APA Resource Document

Resource Document on Mental Health Courts

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Prepared by the Council on Psychiatry and Law

Introduction

Mental health courts (MHCs) are one of a range of "problem-solving courts" operated on the premise that the criminal law can be used to therapeutic ends to the benefit of both individual defendants and society as a whole, a concept known as therapeutic jurisprudence (Winick 2003). Other examples of problem-solving courts include homelessness courts, veterans' treatment courts, and domestic violence courts. Many psychiatrists are unfamiliar with MHCs despite their rapid expansion in recent years. The purpose of this resource document is to describe the concepts behind and operations of MHCs and review their role and effectiveness.

MHCs arose in the United States in 1997 to address the over-representation of incarcerated individuals with mental illness, recognizing that these individuals were more likely to be arrested, to be denied or unable to pay bail, and to have lengthier stays in jails compared to those without mental illness (Landess 2017). The primary goals of MHCs are generally to reduce recidivism and to improve psychiatric functioning.

In 2007, the Council of State Governments on behalf of the Bureau of Justice Assistance helped establish guidance by promoting "ten essential elements" for MHCs that included screening and eligibility for participation; informed consent; individually-tailored treatment plans in lieu of more traditional criminal justice approaches such as arrest or incarceration; collaboration between the criminal justice, mental health, and substance use systems involved in the court program; and monitoring and engagement by the court, including by the use of incentives and sanctions, to optimize the chance of participants' success (CSG, BJA, 2007). In August of 2015 there were over 450 adult MHCs in the United States (SAMHSA GAINS 2015).

Each MHC has legal and clinical criteria that potentially eligible defendants must meet for entrance, as well as legal and clinical criteria required for completion of the program (typically known as "graduation"). Generally, MHCs will examine the types of charges faced by defendants to help determine who can be included as a potential participant. Across the country, qualifying criminal charges are usually misdemeanors but can also include felony charges, sometimes even violent felony charges. Enrollment can occur as early as the time of arraignment to later in court case processing after a period of jail detention. The legal context of the jurisdiction in which the MHC resides is critical, as changes in legislation with respect to the classification of crimes will likely impact the MHC policies.

Clinical criteria vary from a potential participant's self-report of mental illness to a formal diagnostic assessment indicating a serious psychotic or mood disorder according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Steadman 2006, CSG 2009). Also, the underlying offense may be related or unrelated to the potential participant's symptoms of mental illness.

Participants who meet eligibility criteria must also make an informed and voluntary decision to choose the MHC instead of a traditional criminal court procedure. This generally requires that the participant be competent to make such decisions (e.g., adequately understand the charges against them and the consequences of entering a guilty plea). Unlike drug courts, which typically require the defendant to plead guilty, many MHCs accept defendants prior to their entering a plea (Council of State Governments, 2008; Strong, Rantala, and Kyckelhahn, 2016). Upon successful completion of the program, some MHCs will dismiss the charges or reduce their severity.

Details of MHCs vary widely among jurisdictions. Treatment services offered are typically limited to those offered by local community providers who are willing to engage with justice-involved individuals. All specialty courts use some form of sanctions and rewards to monitor progress and allow for the advancement of the participant toward graduation. Incentives across MHCs can range from public recognition of progress, certificates of accomplishments, or movie tickets, among others. If the participant does not follow some particular aspect of the treatment plan, sanctions can include more frequent monitoring, brief jail stays, or incarceration for the maximum allowed sentence on the associated charge and dismissal from the MHC. The level of monitoring ranges from regular appearances in court to monitoring and follow-up by probation and/or designated MHC staff.

Do mental health courts work?

Even after over two decades of research, questions remain regarding how MHCs meet their stated goals of reducing recidivism and improving psychiatric functioning. There are difficulties with sound experimental design in many of the published studies, a lack of transparency and detail about the specific procedures of the MHC(s) being studied, a lack of consistency about definitions of core outcome variables, and a publication bias toward "positive" results. There is generally better evidence for the impact on reducing recidivism than on improving psychiatric symptoms (Swartz, 2016, Binder 2015).

Recidivism

There have been numerous meta-analyses and systematic reviews, and a few multi-site studies, exploring whether MHCs reduce recidivism (Honneger, 2015; Loong, 2019; Canada, 2019; Lowder, 2018, Steadman, 2011). These studies have reported mixed results about the impact on recidivism for MHCs as compared to traditional criminal court processing. A general consensus is that there is likely less recidivism (often broadly defined as re-offending but sometimes more narrowly defined, depending on the study, as a new arrest, a new criminal charge, a new criminal conviction, or jail time) with MHC completion and for MHCs that enroll only those charged with misdemeanors. A number of methodological issues suggest that the results of this research should be interpreted with caution. Many defendants with unsuccessful outcomes in MHCs also have concomitant substance use disorders and long criminal histories. In addition, because arrest and incarceration involve a series of potentially

discretionary decisions between law enforcement and probation and the mental health court participant, and because there is increasing recognition that individuals with mental illness or those from racial or ethnic minorities may be disadvantaged when such decisions are made, results about recidivism have layers that have not yet been clarified in the literature.

Improvement in psychiatric symptoms

In several of the meta-analyses and systemic reviews described above (Honneger, 2015; Canada 2019), approximately one third of studies on the efficacy of MHCs explored therapeutic outcomes. Psychiatric functioning was measured across a range of variables, and differed by study, including emergency room visits, psychiatric hospitalizations, length of hospitalization, time to hospitalization, intensity/type of treatment, symptom severity, access to care, and adherence to treatment. Most of the studies reviewed did not demonstrate any significant difference between inpatient and outpatient service utilization or symptom presentation between comparison groups although an assessment of four MHCs across three states as part of the MacArthur Mental Health Court project found that MHC participants had significantly increased use of mental health and substance use services compared to a control group (Han and Redlich, 2016). However, increased utilization of services may not be the best indicator of improvement in psychiatric symptoms, as individuals with greater access might reasonably utilize more services regardless of their level of clinical stability. In one pilot study by Pinals et al (2019), MHC participants who were provided a specific community-based treatment intervention coordinated with probation showed positive outcomes on several mental health variables. Overall, the MHC literature has lacked details about impact on symptoms, specific services attached to the MHC, and the relationship of those services to the participants' clinical needs.

Participant perception of the MHC process

Because voluntary choice is one of the essential elements of a MHC, individual perception of the participant can be an important indicator of whether the court is serving a therapeutic function that encourages prosocial behavior. There is limited literature about whether participants prefer the MHC approach or traditional criminal court case disposition. Several studies have found that while participants found elements of the MHC court process useful and supportive, perceived voluntariness of treatment was reduced and negative feelings of stress were associated with the expectations and structure imposed (Han and Redlich, 2016; Canada, 2013). One study showed that perceptions of coercion and negative pressures predicted criminal justice involvement during a year of participation (Pratt et al, 2013).

The published evidence to date reflects the lack of consensus regarding efficacy and appropriate outcomes of MHCs and makes it unsurprising that a range of views continue to be expressed about the impact of and need for MHCs.

Potential Benefits and Harms of MHCs

There are numerous national organizations that have expressed opinions about MHCs, from strong support (e.g., National Alliance on Mental Illness, Treatment Advocacy Center) to caution (e.g, Mental Health America, Bazelon Center for Mental Health Law). The following section highlights three major arguments on each side of the debate.

Potential Benefits

Supporters of MHCs argue that the symptoms of mental disorder increase the risk of arrest and incarceration. The delusions and disorganization of psychosis can lead to aggression, for instance, and worsening cravings prompt acquisitive offending to fund drug use. MHCs that provide services to better treat underlying mental disorders and that provide incentives to improve compliance can therefore reduce recidivism. There is evidence that MHCs improve recidivism by providing and engaging individuals with intensive treatment services (see above; also Han and Redlich, 2016).

Those in favor of an increased role for MHCs also argue that the criminal law should be administered in a way that values the psychological wellbeing of the offender and honors the concept of therapeutic jurisprudence. Even if the mental illness is not the underlying variable in the instant offense, this argument holds, people with mental disorders should be routed to treatment and provided supports around psychosocial variables to help them from returning to the criminal justice system. By seeking to understand the reasons for offending, courts can validate the experiences of defendants, increase defendants' sense of dignity and self-worth, and reduce the adverse psychological effects of arrest, detention and prosecution.

In addition, from the earliest stages of MHC development, a primary objective has been to reduce costs by removing people with mental disorders from traditional court dockets. In particular, it was hoped that MHCs would authorize less jail detention and incarceration than traditional approaches. Proponents argue that where impacts have not been demonstrated it is likely due to over-complicated admission and eligibility processes.

Potential Harms

Opponents of MHCs argue that mental disorders do not necessarily cause crime, at least not in the way that treatment through a MHC might change. Data suggest that people with mental illness have the same risk factors and reasons for offending and for the same reasons as the general population (Skeem 2011; Lamberti 2016). By this argument, the goal of reducing recidivism in individuals with mental disorders is most likely to be realized by adopting approaches that have been shown to be effective in other offender populations. Examples of these approaches include the "Risk-Needs-Responsivity" and "Good Lives" models (Andrews, 2015; Ward 2004).

Because mental disorders do not cause crime, the argument continues, treating mental disorders does not reduce crime. Evidence-based interventions such as assertive community treatment are effective at managing psychiatric symptoms but there is no strong evidence that psychological treatment can reduce offending or recidivism. The effectiveness of MHCs may instead be a consequence of the structure, monitoring, and supervision that the court provides (Swartz, 2016; Edgely 2014).

A second potential harm is that the very existence of MHCs perpetuate stigma by implying a link between mental disorders and criminal offending. MHCs distract administrators, legislators, and the public from providing appropriate attention and resources to inadequately funded community mental health care systems. They may also discourage broader reform of the criminal justice system that would benefit all defendants, not just those with mental disorders (Wolff, 2011). MHCs can also have the unintended consequence of coercing participants into a treatment plan that avoids jail time but may result in longer criminal justice involvement and incarceration if they fail to adhere to the requirements of the MHC. Judges and attorneys may even encourage defendants to agree to treatment when they see no viable defense, which may in turn contribute to over-diagnosis and further misallocation of resources.

Another set of systemic critiques argues that MHCs perpetuate, and perhaps exacerbate, underlying disparities in the criminal justice system. Though studies are limited, researchers have repeatedly found racial disparities in MHC outcomes. Racial minorities are more likely to be negatively terminated from MHCs (Ray et al, 2013; Dirks-Linhorst et al, 2013; Redlich et al, 2010). These findings are notable in light of the fact that recent reviews of MHC research have found that a primary limitation of the field is that studies of MHCs have largely focused on white male subjects, despite the overrepresentation of racial and ethnic minorities within the criminal justice system (Honegger, 2015).

A related set of systemic critiques argues that MHCs distract from confronting the root causes of systemic injustice that drive the significant racial and mental-health related disparities prevalent throughout the justice system (Seltzer, 2005). Situating MHCs within the criminal justice system, the argument goes, signals an acceptance of the failing system and makes it more difficult to generate the political will to address the unnecessary and inappropriate arrest and incarceration of both racial minorities and people with mental disorders.

The role of psychiatrists in MHCs

Over the course of the evolution of MHCs in the United States, psychiatrists have played, at most, a supporting role. Judges, attorneys, and sheriffs, along with mental health professionals in psychology and social work, have largely taken the lead in the advocacy, design, implementation, and management of MHCs. This may relate to the cost and paucity of psychiatrists compared to other mental health professionals. With the expansion of MHCs over the past two decades, however, the potential roles for psychiatric expertise have grown. These include:

1. *Serving as consultant and/or member of an advisory board for an existing or planned MHC*

   Psychiatrists are often well positioned to collaborate and negotiate with various stakeholders (e.g., prosecutors, defense attorneys, judges, and community treatment providers) to establish clinical eligibility criteria and the availability of appropriate treatment options and dispositions in a culturally and racially sensitive manner. They can also advocate for services that support a range of non-treatment interventions that enhance engagement with treatment, including insurance, housing, education, vocational training, and necessary entitlements. Additionally, psychiatrists can advise MHCs about treatment for mental illness as well as the critical

importance of tailoring treatment recommendations to individual needs in order to avoid misallocation of potentially limited community resources. Psychiatrists may also be essential partners in developing rigorous and generalizable MHC evaluation programs that can drive the development of consensus guidelines for MHC operations.

2. *Conducting evaluations to help MHCs determine a potential participant's eligibility*

   These evaluations typically involve a clinical interview of the potential participant, review of collateral sources of information, and a written report that includes diagnoses, treatment recommendations, and prognosis. Psychiatrists can provide evaluations of substance use disorders, psychopharmacological responsivity, underlying or co-morbid medical conditions, and other factors, to help inform the court about clinical nuances for an individual. Forensic considerations, such as an assessment of violence risk and malingering, and the use of standardized instruments, can also be provided. While formal forensic psychiatric training is not required, familiarity with core ethical and legal concepts when interfacing with the legal system can help psychiatrists navigate various complex issues (e.g., consent, limits of confidentiality, disclosure of relevant information, self-incrimination) when conducting these evaluations (Glancy et al., 2015). Evaluators should be mindful that their role is to provide a clinical opinion to the courts and not to advocate for or against MHC participation. A participant's eligibility is ultimately a legal determination made by the court (Barber-Rioja et al., 2017).

3. *Treating a patient who is participating in MHC*

   Treatment considerations include ongoing monitoring of symptoms and risk along with modifying treatment management commensurate with patient needs. However, psychiatrists working with MHC-involved patients also have to be mindful of requirements imposed by MHC such as drug testing and disclosure of health information to courtroom "teams", including potentially when participants have not been attending treatment sessions. MHC participants typically sign consent for release to the court of relevant health information as part of the enrollment process, however psychiatrists should ensure that they have reviewed and have a copy of such consent(s) prior to sharing any protected health information. They should also ensure that disclosures are limited to information specified in any consent.

4. *Assessing competency to participate in pre-trial MHCs*

   When a defendant's competence to stand trial is questioned, they will generally not be eligible for a post-adjudication MHC that requires the entering of a guilty plea. Courts may consider a formal assessment of a defendant's adjudicative competency, different from an assessment of MHC eligibility (described in 2. above), if there are concerns about the defendant's ability to understand their legal options or the conditions of MHC. This assessment can help the judge protect a defendant's autonomy and rights.

Conclusion

Efforts to reduce the "criminalization" of individuals with mental illness should be expanded. Those efforts should respect individual autonomy. They should consider public safety, and use, as much as possible, evidence-based approaches to any applicable treatment interventions to promote mental health. While not without controversy, MHCs have emerged as important models of how criminal courts can potentially serve as therapeutic arms of the justice system for individuals with mental illness. Ongoing research will be important to identify the elements that are truly effective among the many variables at play and to ensure equitable and just practices for all.

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