Team police officers (as opposed to the Municipal Court), all increased the odds of negative termination by 119%, 101%, 383%, and 63%, respectively. In addition, committing certain crimes such as stealing, harassment, property maintenance, violating a financial order, inappropriate sexual behavior and weapons offenses: all increased the odds of negative termination. Stealing, in particular, increased the odds of negative termination by the largest percentage, compared to all other crimes: 334%. A surprising finding was that more serious crimes were not associated with negative termination. Factors associated with a decrease in negative termination included having a history of substance abuse, having a larger number of scheduled appearances before the court (which the researchers explain served as a proxy for how long an individual was involved in the court), receiving disability benefits, and being prescribed psychiatric medication.

A study by Redlich, Steadman, Callahan, Clark Robbins, Vessilinov, and Ozdogru (2010) explored the relationship between individual characteristics and MHC completion. Over 400 participants in four MHCs were included in the study. The mean age of participants was 38 years. Forty-two percent of the sample was female and 54% were White. Three out of the four MHCs graduated fewer than 50% of participants. The majority of demographic variables were unrelated to MHC outcomes or compliance. A unique finding of this study was that a significant proportion of clients attended MHC hearings straight from jail. The authors assert that an assumption likely exists that MHC participants make their appearances from the community and not from

jail. They suggest that voluntary court attendance should be further investigated in future MHC research.

Finally, MHCs have changed over time. The first generation of courts targeted participants charged with nonviolent misdemeanor offenses (Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005). The second generation of MHCs includes admitting individuals with felony charges (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005) and the development of juvenile courts. Now it seems that a third-generation or "final-stage diversion" program may be emerging. Fiduccia and Rogers (2012) examined the effectiveness of the ATLAS program, which stands for "Achieving True Liberty And Success" (p. 574). The ATLAS program targets felony offenders with mental health disorders who have repeatedly failed to comply with the conditions of their probation. Similar to a MHC program, participants in the ATLAS program have been charged with a crime, have a mental illness, are required to participate in intensive mental health treatment or face incarceration, and are supervised by a collaborative team of mental health and court staff. The main differences between ATLAS and other diversionary programs are the intensity of the services and that they target individuals who have a history of noncompliance.

Fiduccia and Rogers (2012) compared the ATLAS program participants to traditional criminal court offenders (TCC) with similar demographic, mental health, arrest histories and access to the same resources in the community. They assessed the re-arrest rates of both groups at 12 and 24 months. Though the findings were not statistically significant, nearly 50% of the ATLAS participants graduated from the program and had not been arrested in 24 months. Comparing their results to MHC research, Fiduccia and Rogers (2012) suggested that one of the strengths of their study was assessing re-arrest at 24 months. As they noted, the majority of MHC studies assess outcomes no later 12 months. Fiduccia and Rogers (2012) observed that ATLAS participants, who succeeded in the first 3 months, had a 90.9% likelihood of not being arrested at the 12-month assessment period and that re-arrest rates doubled during the second 12-month period. They suggest that diversion programs should consider the addition of relapse prevention or continued care services upon the completion of services. It is too soon to know if the third-generation of MHCs is upon us. Given the relatively significant numbers of individuals who are either ejected from MHCs for noncompliance or who choose not to participate, a third generation may be necessary.

LIMITATIONS, DIRECTIONS FOR FUTURE RESEARCH, AND SOCIAL WORK IMPLICATIONS

Limitations

Two limitations of this narrative literature must be acknowledged. First, systematic efforts were used to capture all relevant materials and to be as

thorough as possible, however not every article related to MHC's could be included in this narrative (see the appendix). Second, the authors focused on four main areas of discussion that reflect central issues of concern with respect to MHC published research. We believe this narrative accurately represents relevant themes in the literature. Other researchers evaluating the literature have focused on other themes. Despite these limitations, we believe that narrative reviews can provide a much-needed summation of a scattered assortment of articles on a particular topic (Baumeister & Leary, 1997).

Directions for Future Research

The first theme that emerged was related to how MHCs function, including their selection process, the role of the judge, and the inner workings of MHC treatment teams. Evidence has suggested that a three-stage screening process may exist for some MHCs. Reasons for rejection include not having a mental illness or committing a crime of a violent nature. It was also found that judges play a key role in the success of MHCs, though new research has also highlighted the importance of case managers acting essentially as "boundary spanners." The MHC personnel have nontraditional relationships with their clients that are geared toward rehabilitation instead of punishment. MHC teams are multidisciplinary and nonadversarial in nature. Some MHC teams are comprised of individuals who have self-selected their positions and are focused on the common goal of meeting the needs of the client. If court personnel positively influence MHC outcomes, then it is important that future research examine and understand the nature of those relationships. Qualitative studies may be helpful in unveiling the roles of critical players and understanding the relationships between MHC staff and its participants.

The second theme addressed the theoretical basis of MHCs. Only one article exists (Johnston, 2011) that solely addresses the lack of theoretical understanding of MHCs. The majority of the scant literature has focused on TJ as the underlying theoretical paradigm. Criticisms of TJ have emerged and new suggestions have been put forth that include social learning theories related to rehabilitation or criminological theories of deterrence. Other researchers have recommended that MHCs expand their focus to include problem-solving jurisprudence, TTM, as well as motivational interviewing techniques. Understanding the theory behind why MHCs should work, may serve to better clarify their operation and their overall purpose and provide a justification for the continued development of MHCs. Future research should address these gaps in knowledge.

The third theme of this review addressed whether or not MHCs can achieve their overarching goals of reduced recidivism and improved psychosocial functioning. With few exceptions, most studies continue to show reductions in recidivism and improvements in psychosocial functioning. Although matched samples of persons with mental illness who did not

participate in a MHC as well as a lack of randomized controlled evaluations hamper efforts to draw firm causal conclusions, generally, it seems that those who participate in MHCs are benefiting. In addition, some newer evidence suggests that even some participation (i.e., without receiving the full "dose") in a MHC seems to be better than none. There exists a need for additional studies to further identify why MHCs change behavior and reduce offending probabilities. A stronger set of future studies of MHCs will hopefully begin to add clarity and unravel the nature and functioning of MHCs.

Finally, the fourth theme to emerge was that a nonnegligible segment of the potential MHC population chooses not to participate and/or are negatively terminated from these programs. Some of the most common reasons for lack of participation and or noncompliance include committing new crimes, not adhering to treatment plans, substance abuse issues, and having multiple diagnoses. Study authors should provide the specific criteria used to determine what constitutes noncompliance. Documenting selection criteria may lead to a better understanding of which individuals are best suited for MHCs. There should also be a more direct effort to explore the reasons why some individuals opted not to participate in MHCs. Future researchers could carefully document the rationale for not wanting to participate. It seems reasonable to presume that most rational individuals would choose treatment over incarceration yet many eligible MHC participants choose society's severe punishment over treatment. Future research could examine why some individuals refuse participation. Admission practices or programs could be altered accordingly to capture all those who could benefit from MHC programming.

Social Work Implications

In a recent study of the criminal justice content of American MSW programs, researchers convincingly argued for an increased level of such content (Epperson, Roberts, Ivanoff, Tripodi, & Gilmer, 2013). They noted that social workers are increasingly in contact with individuals affected by the criminal justice system. MHCs link participants to community mental health treatment services, which are at least in part being provided by social workers. Social workers, serve as the primary providers of clinical services to clients with mental health needs in the community (Newhill & Korr, 2004). Social workers are also members of the very task forces that develop MHC programs and also serve as members of the interdisciplinary teams that typically characterize MHC professional staff (Tyuse & Linhorst, 2005). Thus given the fact that social workers are increasingly interacting with individuals impacted by the criminal justice system and serve the needs of this ever-expanding population, schools of social work should adapt to this evolving reality.

The fact that social workers increasingly interact with individuals affected by or who are involved with the criminal justice system may have implications for the profession. One implication is that there may be a

notable increase in the number of social workers interacting with clients having a history of crime, potentially violent crime. Social workers may also be working with MHC participants who perceive that they been coerced into treatment (Boothroyd et al., 2003). This perception might make them reluctant to fully participate in treatment. Individuals who perceive their treatment as being involuntary may be more clinically challenging than individuals who perceive their treatment as being voluntary.

The United States has the highest incarceration rate in the world, with 2.2 million individuals confined in jails or prisons, many of whom will eventually be released to the community (The Sentencing Project, 2013). Approximately 6.98 million individuals are involved with justice services in some capacity (Glaze & Parks, 2012). Now, more than ever, social workers are poised with the unique opportunity to become leaders in the field of forensic social work. It is recommended that social work researchers begin addressing the needs of the ballooning incarcerated population, at least half of whom have mental illnesses, substance abuse issues, and histories of abuse and trauma (James & Glaze, 2006). Researchers also need to expand their focus beyond MHCs and consider alternate programming. For instance, the Legal Aid Society recently piloted a program in New York City, called the Misdemeanor Arrangement Project (MAP). MAP is diversion program that targets initial arraignment or an individual's first appearance in court. Early results are promising (Policy Research Associates, 2013). The program is also particularly reliant on social workers who must possess the skill set necessary to work within the challenging legal environment. Finally, meta-analytic studies of MHCs should be conducted no less than every 2 years. Systematic reviews are one way to continually contribute to the knowledge base (Wells & Littell, 2009) of MHC research.

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APPENDIX

This narrative review consisted of a literature search conducted from 1997 through February 2013. This time frame was chosen because we were familiar with the MHC literature and knew that these programs first emerged in Broward County, Florida in 1997 (Lurigio & Snowden, 2009). February 2013 was chosen as a cutoff point after a special issue of *American Behavioral Scientist* was published about MHCs. We wanted to include the most recent

literature to ensure comprehensiveness. Database searches included *MEDLINE*, *PsychINFO*, *PubMed*, *ERIC*, *Social Science Abstracts*, *Social Work Abstracts*, *Social Science Citation Index*, *Sociological Abstracts*, *Social*, *Psychological*, *Criminological*, the *Cochrane Library databas*e, and the *National Criminal Justice Reference Service* databases. Other search strategies included the hand searches of journal article reference sections, reviewing government websites such as the National Institute of Justice, foundation websites, newsletters, policy research organizations, and searching Google and Google Scholar using the search terms of *mental health courts*, *mental health court programs*, *mentally ill offender*, *jail diversion programs*, and *problem solving courts*. Over 50 articles were located that dealt directly with mental health courts. All articles were retrieved and reviewed in hardcopy form. Each study's major components were tabled. We then categorized the articles, trying carefully to capture the overarching themes of the MHC literature. Forty-six of those articles were ultimately used for this narrative review because they directly corresponded to the overarching themes that emerged. Finally, we tabled all MHC studies that were experimental, quasi-experimental, or observational and that were published in academic journals.