Mental Health Courts:

A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE

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Executive Summary

Overview

In recent years, the large number of individuals with mental illnesses involved in the criminal justice system has become a pressing policy issue within both the criminal justice and mental health systems. The prevalence of serious mental illnesses among all people entering jails, for example, is estimated to be 16.9 percent (14.5 percent of men and 31 percent of women).[1] People with mental illnesses often cycle repeatedly through courtrooms, jails, and prisons that are ill-equipped to address their needs and, in particular, to provide adequate treatment. Over the past decade or so, policymakers and practitioners have been exploring new ways of responding to these individuals to break this costly and damaging cycle and to otherwise improve outcomes for the systems and individuals involved. One of the most popular responses to emerge has been the mental health court, which combines court supervision with community-based treatment services, usually in lieu of a jail or prison sentence.

Mental health courts generally share the following goals: to improve public safety by reducing criminal recidivism; to improve the quality of life of people with mental illnesses and increase their participation in effective treatment; and to reduce court- and corrections-related costs through administrative efficiencies and often by providing an alternative to incarceration.

This guide is intended to assist policymakers and practitioners in assessing the utility of mental health courts. After briefly describing who participates in mental health courts and how these courts function, this guide reviews research findings that address the extent to which mental health courts have been found to achieve their stated goals. Because mental health courts are relatively new, many unanswered questions remain on how they work, for whom, and under what circumstances; these outstanding research questions are highlighted in the final portion of this guide.

Methodology

To develop this guide, the authors conducted an extensive literature review, worked closely with researchers and court practitioners from across the country to identify common questions about mental health courts, and distilled answers from the available research. The authors then convened an advisory group of leading researchers and practitioners that met in October 2008. The advisory group reviewed summaries of research findings and provided input on which studies to include in the guide, how to interpret their findings, and what policy statements could be derived from the relevant research.

Conclusions

The body of research on mental health courts is quite limited at this stage, both in terms of the number of studies and their scope. The studies conducted to date have measured and reported different outcomes, partly because mental health courts vary in terms of who participates and how the courts operate.

Despite these limitations, the authors and the advisory group were able to reach consensus on a number of conclusions, including

...the design and function of mental health courts...

- In general, mental health courts are increasingly likely to accept individuals charged with more serious offenses including felonies and, in some jurisdictions, violent crimes.
- Most mental health court participants have serious mental illnesses, and many also have co-occurring substance use disorders.
- Mental health court "team members" usually include a judge, representatives from the defense bar and the district attorney's office, probation/parole officers, and case managers and/or representatives from the mental health system.
- Referrals to a mental health court program most commonly come from defense attorneys, judges, jail staff, or family members.
- Mental health courts employ incentives and sanctions tailored to the circumstances and needs of each participant to motivate him or her to engage in treatment and comply with the terms of participation.

...and what research suggests about mental health court outcomes...

- Participants in some mental health courts have lower rates of recidivism—and, in particular, are less likely to be arrested for new crimes—than individuals with mental illnesses who go through the traditional criminal court system. Some empirical evidence shows this trend continues after graduation when individuals are no longer under court supervision.
- Mental health courts are more effective than the traditional court system and jails at connecting participants with mental health treatment services.
- Over time, mental health courts have the potential to save money through reduced recidivism and the associated jail and court costs that are avoided, and also through decreased use of the most expensive treatment options, such as inpatient care.

In short, existing research supports the idea that mental health courts may produce positive outcomes for their participants and for the public; however, much more data are needed to bolster confidence in these conclusions. Furthermore, for policymakers and practitioners to be able to design the most effective courts, they need empirical evidence about *which* aspects of mental health courts have the greatest positive effects, *why,* and for *whom*.

Answering these questions will help to strengthen the mental health court model by identifying appropriate target populations and revealing key practices. In addition, further research may pinpoint elements of mental health courts that traditional courts could implement to possibly improve outcomes for people with mental illnesses across the criminal justice system. With these goals in mind, this guide identifies key areas for future research that could augment the encouraging findings to date.

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*Advisory group members' titles and agency affiliations reflect the positions they held at the time of their involvement with this project.

Introduction

Large numbers of people with mental illnesses come into contact with the criminal justice system, often resulting in tragic outcomes; ineffective use of law enforcement, court, and corrections dollars; failure to link individuals to effective treatment; and lack of improvements to public safety. The prevalence of serious mental illnesses among people entering jails, for example, is estimated to be 16.9 percent (14.5 percent of men and 31 percent of women).[2]

Too often people with serious mental illnesses at risk of criminal justice involvement cycle repeatedly through courts and correctional facilities, frequently for minor offenses. A study by the U.S. Department of Justice found that half of all jail, state prison, and federal inmates with mental illnesses reported three or more prior convictions.[3] Lack of accessible treatment in the community can prompt their contact with the criminal justice system. Compounding the problem, many courts and correctional agencies cannot provide needed mental health treatment as part of confinement or connect individuals with effective treatment services in the community when they are released from jail or prison. Frequent involvement with the criminal justice system adversely affects the well-being of these individuals, consumes scarce resources, and can compromise public safety.

As people with mental illnesses continue to come in contact with the criminal justice system, communities across the United States struggle to develop interventions and supports that improve outcomes for these individuals, their service providers, and the public. Policymakers and practitioners in a growing number of jurisdictions have developed a number of community-based criminal justice/mental health initiatives. These programs include specialized responses by law enforcement, community corrections, and courts.*

EMERGENCE OF COURT RESPONSES

Although few jurisdictions maintain comprehensive court statistics, anecdotal reports suggest that the influx of people with mental illnesses into the criminal justice system has had a significant impact on court functions. Court staff often wrestle with how to handle these cases, which can be complicated and consume a disproportionate share of limited resources. Consequently, many courts now connect these individuals with treatment services in the community in the hopes of reducing their chances for criminal justice involvement. The most common mechanism for making that connection is the use of mental health courts—problem-solving courts derived from the drug court model.†

*This publication focuses on mental health courts. Other works in the MacArthur Foundation-supported series of guides on research-informed policy and practice include *Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision* and *Law Enforcement Responses to People with Mental Illnesses*. Find these publications at http://consensusproject.org/jc_publications/outcomes-mental-illness-community-corrections and http://www.consensusproject.org/jc_publications/law-enforcement-responses-to-people-with-mental-illnesses.

†Problem-solving courts include, but are not limited to, domestic violence, drug, and mental health courts. Though often very different in focus, they share a number of common principles: (1) enhanced information about issues and participants, (2) community engagement, (3) collaboration among justice officials and community organizations, (4) individualized justice, (5) accountability, and (6) analysis of outcomes. Robert V. Wolf, *Principles of Problem-Solving Justice* (New York: Center for Court Innovation, 2007).

Mental health courts have several goals: to improve public safety by reducing the recidivism rates of people with mental illnesses, to reduce corrections costs by providing alternatives to incarceration, and to improve the quality of life of people with mental illnesses by connecting them with treatment and preventing re-involvement in the criminal justice system. The first mental health court began operating in 1997; since then, some form of these courts has emerged in most states. As of 2009, there are more than 250 mental health courts across the country, with many additional courts in the planning phase.[4]

PURPOSE OF THIS GUIDE

This guide is intended to provide policymakers and practitioners with a clearer sense of how mental health courts work and the types of outcomes they may produce so these change agents can make informed decisions about whether to implement such a program or how to refine existing mental health courts. This guide draws on research findings to describe the key characteristics of mental health courts and to examine whether they achieve their stated goals, such as reduced recidivism among participants. This guide is not meant to be an exhaustive inventory of studies on the subject or a systematic review of the research literature. Because mental health courts are a relatively new mode of court intervention, there are many unanswered questions about how they work, for whom, and under what circumstances; these outstanding research questions are highlighted in this guide for researchers interested in expanding the existing body of knowledge about these programs.

HOW THIS GUIDE IS ORGANIZED

This guide is divided into two main sections: mental health court design and function, and mental health court outcomes. Each section is organized around the questions policymakers most often pose. This guide provides succinct answers to those questions in the form of policy statements along with brief summaries of the research supporting those statements.

Mental Health Court Design and Function: This section documents what the research says about the design of mental health courts, with a focus on the characteristics of participants (criminal charges, mental health diagnoses, and demographics) and how the courts operate (pre- or post-adjudication, staffing, program referrals, treatment linkages, incentives and sanctions, and issues of competency and coercion). It references the 10 essential elements of a mental health court, which are listed in appendix A.

Mental Health Court Outcomes: This section describes the research on the outcomes of mental health courts, including participants' recidivism rates and changes in mental health functioning, and cost savings.

The guide includes a third section that identifies gaps in the available research. It is complemented by appendix B, a list of unanswered questions. This appendix provides a framework for future studies and suggests the potential impact of additional research on the design and implementation of mental health courts.

HOW THIS GUIDE WAS DEVELOPED

The authors, in consultation with an advisory group of leading researchers and court practitioners, conducted an extensive review of the literature to find answers to the questions that policymakers typically ask about mental health courts. The advisory group then reviewed summaries of research findings and provided input on which studies to include in the guide, how to interpret their findings, and what policy statements could be derived from the relevant research.

Study Limitations

THE AUTHORS EXERCISED CAUTION IN DEVELOPING POLICY STATEMENTS due to the methodological limitations of studies of mental health courts. Because mental health courts have existed for only a short period of time, are often very small (frequently having only a few dozen participants), and vary considerably in the services offered and length of supervision, generalizing from reported outcomes could be misleading. Furthermore, because mental health courts are relatively new, studies have been based on short follow-up periods and do not indicate the long-term impact of these programs. Lastly, few studies consider community context, which impacts treatment services offered, public sentiment, and the indirect outcomes of mental health courts. Through jail and court staff's increased awareness of mental health issues, these indirect outcomes can include changes in traditional court processing and improved treatment services for individuals with mental illnesses involved in the criminal justice system who do not participate in the mental health court.[5]

The authors and advisory group are confident the research summaries and policy statements in this guide represent the full range of the field's best evidence about mental health courts at this writing. It is not an exhaustive list of studies; rather, research was selected that had sufficient detail to support policy statements. **That said, the authors and advisory group did not establish a specific methodological standard for including or excluding research but instead included a variety of research studies, some with more robust methodologies than others.** For example, studies with large sample sizes and in which participants are randomly assigned to experimental and control groups tend to produce more reliable findings. As a result, the findings presented in this guide vary in terms of their strength. In addition, whereas Section II (outcomes) cites only peer-reviewed studies, Section I (design and function) draws upon a wider body of literature as the policy statements derived from the research are mostly descriptive.

A NOTE ABOUT MENTAL HEALTH COURTS

The focus on mental health courts in this guide does not imply they represent the best or only court-based response to people with mental illnesses. Mental health courts are better known and more studied than any other court-based initiative focused on mental health, but there are many other types of court programs that may prove to be as or more effective for certain types of criminal defendants. These other interventions include forms of pre-trial diversion, use of court-appointed mental health advocates and case managers, and mandatory treatment as part of probation or parole.[6]

Furthermore, criminal justice and mental health experts have expressed several concerns about mental health courts that should be kept in mind when reviewing the research and policy statements in this guide.[7] At base is the issue of "net-widening," which occurs when individuals who might otherwise be diverted from court processing are brought into specialized programs such as mental health courts because these programs appear to be in their best interest. This may result in increased engagement with the criminal justice system.

Individuals with mental illnesses are often arrested for low-level misdemeanors and public nuisance crimes. In a traditional court, these charges often incur minimal punishment, and, in some cases, the charges are dropped altogether. In a mental health court, however, participants often are required to take part in the program for periods ranging from six months to two years, depending on the criminal charge and the design of the court. As a result, some participants remain under court supervision for much longer than if

they had been adjudicated in a traditional court. It can be unclear whether participation is always in their best interest because the intensive supervision provided through mental health courts may increase the chance of individuals being caught committing minor infractions, which could lead to additional charges and deeper involvement with the criminal justice system.[8]

Many experts feel these individuals do not belong under criminal justice supervision and should be diverted back into the community with better connection to treatment services that might have prevented their arrest had they been more accessible initially. To date, there has been too little research to draw any conclusions.

SECTION ONE

Mental Health Court Design and Function

As with many other collaborative initiatives, mental health courts are designed to bridge systems and agencies. The criminal justice system was not designed to provide mental health treatment; its main purposes are to ensure public safety, promote justice, and punish and prevent criminal behavior. The mental health system, in contrast, focuses primarily on the treatment of illnesses, public health, and harm reduction. Despite these differing mandates, the two systems have been thrust together because of overlapping commitments to the same people. Mental health courts attempt to coordinate these responses under the purview of the courts so that each system can fulfill its duty and produce the best outcomes for people with mental illnesses and their communities.

The court alone does not comprise a comprehensive treatment intervention; instead, mental health courts motivate individuals to connect to community-based treatment services while the court monitors their progress and ensures public safety. Thus, collaboration between criminal justice agencies and mental health treatment providers is critical.

Despite general similarities among mental health courts, each court develops locally, based on the needs and legal regulations of that particular jurisdiction and the treatment services available. As a result, there is no single mental

Definition: Mental Health Courts

THE CURRENT WORKING DEFINITION OF A MENTAL HEALTH COURT is a court with a specialized docket for certain defendants with mental illnesses.[9] These courts vary as to the types of charges and mental illness diagnoses accepted as well as the participants' demographics and plea requirements, but they are united by the common themes of substituting a problem-solving model for traditional criminal court processing and an emphasis on linking defendants to effective treatment and supports. In general, mental health court participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions; non-adherence may be sanctioned, and success or graduation is defined according to predetermined criteria.[10] In addition, court researchers and practitioners have identified "10 Essential Elements" (listed in appendix A) that describe key characteristics of mental health courts.[11] The authors of this guide used the definition above and the 10 Essential Elements to determine what constitutes a mental health court.

health court model. To understand how mental health courts work, researchers have attempted to look at a number of different aspects of their design and functioning. Although trends have been observed and some conclusions can be drawn, the policy statements below are fairly general because there is much variation within the field.

This section poses and answers common questions about the design and function of mental health courts, deriving policy statements from relevant research. In some cases, sidebars provide additional context or address the *"why"* of a policy statement. The research cited in this section represents both single and multi-site studies, including some that have not been peer-reviewed.

Research Findings*

A. WHO PARTICIPATES IN MENTAL HEALTH COURTS?

1. With what types of crimes are mental health court participants charged?

a. Mental health courts accept individuals charged with a wide variety of offenses and may focus on individuals charged with misdemeanor crimes, felonies, or both.

- According to a 2006 survey of 87 mental health courts around the country, 40 percent accepted only individuals charged with misdemeanor crimes; 10 percent accepted only individuals charged with felonies; and 50 percent accepted both types of charges.[12]
- A 2003 national survey of 20 mental health courts found that half accepted only people charged with misdemeanors and half took people charged with misdemeanors or felonies.[13]

Jurisdictional Limits

IN SOME CASES, the acceptance of individuals with misdemeanor or felony charges into the mental health court program reflects a jurisdictional limitation of the court in question, rather than a policy choice per se. For example, a mental health court that operates within a municipal court with jurisdiction primarily over misdemeanor charges will limit the program's target population to individuals with misdemeanor charges. Similarly, a trial court with jurisdiction over felonies will generally lead the related mental health court to focus on individuals with felony charges. Court systems vary widely across states, and this variation should be taken into account when examining the target population served by a mental health court.

In many cases, however, the decision to accept individuals charged with certain types of crimes is based on other factors. Constraints or preferences of initial funders, including the federal Bureau of Justice Assistance, and concerns for public safety accounted for much of the reason why early mental health courts accepted mostly people charged with misdemeanor crimes, even if the court's jurisdiction was broader.

*The years provided for the various studies in this guide reflect the *year of publication* for the article or report describing the research conducted.

b. The first mental health courts usually focused on individuals charged with misdemeanor crimes, but more recently, courts have begun to include people charged with felonies.

- According to a 2002 study of eight "first generation" mental health courts, seven focused on individuals charged with misdemeanors, often with restrictions on the types of misdemeanors.[14]
- A 2003 study of the Broward County (Fla.) mental health court found that, at its inception in 1997, the court accepted only individuals charged with a nonviolent misdemeanor, ordinance violation, or criminal traffic offense.[15]
- A 2005 study of "first and second generation" mental health courts determined that four of the six "first generation" mental health courts that originally accepted only people charged with misdemeanor crimes had begun to accept people charged with felony offenses on a case-by-case basis. Of the seven "second generation" mental health courts examined, all accepted individuals with felony charges; three either focused on or accepted only people charged with felonies; and only one focused primarily on misdemeanors.[16]

c. Mental health courts are increasingly likely to admit individuals charged with violent crimes if specific conditions are met.

- A 2003 national survey of 20 mental health courts revealed that only four had blanket exclusion rules for anyone with a history of violence.[17]
- A 2003 study of the Santa Barbara (Calif.) mental health court reported that individuals with past violent charges were admitted if the district attorney and other mental health court team members determined they no longer posed a threat to others.[18]
- According to a study of the Brooklyn (N.Y.) mental health court, when the program started in 2002, the court took only individuals charged with nonviolent felonies, but expanded to include individuals with violent felony charges on a case-by-case basis. As of June 2004, 39 percent of participants had entered the mental health court charged with a violent crime.[19]
- A 2005 study of the Community Resource Court in Orange County (N.C.) determined that although the majority of program participants were charged with misdemeanors (88.6 percent), the court accepted some individuals charged with violent felonies (2.4 percent of all participants) with the victim's approval.[20]

Expanding to Include Serious and Violent Crimes and Involve Victims

***WHY* HAVE MENTAL HEALTH COURTS MOVED IN THE DIRECTION** of admitting individuals charged with felonies, including violent felonies? When mental health courts first emerged, there were unanswered public safety concerns about releasing into the community individuals who might otherwise be incarcerated. Because the mental health court was an untested model, many jurisdictions chose to see how people charged with nonviolent misdemeanors fared in the program before expanding to admit individuals charged with more serious crimes. Once court officials and community providers became accustomed to the mental health court model and confident in its outcomes, they often began to support the idea of enrolling individuals with prior felony convictions or a history of violence and those currently charged with felonies, including violent crimes. Firsthand exposure to the positive influence of treatment on defendants' behavior can increase willingness to use court supervision as an alternative to incarceration. For example, some violent behavior can be attributed to untreated mental illness, and, once policymakers and practitioners observe that mental health courts support medication adherence, they tend to be more interested in applying the same intervention to people charged with serious or violent crimes.

Another reason for the shift toward accepting people charged with felony crimes was the two-pronged concern over the length of participation in some mental health courts. First, in many jurisdictions, individuals charged with misdemeanors in the traditional court system would face, at most, a year of supervision if convicted, and thus defense counsel and potential participants would not agree to longer periods of supervision under the mental health court program. Second, some jurisdictions decided to focus on people with felony charges to allow court professionals to engage participants in community-based treatment for longer periods of time, which was perceived as necessary to produce positive outcomes. The longer stays for individuals charged with serious crimes was not longer than the prison sentences they would have faced if convicted.

Lastly, it is worth noting that there is often great variation in how the same criminal action can be charged across jurisdictions and even within a jurisdiction. An act considered to be a felony in one jurisdiction may be charged as a gross misdemeanor in another. Furthermore, as law enforcement officers and prosecutors become more aware of the availability and utility of a mental health court they may be more apt to use their discretion in deciding what charges to file. Some courts that officially do not accept individuals with felony charges may make exceptions in extenuating circumstances and if the charges are nonviolent.

On a related note, as more mental health courts have begun to take on cases involving violent crimes, the number of victims involved in mental health court cases has increased. It is difficult to determine how many mental health court cases involve victims because few courts track such data. Although little has been written about the role crime victims play in these specialized courts, some mental health courts have begun to adopt victims' rights policies that might otherwise not be available, but which are afforded in traditional courts.* For example, some mental health courts require the victim's consent before a potential participant is allowed to enter the program; other mental health courts collect contact information from all victims so court staff can notify them of important court events and even connect them to needed resources. At this writing, most of these practices are sporadic and usually not required by law.

*For more information about crime victims whose cases are addressed in mental health courts, and for examples of how programs are including victims, see the Justice Center's 2008 publication, *A Guide to the Role of Crime Victims in Mental Health Courts*.

2. What types of mental health diagnoses do court participants have?

a. Most courts accept primarily individuals diagnosed as having (or who show signs of having) serious mental illnesses.

- A 2005 national survey of 90 mental health courts indicated that 16 percent of responding courts had some specifications as to what types of mental illnesses they accepted, but they did not report the nature of those specifications; 37 percent of responding courts accepted individuals with an Axis I disorder; 21 percent accepted individuals with a "serious and/or serious and persistent" mental illness; and 26 percent had no mental illness-specific admissions criteria.*[21]
- A 2005 study of seven mental health courts found that the most common diagnoses accepted among those courts included schizophrenia, schizoaffective disorder, bipolar disorder, and depressive or other mood disorders.[22]
- According to a 2005 study of the Broward County (Fla.) mental health court, 17 percent of participants were diagnosed with schizophrenia, 25 percent with major depression, 24 percent with bipolar disorder, and 34 percent with other disorders.[23]
- A 2007 study of the Allegheny County (Pa.) mental health court determined that 21 percent of participants were diagnosed with bipolar disorder, 29 percent with schizophrenia and other psychotic disorders, and six percent with major depressive disorder.[24]

b. Many mental health court participants have co-occurring substance use disorders.

- According to a 2003 study of the Santa Barbara (Calif.) mental health court, 114 of the 137 participants (83 percent) had a co-occurring substance use diagnosis.[25]
- A 2008 study of the Anchorage (Alaska) mental health court found that 59 percent of program graduates had both a mental illness and a substance-related disorder.[26]
- A study of the San Francisco (Calif.) behavioral health court published in 2007 showed that 56 percent of participants had a dual diagnosis of a severe mental disorder and a substance-related disorder.[27]

*See the sidebar on page 11 for more information on mental illness diagnoses.

Definitions: Serious Mental Illnesses and Co-occurring Disorders

What is mental illness?

According to the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health, *mental illness* is a term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.[28] A mental illness diagnosis is made only when certain clusters of symptoms are present for a certain period of time, other clusters of symptoms are not present, and the symptoms that are present cause significant distress or impairment in social, occupational, or other areas of functioning.

Federal and state regulations apply the following classifications in determining eligibility for publicly funded mental health treatment services:

- **Serious mental illness (SMI):** A term that generally applies to mental disorders that significantly interfere with some area of social functioning (e.g., work, school, family, leisure).[29]
- **Severe mental illness or severe and persistent mental illness (SPMI):** Terms that apply to more seriously affected individuals. This category includes schizophrenia, bipolar disorder, severe forms of depression, panic disorder, and obsessive-compulsive disorder. These terms are often used to describe clients with the highest levels of clinical need.[30]

What are co-occurring disorders?

The authors use the term *co-occurring disorders* to refer to substance-related and mental disorders that are diagnosed as being present in an individual at the same time. Co-occurring disorders exist when at least one disorder of each type can be established independently of the other and is not simply a cluster of symptoms resulting from a single disorder.[31]

What are Axis I and Axis II Disorders?

Axis I disorders, as they are referred to in the *Diagnostic and Statistical Manual of Mental Disorders* Fourth Edition (DSM-IV), include clinical syndromes such as depression, schizophrenia, and bipolar disorder.[32] Axis II disorders, as defined by DSM-IV, are developmental and personality disorders, including paranoid, antisocial, and borderline personality disorders. Most mental health courts require participants to have an Axis I diagnosis, but many mental health courts also accept individuals who have a co-occurring Axis II disorder.

Although most mental health courts focus on individuals with serious mental illnesses, their specific target populations are often shaped by state mental health "priority population" definitions because these definitions affect the relative availability of treatment services that community providers can offer and be reimbursed for by the state or federal government.

3. What are the demographic characteristics of mental health court participants?

a. Some research indicates that women and Caucasians may be overrepresented in mental health courts, compared with their proportion of the local criminal justice population, and that this ''bias'' seems to occur at the point of referral, rather than acceptance, into the program.

- A 2005 study of seven mental health courts found that, compared with the local jail and prison population, individuals referred to these courts were more likely to be older, white, and women.[33]
- A 2005 study of the Community Resource Court in Orange County (N.C.) determined that women and whites were overrepresented in the program, but only slightly.[34]

B. HOW DO MENTAL HEALTH COURTS FUNCTION?

1. Do mental health courts admit individuals before or after their cases are adjudicated?

a. There are examples of pre-adjudication and post-adjudication mental health courts.

- According to a 2002 study of eight early mental health courts, two used only a pre-adjudication model; three used only a probation-based model; and three used a post-adjudication model in conjunction with one of the other two models.[35]
- A 2005 study of seven "second generation" mental health courts found that six used a post-adjudication model and only one used a pre-adjudication model.[36]
- A 2003 national survey of 20 mental health courts reported that about half required a "guilty" or "no contest" plea to participate in the program. Additionally, more than one-third allowed for either a dismissal of charges or expungement once participants completed the program.[37]
- According to a 2005 study of the Clark County (Wash.) mental health court, the court originally offered its program on a pre-plea basis but became a post-pleas program after receiving Substance Abuse and Mental Health Services Administration (SAMHSA) funds in October 2001.[38]
- A 2001 study of the mental health court in Anchorage (Alaska) reported that court participants were required to waive their right to trial and plead guilty to participate.[39]

Definition: Pre- and Post-Adjudication Models

MENTAL HEALTH COURTS USING A PRE-ADJUDICATION MODEL do not require a guilty plea or conviction before individuals join the program. Charges are often held in abeyance until program completion at which point the charges are dropped. A post-adjudication model, however, does require a guilty plea or conviction before a potential participant is allowed to enter a mental health court; however, some courts allow participants' records to be expunged upon their successful completion of the program.

b. Most, but not all, mental health courts that primarily accept individuals charged with felony crimes enroll participants after adjudication and require them to plead guilty.

- A 2006 study of the Brooklyn (N.Y.) mental health court reported that the program required potential participants to plead guilty before being accepted.[40]
- According to a study of the Allegheny County (Pa.) mental health court, the prosecutor offered a plea to potential participants. Individuals who agreed to the plea could enter the mental health court.[41]
- A 2007 study of the San Francisco (Calif.) behavioral health court found that the program accepts individuals charged with felonies, including violent felonies, but does not necessarily require participants to plead guilty.[42]

Admitted Without Pleading Guilty

DISTRICT ATTORNEYS GENERALLY REQUIRE people charged with serious crimes to plead guilty in order to enter a mental health court. The San Francisco Behavioral Health Court (BHC), however, is an example of a mental health court that focuses on individuals charged with felonies but does not always require participants to plead guilty before enrolling. The BHC team has chosen to be flexible in this way for two reasons. First, waiving the requirement of a guilty plea prevents a felony criminal conviction, which could negatively affect the person's chances of finding housing and employment after graduating from the program. Second, BHC team members believe participants should not be forced to give up certain constitutional rights (such as the right to a jury trial) in order to access needed mental health treatment. No research has been done to compare the effectiveness of mental health courts that require guilty pleas and those that do not, but given the potential negative consequences of a felony conviction, it is worth studying whether the same degree of public safety can be achieved without requiring a guilty plea.

2. Who typically staffs a mental health court?

a. Mental health court "team members" usually include a judge, representatives from the prosecutor's office and defense bar, probation or parole officers, and a case manager and/or representatives from the mental health treatment system.

- A 2003 study of the mental health court in Santa Barbara (Calif.) found that the mental health court team was made up of judges, district attorneys, public defenders, probation officers, sheriffs, chief administrators for alcohol, drug, and mental health services, a case manager, and an "intensive care team."*[43]
- According to a 2005 study of the Clark County (Wash.) mental health court, the court team comprised a judge, attorneys, probation staff, mental health professionals, and case managers.[44]
- A 2006 study of the Brooklyn (N.Y.) mental health court determined that the court team consisted of a judge, a project director, a clinical director, social workers, forensic directors, a resource coordinator, a psychiatrist, an assistant district attorney, members of the defense bar, and administrative staff.[45]
- According to a 2003 study of the mental health courts in Seattle and in King County (Wash.), both courts' teams included judges, clinical social workers (sometimes referred to as "court monitors"), prosecuting attorneys, probation counselors, defense attorneys supported by part-time social workers, and program managers/coordinators.[46]
- According to a study of the Allegheny County (Pa.) mental health court released in 2007, the court team was made up of the judge, an assistant district attorney, a public defender, a mental health court monitor, forensics support specialists (who serve as case managers), and a probation liaison.[47]

3. How are potential participants referred to mental health courts?

a. Defense attorneys and other criminal justice officials, such as judges and jail staff, as well as family members typically refer potential participants to the mental health court.

- According to a 2006 study of the Brooklyn (N.Y.) mental health court, the program received the plurality of its participant referrals (44 percent) from defense attorneys. Thirty percent of referrals came from competency hearings, 10 percent from the district attorney, 10 percent from other judges, and five percent from other "problem-solving courts."[48]

*The "intensive care team" follows the Assertive Community Treatment (ACT) model of service delivery. ACT features a team approach with a small case manager-to-client ratio; treatment provided where the client lives, with a focus on helping the client obtain his or her basic needs; and assertive, persistent engagement of clients that lack motivation. For more information, see Cosden, Merith et al. (2003) Evaluation of a Mental Health Treatment Court with Assertive Community Treatment. *Behavioral Sciences and Law,* 21: 415–427.

- A 2003 study of the Santa Barbara (Calif.) mental health court found that most participants were referred by a judge, an attorney, jail personnel, or a family member.[49]
- A 2007 study of the Allegheny County (Pa.) mental health court reported that referrals came from jail staff, the district attorney's office, the public defender's office, treatment providers, or family members.[50]
- A 2000 study of four mental health courts determined that the primary sources of referral were staff members at the county jail.[51]

4. How quickly do potential participants enroll in the mental health court?

a. Waiting periods between referral and enrollment vary widely across mental health courts.

- According to a 2005 study of seven mental health courts, the wait time between program referral and entrance ranged from 0 to 45 days. In 39 of the cases studied (14 percent), there was no waiting period. When these cases were excluded, the average length of time between referral and entry was 32 days.[52]
- A 2001 study of the Broward County (Fla.) mental health court notes that the court heard cases every day of the week, and, therefore, frequently was able to admit individuals within a few hours of referral.[53]
- A 2006 study of the Brooklyn (N.Y.) mental health court estimated that the time from referral to acceptance was approximately two to three months.[54]
- A 2005 study of the Community Resource Court in Orange County (N.C.) found that individuals rarely spent time in jail while awaiting program placement because those charged with minor crimes were usually released even if they could not post bail.[55]

Waiting in Jail

WHY IS THE LENGTH OF TIME FROM REFERRAL TO ENTRY into a treatment program so important? Many individuals with mental illnesses cannot post even minimal bond amounts, so they remain in jail while awaiting placement in a treatment facility or outpatient program as the start of their mental health court participation. Such periods of limbo introduce due process concerns. Potential mental health court participants cannot remain in jail longer than they would have if their case had been adjudicated by a traditional court. Also, jail time can have negative effects on people with mental illnesses, particularly if they are not receiving appropriate treatment services while they are incarcerated. Delayed enrollment tends to be a problem when courts are trying to place individuals with more serious criminal charges and those whose terms of participation require inpatient treatment.

One of the primary goals of mental health courts is to reduce jail time, so minimizing waiting periods is crucial. Jail is costly, and the days people spend in jail before being placed in a treatment program should be, but often are not, factored into the costs of mental health courts. Some courts have averted the problem. For example, potential participants in the Orange County (N.C.) Community Resource Court rarely spend time in jail while awaiting placement in the program because the court routinely releases individuals charged with minor crimes even if they cannot post bail.

5. How are mental health court participants linked to treatment services in the community?

a. Typically, case managers connect participants with treatment services in the community, attempting to re-enroll them in any treatment programs they participated in previously.

- A 2003 survey of 20 mental health courts identified three main pathways for linking participants to treatment services: some participants already had established treatment providers in the community; others received direct referrals to community providers from the mental health court team; and a small percentage were given general information and encouraged to enroll in treatment on their own.[56]
- A 2003 study of the Santa Barbara (Calif.) mental health court reported that each participant had a case manager responsible for establishing links with treatment providers, transportation services, housing, vocational training, group skills training, and substance abuse management.[57]

Providing Treatment Services

THE TREATMENT SERVICES THAT MENTAL HEALTH COURT PARTICIPANTS receive vary widely, depending on each individual's needs and the community resources available. Mental health courts do not typically operate or fund treatment services. Although court staff cannot directly control the quality of treatment services, they should develop close relationships with service providers to ensure participants receive the best care possible. Most courts contract with residential day treatment providers and ambulatory programs as needed and also link participants with education (for example, GED courses) or vocational training. Attempts are made to identify participants with co-occurring disorders and refer them to providers with the capacity to deliver integrated services.

Some mental health courts, particularly those that work with multiple treatment service providers, employ staff members who serve as participants' case managers. Courts that use one main service provider often rely on the provider to supply case managers while the court team acts as the participants' court liaisons. When available, some mental health courts use Assertive Community Treatment (ACT) teams to provide participants with intensive wraparound support services.

6. How do mental health courts encourage participants to engage in treatment?

a. Mental health court team members often use individualized incentives to motivate participants to engage in treatment.

- According to a 2008 study of the mental health court in Salt Lake County (Utah), participants who adhere to their terms of participation were most often rewarded with verbal praise and placement on the "Rocket Docket," which acknowledges their hard work and allows them to appear before the judge at the beginning of the status hearings and leave court earlier than those who are noncompliant.[58]
- According to a 2008 study of the Palmer (Ark.) mental health court, team members used a variety of incentives, including individual praise and applause, program completion certificates, and fewer court appearances, to encourage participants to engage in treatment.[59]

b. Mental health court teams employ a variety of sanctions tailored to participants' specific circumstances to encourage them to comply with the terms of participation and their treatment plans.

- A 2003 survey of 20 mental health courts reported that in response to participants' noncompliance 64 percent used jail time as a sanction; 36 percent adjusted treatment services; 27 percent used reprimands and increased the frequency of court appearances and "judicial persuasion"; and 18 percent considered expelling noncompliant participants.[60]
- According to a 2008 study, the mental health court in Salt Lake County (Utah) used various sanctions to respond to noncompliant participants: most commonly, participation in community service, removal from the "Rocket Docket" (see policy statement a. above), and/or verbal warnings.[61]

c. In some instances, mental health courts use jail time as a sanction for noncompliance.

- According to a 2006 survey of 90 mental health courts around the country, 33 percent used jail as a sanction in less than five percent of their cases; 39 percent used jail as a sanction in 5–20 percent of their cases, and 18 percent used jail as a sanction in 20–50 percent of their cases. Only two percent of courts used jail as a sanction in more than 50 percent of their cases, and eight percent never used jail as a sanction.[62]
- A 2002 national survey of eight mental health courts found that only one court, which handled primarily felonies, frequently used jail as a sanction. Six courts rarely placed noncompliant participants in jail.*[63]

*The eighth court used community service as a sanction instead of jail time.

The Use of Jail as a Sanction

ALTHOUGH MENTAL HEALTH COURTS SOMETIMES USE INCARCERATION to punish noncompliant participants, they may do so reluctantly. Why is this? Serious mental illness is often life long and naturally includes progress as well as setbacks. Specialized courts, therefore, can be ambivalent about imposing punishment as severe as incarceration when the perceived cause of the rule-breaking is mental illness.[64] Additionally, because spending time in jail can be extremely stressful, judges may be reluctant to impose a sanction that might lead to deterioration of the person's mental and emotional state.

It is important to note that sanctions, including the use of jail time, and incentives have not been studied for their effectiveness. This guide seeks only to describe the types of incentives and sanctions in use by some mental health courts.*

7. Do mental health court participants enter the courts voluntarily and aware of the program's requirements?

a. Although mental health court participants rarely feel coerced to enroll, there are indications that they are not always fully aware of their obligations under the program. Additionally, there is some evidence that truly voluntary participation, along with being knowledgeable about the terms of participation, is associated with successful outcomes.

- Participants interviewed as part of a 2002 study of the Broward County (Fla.) mental health court perceived "very little coercion" in their decision to enroll in the court.[65]
- According to a 2003 study of the Broward County (Fla.) mental health court, transcripts showed that the mental health court's primary purpose and focus was explicitly announced in only 28 percent of cases. Slightly more than half (54 percent) of the participants indicated they were told about the court's voluntary nature, but 55 percent of these individuals reported it was explained to them only after their initial hearing.[66]
- A 2005 study of 10 mental health courts showed that most participants did not feel coerced throughout the process. Courts reported, however, that some of their participants entered the mental health court even though they were not fully aware of the program's procedures. The study also revealed that individuals who entered voluntarily and with full knowledge of the program were more likely to be successful, whereas those who felt coerced into participating were less likely to comply with treatment.[67]

*For more information about sanctions and rewards in mental health courts, see the Council of State Governments Justice Center's 2008 publication, *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* (New York: Council of State Governments).

Competency and Coercion

ONLY INDIVIDUALS WHO ARE DEEMED MENTALLY COMPETENT TO STAND TRIAL are eligible for mental health courts. Before entering a mental health court program, the "defendant must be able to weigh the likely sentence and probationary period associated with conviction against the scope and duration of supervised treatment required by the mental health court."[68] Because mental health courts specifically reach out to individuals with mental illnesses, court staff must be particularly aware of mental competency even though there are no special proceedings to address competency issues, as only mentally competent individuals may be admitted. Individuals who are initially deemed incompetent may be referred and admitted to a mental health court after their competency is restored, much like in the traditional court system.

Even when potential participants are deemed legally competent, it is important that they understand the mental health court's terms of participation and rules. Mental health courts use different methods to ensure potential participants are fully aware of the requirements; however, surveys suggest more work in this area may be needed and that the absence of "perceived coercion" is not a reliable indicator that participants are fully informed about the voluntary nature of the court, the process, and their obligations.

SECTION TWO

Mental Health Court Outcomes

As the number of mental health courts has increased so has the model's visibility and strong anecdotal support for the benefits of these specialized courts. Mental health court staff and participants often emphasize how the court helps individuals stay out of the criminal justice system, remain in treatment, and find housing and employment. Despite these accounts, there is very little empirical evidence about the impact of mental health courts.

Because most mental health courts operate with small budgets, finding the resources necessary to collect, record, and analyze data is difficult, leaving programs unable to demonstrate quantitatively their capacity to achieve positive outcomes. Yet these are the data policymakers find most compelling and useful to support continued or expanded funding.[69] In addition, because mental health courts are relatively new, only a few formal outcome studies have been conducted. Most of these studies did not follow participants beyond 12 months after program participation, limiting conclusions about the long-term impact of participating in a mental health court. Nevertheless, preliminary evidence indicates that mental health court participation is associated with positive outcomes in several categories, including lower criminal recidivism rates, increased treatment engagement, and cost savings. What is not yet known is *why* some individuals do well in mental health courts and others do not, or *why* certain programs seem to be more effective than others. Further research is necessary to help mental health courts refine their target populations and make more informed decisions about whom to accept and the best treatment interventions to employ.

This section poses common questions policymakers and practitioners ask about mental health court outcomes, such as criminal recidivism rates, treatment participation and its effects, and cost savings. Succinct policy statements answering these questions are derived from evaluations of mental health courts. Several sidebars are included to provide additional context for the policy statements or to address factors that might affect the research findings. This section draws on a narrower body of research than the preceding section, citing only studies that have been peer-reviewed—suggesting their research methods and data analysis have been subject to scrutiny—and whose methodological rigor met a minimal standard set by the publication's advisory group.

Several of these studies compare the outcomes of mental health court participants with those of a group of individuals with mental illnesses who went through the traditional court process. Other studies compare the outcomes of participants before and after enrollment, a research design that can reveal changes in individuals' recidivism or connection to

treatment, for example, but cannot prove that such improvements are the result of the mental health court and would not have occurred in a traditional court setting.

When summarizing the findings of these studies, specific phrases are used consistently to convey the advisory group's assessment of the strength of the evidence behind a given finding. In general, the following three phrases are used, in descending order of strength: "research strongly suggests," "there is some research to suggest," and "there is some empirical evidence to support the belief that." For more on the methodology of each study, readers can refer to the bibliography for the original research citation information.

Defining Success

IN THIS PUBLICATION, "IMPROVED CRIMINAL JUSTICE OUTCOMES" generally refers to a reduction in overall interaction with the justice system, including a reduction in recidivism rates. Recidivism refers to a return to prison and/or jail with either a new conviction or as the result of violating the terms of supervision. The phrase "improved mental health outcomes" generally refers to improved functioning, a reduction in impairment, and/or a long-term engagement in treatment when appropriate.

"Success" is a popular term, but there is no standardized definition of what it means for a mental health court participant to achieve "success." Court programs and researchers often look at graduation rates, improved mental health functioning, linkages to treatment, and/or recidivism rates when measuring a participant's improvement. No matter what the benchmark, "success" should be measured *individually,* examining each person before, during, and after mental health court participation and including an analogous comparison group. In addition, it should be noted that individuals with mental illnesses may go through periods of improved mental health functioning and engagement in treatment, but will also experience downturns that do not necessarily indicate failure on the part of the participant or the program.

Most jurisdictions implement mental health courts in the hope of having a system-wide impact, such as improved public safety and reduced jail populations. These broader outcomes have yet to be studied in depth and need to be assessed.

Research Findings

A. RECIDIVISM

1. How do mental health courts impact public safety?

a. Research strongly suggests that mental health court participants have lower rates of new criminal charges while under court supervision than individuals with mental illnesses who go through the traditional criminal court system. There is some empirical evidence to support the belief that this trend may continue after graduation, when individuals are no longer supervised by the court.

- A 2007 study of the San Francisco (Calif.) behavioral health court (BHC), which compared participants with a similar group of individuals with mental illnesses booked into the county jail during the same period, found that 18 months into the BHC program participants had about a 26 percent lower risk of new criminal charges and a 55 percent lower risk of new criminal charges for violent crimes than the group of comparable individuals. The study also found that after BHC participation ended, graduates continued to show a longer interval before new charges compared with those who received treatment as usual (a 39 percent lower risk of being arrested for a new offense and a 54 percent lower risk of being arrested for a violent crime than the control group).[70]
- A 2006 study of the Orange County (N.C.) mental health court reported that in a 12-month follow-up period after program completion, mental health court participants had a re-arrest rate roughly half that of a comparison group of individuals with mental illnesses who went through the traditional court system in the year before the mental health court began and who would have been eligible for the mental health court had it existed at the time. When mental health court participants did incur new criminal charges, the charges were significantly less severe than those of the comparison group.[71]
- A 2005 study of the Broward County (Fla.) mental health court found that one year after enrollment the mean number of arrests for their participants was not significantly lower than a matched comparison group of defendants.*[72]
- According to a 2003 random assignment study of the Santa Barbara (Calif.) mental health court, which features Assertive Community Treatment (ACT), mental health court participants were as likely to spend time in jail as the group receiving less intensive mental health treatment through the traditional court system. However, mental health court participants were more likely to serve jail time on a probation violation or sanction, whereas members of the comparison group were more likely to spend time in jail related to a new crime.[73]

*See sidebar on page 24.

Explaining Discrepancies in Outcomes

WHY MIGHT FINDINGS FROM ONE STUDY SUGGEST A POSITIVE IMPACT of the mental health court program while findings from another study suggest no impact or a negative impact? One possible explanation is that the courts themselves differ in important ways—either by design or in reality. Although the authors of this guide have strived to include only mental health courts that adhere to the 10 Essential Elements mentioned previously and are recognized by the field, there may be disagreement about the courts selected and the extent to which they reflect the essential elements in practice. For example, one mental health court study found that participants were not always connected with treatment services. This may account for the fact that their recidivism rates were similar to the rates among the comparison group.

On the other hand, rigorous and consistent monitoring—an essential element of mental health courts—can lead to outcomes that are partly negative. Because mental health court participants are so closely monitored, small violations of their terms of participation and conditional release are more likely to be noted. Depending on the response of mental health court team members and probation officers, and whether infractions are reported, participants may experience jail stays that might not have occurred if they had not been involved in the mental health court. As the Santa Barbara (Calif.) mental health court study found, participants were as likely to spend additional time in jail as people whose cases were processed in the traditional court system. This does not negate the potential value of mental health courts, however. This study shows that participants were more likely to be placed in jail for a technical violation rather than for new criminal charges.

b. There is some research to suggest that mental health court participants have lower rates of recidivism after one year of participation than before enrolling in the court. No studies have found that participants are *more* likely to be arrested.

- According to a 2005 study of the Clark County (Wash.) mental health court, the average number of arrests among participants one year after enrollment was more than four times lower than the average number of arrests in the year before they entered the program. In addition, participation was associated with a 62 percent reduction in re-arrest for probation violations.[74]
- A 2005 study of the Broward County (Fla.) mental health court found that the average number of arrests for mental health court participants one year after enrollment was significantly lower than their mean arrest rate in the year before they entered the program.[75]

c. There is some research to suggest that the criminal justice outcomes of mental health court participants who graduate are better than those of individuals who start but do not complete the program or whose cases are processed by the traditional court system.

- A 2005 study of the Clark County (Wash.) mental health court showed that participants who were terminated from the program were 3.7 times more likely to recidivate than participants who graduated.[76]
- According to a 2006 study of the Orange County (N.C.) mental health court, the arrest rates of court graduates one year after program entry were less than one-fourth the rates of people with mental illnesses whose cases were processed by the traditional court. The arrest rates of those who did not complete the program were not significantly different from those of traditional court defendants.[77]

B. MENTAL HEALTH OUTCOMES

1. Are mental health court participants more likely to be engaged in treatment services?

a. There is some research to suggest that mental health courts are a more effective means of connecting individuals with treatment services than the traditional court system or jails.

- A 2003 study of the Broward County (Fla.) mental health court determined that the program increased defendants' access to treatment services and that mental health court participants were more likely than non-participants to continue treatment after the program concluded.[78]
- According to a 2003 study of the Clark County (Wash.) mental health court, participants had significantly more case management, outpatient service days, and medication monitoring after enrollment than before enrollment. Additionally, participants had fewer crisis intervention and inpatient treatment days post-enrollment.[79]

b. There is some empirical evidence to support the belief that, when compared with participants' mental health status before enrollment, mental health courts have a positive effect on participants' mental health.

- A 2005 study of the Santa Barbara (Calif.) mental health court reported that participants showed less distress and greater improvements in life satisfaction and independent living; however, the "treatment as usual" study group also experienced improved outcomes. The researchers hypothesized that the mental health court increased awareness of mental health issues across the court system, which led to higher levels of client engagement.[80]

C. COST SAVINGS

1. Do mental health courts result in cost savings, and, if so, for whom?

a. There is some research to suggest that over time mental health courts have the potential to lead to cost savings through lower recidivism and the associated jail and court costs and through a reduction in use of the most expensive types of mental health treatment.

- A 2007 study of the Allegheny County (Pa.) mental health court using administrative data from seven state and county agencies found that the mental health court did not *substantially increase* costs, at least in the short term, over traditional court adjudication and processing. The study's findings also suggest that over the longer term the mental health court may result in a net savings to government, to the extent that mental health court participation is associated with decreases in criminal recidivism and the most expensive types of mental health treatment, such as hospitalization and other forms of inpatient care.[81]
- Although the numbers were too small to be conclusive, the 2007 study of the Allegheny County (Pa.) mental health court also showed that the more serious the charge (felonies as opposed to misdemeanors) and the illness (based on scores indicating psychotic severity and low functioning), the higher the estimated cost savings from participation. However, none of the savings were statistically significant in the first year of mental health court participation.[82]

Cost Saving or Cost Shifting?

DESPITE THE POSITIVE FINDINGS PRESENTED ABOVE, it is too early to declare that mental health courts produce cost savings, particularly because the Allegheny County (Pa.) study is the first to study this issue. One concern is whether mental health courts save resources or simply shift costs to other levels of government. For example, although counties typically pay for court and jail costs, the expensive services that mental health court participants receive are often paid for by the state and federal government (if participants are eligible for Medicaid benefits, as many are). Costs could also be shifted locally, with corrections costs being replaced by the costs associated with mental health treatment (e.g., salaries for court case managers). Some studies, such as those evaluating mental health courts in Allegheny County (Pa.) and Broward County (Fla.), have shown that participation results in fewer jail days, a finding that implies cost savings.[83] Yet this is an oversimplification of the many costs involved in operating a mental health court, and more research is needed on the subject.

Thus far, no studies have looked at how the specific design of a mental health court and its program elements affect participant outcomes. As a result, the field lacks any way to determine what about mental health courts produce positive results and the best program models. This limits the ability of policymakers and practitioners to design increasingly effective programs and should be a critical focus of future research on mental health courts.

SECTION THREE

Future Research Questions and Implications for Policy and Practice

Although studies of mental health courts conducted to date have yielded some positive results, much more research is needed to confirm these findings and to determine what factors make mental health courts work, for whom, and under what circumstances. Only in this way can policymakers and practitioners make informed decisions about whether to start a mental health court and, if so, how to design it. These future studies need to be stronger methodologically, with larger sample sizes and appropriate comparison or control groups. They also need to look at the longer-term effects of participation and, in particular, whether reduced recidivism and treatment linkages are sustained over longer periods of time.

There are three main categories of questions about mental health courts that researchers need to address (additional research questions are in appendix B):

1. ***Do mental health courts accomplish their goals of improved criminal justice outcomes for participants, increased linkages to treatment for participants, enhanced public safety, and effective use of limited resources?*** *Do mental health courts lead to fewer new charges for participants during and after the program, and do individuals experience improved mental health functioning? Do mental health courts have a system-wide impact by reducing corrections costs, court processing costs, or jail overcrowding and by increasing public safety?*
2. ***For whom do mental health courts work?*** *Are differences in participant demographics associated with different outcomes? Do individuals with certain mental health diagnoses have better outcomes in these programs than others? Do participants' criminal histories and other background factors affect their criminal justice or mental health outcomes? Are there differences between individuals who choose to participate and those who decline the mental health court option?*
3. ***What elements of mental health courts have the most impact?*** *Which aspects of mental health courts, such as length of stay have the most significant effect on a court's overall outcomes? Which specific types of mental health treatment services produce the best mental health and criminal justice outcomes for participants?*

In addition, the following confounding variables should be considered when examining the effectiveness of mental health courts:

- Mental health courts primarily accept individuals with significant, life-long symptoms, so a lack of notable improvement in mental health functioning does not necessarily imply the program is not having a positive effect on its participants.

- Participant self-selection must be considered when analyzing the positive outcomes measured in mental health court studies. Self-selection occurs when individuals who are self-motivated to seek treatment are more likely to volunteer and qualify for and graduate from mental health courts, making the program look more effective than it actually might be.
- The court team's impact is also difficult to measure. The team is central to the mental health court program and its composition and dynamics vary greatly among jurisdictions. Therefore, it may be hard to determine how the court team can be most effective in improving participants' outcomes or what makes some teams function better than others.
- Mental health courts do not have control over the existing treatment options in the community and have limited opportunities to hold providers accountable or monitor the quality of the services they provide, yet outcomes depend heavily on the range and quality of treatment services. In this situation, communication between court staff and treatment providers is critical to establish a mutual understanding of the court's goals and to ensure everyone feels invested in the participants' outcomes.
- In some cases, the very existence of a mental health court in a community can raise local awareness of mental health issues, lead to an increase in available treatment, and spark improvements in the quality of those treatment services—changes that would likely lead to better mental health outcomes for individuals who go through the traditional court system. These results would appear to lessen the impact of the mental health court, unless researchers and policymakers are looking for potential system-wide benefits of mental health courts.

These factors reinforce that studies of these specialized courts must be as complex as the courts are themselves and underscore, in particular, the importance of evaluating a mental health court in the context of the surrounding community and criminal justice system.

Future research findings about the aspects of mental health courts that correlate to overall "success" hold the potential to guide their design and implementation. The findings can direct programs to appropriate defendants and tailor them to the needs of the individual and the community. It is important to note, however, that there always will be more criminal defendants with mental illnesses than can be admitted as participants in these specialized courts. In fact, given the thousands of people with mental illnesses entering the criminal justice system, even if mental health courts continue to proliferate, they will be able to reach only a small fraction of this population.

Accordingly, more research must be conducted to determine the effects of traditional court processing on the criminal justice and mental health outcomes of individuals with mental illnesses as well. This information would not only suggest other ways to improve how traditional court systems respond to people with mental illnesses but also provide a baseline against which to measure the effects of mental health courts. Also needed are studies that examine the outcomes of other types of court interventions that might have a greater system-wide reach than mental health courts. Such studies would help policymakers understand the likely impact of different interventions and choose among them.

Conclusion

Mental health courts are one of many court-based responses designed to improve outcomes for people with mental illnesses who are involved in the criminal justice system. Despite the popularity of these courts, researchers have only begun to study their processes and outcomes. This guide has attempted to capture conclusions that can be drawn from the existing body of research at the time of this writing.

No two mental health courts are exactly alike. Each is shaped by the target population, jurisdictional constraints, available treatment services, and other community factors. Yet these courts have several essential characteristics in common, including the court team's general composition and the process through which someone is referred to the program and connected with treatment services. The studies included in this publication show that mental health courts have evolved since their inception and, as they become better known and accepted, are increasingly likely to accept individuals with a wider array of charges, including felonies and, in some jurisdictions, even violent crimes. And all of these courts share the same overall goals—to better address the needs of individuals with mental illnesses involved in the criminal justice system by reducing recidivism and increasing public safety, linking individuals to treatment services, and producing cost-savings for taxpayers.

Most of what is known about mental health courts and how they operate has been drawn from surveys or single-site observations. As a result, there are many important questions yet to be answered, including who is most successfully served by a mental health court, whether some models are more effective than others, and what program elements are most critical to the court's overall functioning. Answers to these questions can help address whether mental health courts can achieve their primary goals.

Studies on mental health court outcomes, although still very limited, indicate that participants and the public can experience positive outcomes. Mental health court participants tend to have lower rates of criminal activity and increased linkages to treatment services when compared with defendants with mental illnesses who go through the traditional court system and also when compared with their own past involvement in the criminal justice system. Only one study has assessed the cost savings, but it found that the mental health court studied was not more expensive than the traditional court and that the court had the potential for cost savings over time.

It is still unknown why some mental health courts appear to be more successful than others and why some participants in the same program fare better than their peers. Future studies must look at the types of mental health court models and practices that produce the best outcomes for different types of participants. As such research becomes available, the findings can be used to better define mental health court target populations and tailor services to meet participants' needs, thus increasing the likelihood of positive outcomes. Finally, because many individuals with mental illnesses involved in the criminal justice system do not have the opportunity to participate in a mental health court, even as the number of these courts continues to grow, good practices in this realm should prompt changes in how traditional courts respond to individuals with mental illnesses.

Appendix A
Essential Elements of a Mental Health Court

Element 1—Planning and Administration:
A broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court.

Element 2—Target Population:
Eligibility criteria address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria also take into account the relationship between mental illness and a defendant's offenses, while allowing the individual circumstances of each case to be considered.

Element 3—Timely Participation Identification and Linkage to Services:
Participants are identified, referred and accepted into mental health courts, and then linked to community-based providers as quickly as possible.

Element 4—Terms of Participation:
Terms of participation are clear, promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.

Element 5—Informed Choice:
Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant's competency whenever they arise.

Element 6—Treatment Supports and Services:
Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use—and increase the availability of—treatment services that are evidence-based.

Element 7—Confidentiality:
Health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and their constitutional rights as defendants. Information gathered as part of the participants' court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.

Element 8—Court Team:
A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.

Element 9—Monitoring Adherence to Court Requirements:
Criminal justice and mental health staff collaboratively monitor participants' adherence to court conditions, offer individualized graduated

incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery.

Element 10—Sustainability:
Data are collected and analyzed to demonstrate the impact of the mental health court, its performance is assessed periodically (and procedures are modified accordingly), court processes are institutionalized, and support for the court in the community is cultivated and expanded.

Detailed explanations of these elements are available at http://consensusproject.org/jc_publications/essential-elements-of-a-mental-health-court.

Appendix B
Areas for Further Research/ Outstanding Research Questions

A. MENTAL HEALTH COURT PROGRAM DESIGN QUESTIONS

1. **How do mental health courts select a target population?**
   a. What are the demographic differences, if any, among individuals who enroll in the mental health court, individuals who are eligible but decline participation, and individuals with mental illnesses who are deemed ineligible?
   b. How do the employment and housing statuses of mental health court participants affect the likelihood they will be referred or accepted?
   c. Do program restrictions favor referral of one demographic group over another?
   d. Do courts with specific referral policies save resources by reducing the number of screenings and by screening only individuals who are likely to be eligible to participate?

2. **How do varying criminal charges and plea requirements affect processing, use of sanctions and/or rewards, and program graduation rates?**
   a. How has the shift toward accepting individuals with felony charges affected the mental health court's overall operation, such as the amount of supervision staffing required or the relationships with community mental health service providers?
   b. What procedural and policy differences, including the use of sanctions and rewards, exist between pre- and post-adjudication courts?
   c. What procedural and policy differences exist between individuals charged with misdemeanor offenses and those charged with felony offenses?

3. **How does the level of available community-based treatment affect mental health court operations?**
   a. How has the availability of treatment services in the community shaped the mental health court's target population and operations, and the way individuals are linked to services?
   b. To what extent are evidence-based practices that are associated with positive outcomes available in the community for the target population?
   c. To what extent are the evidence-based practices implemented with fidelity to the model?
   d. How does the use of a primary/single treatment provider impact program function and outcomes compared with the use of multiple community providers?

4. Do people referred to the mental health court spend more or less time in jail awaiting disposition than those who are ineligible for the court?

a. How does jail wait-time prior to program enrollment and/or treatment program placement affect participants' willingness to participate?

b. What can be done to reduce jail stays prior to enrollment?

5. How, if at all, do sanctions and incentives affect a person's chances of successfully graduating from the mental health court?

a. Do increased court appearances result in increased adherence to the terms of participation?

b. Do short periods of incarceration impact rates of subsequent violations? For which participants?

c. Do participants who receive rewards for compliance adhere more to the terms of participation than those who are not rewarded for compliance?

6. Do processes that help participants fully understand what the mental health court program entails lead to better success rates?

a. What are the procedural differences between courts that clearly state the voluntary nature of participation and those that do not?

b. What are the effects, if any, on completion rates when eligible individuals are asked about their perceptions of coercion and procedural justice before enrolling in the court?

B. MENTAL HEALTH COURT OUTCOMES

1. What is the long-term impact of mental health court participation on participants' mental health and use of treatment services?

a. How does participation affect court participants' mental health functioning after court supervision ends?

b. What types of treatment services produce the best mental health and criminal justice outcomes for participants?

c. To what extent do evidence-based practices for the general population generalize to the court participants?

d. How do programs ensure participants remain connected with community services after they graduate from the court?

e. What are the mental health court's effects on community treatment resources for non-participants?

2. What is the long-term impact of mental health court participation on participants' recidivism rates?

a. What elements of a mental health court are necessary to ensure a high rate of participant success?

b. What is the relationship between court supervision, access to services (including housing, transportation, and health), and recidivism?

c. Are there differences in the recidivism rates of participants in mental health courts that use a pre-adjudication model versus those that enroll individuals after adjudication?

d. Are there differences in the recidivism rates of participants in the court and those who were eligible but declined to enroll?

e. How do mental health diagnosis, demographics, education and income level, criminal history, and present charges affect a participant's recidivism rate? Which individual attributes, alone or combined, are associated with the lowest recidivism rates?

f. How is community safety affected by the presence of a mental health court in the jurisdiction?

3. How does program design affect outcomes?

a. Is a longer length of stay in the court associated with better outcomes?

b. Are the recidivism rates different for participants charged with misdemeanors than those charged with felonies once enrolled in the mental health court?

c. Do participants in courts that use jail as a sanction have higher or lower recidivism rates overall compared with participants in courts that use alternative sanctions?

d. How do mental health outcomes differ between programs that rely on one primary treatment provider and programs that use a variety of providers?

e. Are there specific mental health court team members who are essential for participants to experience improved criminal justice and mental health outcomes?

4. How long does it take for mental health courts to become cost effective? Are certain models more cost effective than others?

a. Can mental health courts support their own growth while participants remain in the program for extended periods of time?

b. What are the costs and benefits of the mental health court for the different systems with which it interacts—courts, corrections, and public health?

c. Do these costs and benefits differ depending on the characteristics of participants, especially their type of criminal offense?

d. Do mental health courts that accept only individuals with misdemeanor charges demonstrate cost effectiveness?

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