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The Impact of Treatment on the Public Safety Outcomes of Mental Health Court Participants

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Abstract

Three mental health courts (MHCs) are included in this study of whether enrollment in MHC affects community treatment access, utilization, time to service, program outcome, arrests, and jail days. Researchers approached newly enrolled MHC participants (n = 296) and similar "treatment as usual" (TAU) jail detainees (n = 386) screened as eligible for study participation. Baseline and 6-month interviews were conducted, and respondents allowed researchers access to their mental health and criminal justice records. We found that on discharge from jail on target charges, MHC participants accessed community treatment more quickly than did the TAU respondents. Furthermore, prior to enrollment in MHC, this sample had twice as many crisis treatment episodes as the TAUs, and they received more therapeutic treatment episodes. One year after enrollment, the MHC sample had more intensive and therapeutic treatment episodes than the TAUs. We found no relationship between the type of treatment intervention received (or not) and whether the MHC enrollees were arrested or in jail following MHC enrollment.

Keywords

mental, health, courts

As the name suggests "mental health treatment courts" (MHCs) are intended to use judicial leverage to link clients to mental health services. Mental health treatment is

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a critical characteristic of these specialty courts based on the principles of therapeutic jurisprudence (Steadman, Davidson, & Brown, 2001). As a form of jail diversion for justice-involved persons with mental illness, MHCs are also expected to reduce recidivism through enhancing treatment accessibility and utilization. Implicit in these courts are two assumptions, both of which might be correct but are empirically untested. The first, and likely more common, assumption is that individuals served by the MHCs are treatment resistant (Lamb, Weinberger, Marsh, & Gross, 2007) and require sanctions and incentives to ensure mental health treatment compliance as a condition of program participation. The second assumption is that without court intervention, most needed treatment services would not be available to the population served by treatment courts because of a "client resistant" community of providers and funders. In both cases the "power of the gavel" is used to compel providers and justice-involved consumers into a legally binding, yet voluntary relationship to offer and accept mental health treatment. Available evidence-based treatment is a crucial key to mental health courts as stated in the *Essential Elements of a Mental Health Court*: "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 and services that are evidence-based" (Thompson, Osher, & Tomasini-Joshi, 2007).

In a national survey of MHCs, researchers found that MHC judges do indeed mandate community mental health treatment engagement, including both medication compliance and adhering to other court conditions as requirements of program participation (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). Some studies explored the implementation of this mandate and found that MHC clients do receive more services after program entry (Boothroyd, Poythress, McGaha, & Petrila, 2003; Cosden, Ellens, Schnell, & Yamini-Diouf, 2005; Herinckx, Swart, Ama, Dolezal, & King, 2005; Trupin & Richards, 2003). Goss (2008) observes that the availability of community mental health treatment is sorely limited in many rural areas, dissuading judges from seeking alternatives to jail for this population, resulting in the jail being the de facto indigent mental health center. Rural areas are traditionally underserved areas for mental health treatment (Wang et al., 2005), but the problem of access extends more broadly. In the general, noninstitutionalized, nonhomeless U.S. population, fewer than half of persons with a serious depressive disorder (38%) or bipolar disorder (39%) received "minimally adequate" mental health services in the prior year (Wang et al., 2005). Thus, linking justice-involved persons with mental illness to suitable and sustainable community mental health services requires first that those services be in place.

Studies have demonstrated that MHCs do generally increase participants' access and utilization of community treatment (Redlich et al., 2010). Few studies have tackled the complex question if treatment is related to public safety outcomes, namely improved arrests and jail days. Recently, Constantine, Robst, Andel, and Teague (2012) examined arrests by quarter in two jurisdictions following either outpatient or emergency/inpatient treatment. They found that outpatient treatment was associated

with reduced arrests in both jurisdictions for the first quarter; however, the reduction was sustained in only one county. Emergency or inpatient treatment was associated with increased risk of arrest in both jurisdictions (Constantine et al., 2012). Steadman, Redlich, Callahan, Robbins, and Vesselinov (2011) found a significant reduction in arrests in the 18 months following mental health court enrollment versus no significant decline for a comparison group. Similarly, McNiel and Binder (2007) found a reduction in new violent charges and a longer period until any new charges among MHC graduates compared with treatment as usual jail detainees. Additional earlier studies show improvements in arrests and jail days following MHC enrollment, but do not link these improved public safety outcomes to the mechanism, such as treatment. A diagnosis of schizophrenia and being a MHC graduate has been found to be associated with lower recidivism rates, whereas program termination, more bookings, and more psychiatric hospitalizations were associated with higher recidivism (Herinckx et al., 2005). Findings from the King County (Seattle, WA) MHC showed a reduction in recidivism and jail days in participants compared with individuals who opt out of the MHC (Trupin & Richards, 2003). However, neither determined what role, if any, treatment played in affecting the reduction in arrests and jail days. These studies hint that treatment might be related to outcomes, but thus far no treatment effects have been consistently empirically observed, perhaps in part because of small sample size, limited access to treatment data, or no comparison group.

Jail diversion studies of other types of jail diversion programs also report similar results. Steadman and Naples (2005) report that diverted individuals received significantly more counseling, medication, and hospitalization after diversion with no change in their psychiatric symptoms as measured by the Colorado Symptom Index and no relationship between treatment and arrests and jail days at the 12-month follow-up. Case, Steadman, Dupuis, and Morris (2009) conclude that

> in general, the studies reviewing the effectiveness of jail diversion have found support for its role in reducing arrests and jail days, but there is little support for the role of jail diversion in achieving mental health or quality of life improvements, such as access to high quality services or a reduction in mental health symptomatology. (p. 662)

As posited by Skeem, Manchak, and Peterson (2011), grouping all justice-involved persons with mental illness together may be part of the difficulty in finding a treatment effect. In particular, they argue that most people in jail diversion program are a heterogeneous group with numerous criminogenic risk factors (e.g., early-onset criminal involvement, numerous arrests, diversity in arrests) along with mental illness. Treating mental illness as the primary intervention does not address the underlying roots of the criminal behavior. They argue that smaller, more homogeneous cohorts of persons whose mental disorder is linked to their criminal behavior would allow for demonstrating whether treatment would be an effective and direct intervention to reduce recidivism. This is consistent with Cullen and Gendreau's (2001) argument to move

away from the "nothing works" ideology and policy in corrections to use evidence-based practices to target interventions to cohorts for which they do show promise of reducing recidivism.

This article examines the relationship between the utilization of mental health services for MHC enrollees and public safety outcomes—defined as annualized arrest rates and annualized jail days—and describes the methodological difficulties with measuring the nature of the relationship between access to and receipt of community treatment services and the public safety outcomes.

Method

Site Selection and Subject Enrollment

Four MHCs were selected to participate in this prospective, longitudinal, quasi-experimental, multisite study. Site selection was based on a number of factors including having a large enough caseload from which to draw a sample, being well established—determined by length of time in operation—and being representative of the variations among courts with regard to sanctioning and admission of felony and misdemeanant participants. In addition, sites needed to have a sufficiently large jail from which to draw a comparison sample. Using these criteria, we selected San Francisco County, California; Santa Clara County (San Jose), California; Hennepin County (Minneapolis), Minneapolis; and Marion County (Indianapolis), Indiana as the study sites. The four courts shared many structural features. For example, all were mature courts who had begun operating between 1997 and 2006. All courts accepted both felony and misdemeanor charges with general exclusion for violent crimes, but did include some on a case-by-case basis. They all had a maximum period of supervision of 2 years, with the modal time being 1 year and with the 2-year limit being more a guideline that was sometimes extended. They all had Axis I diagnoses as enrollment criteria. They did differ on whom their enrollees were in that they reflected the demographics of their localities and the diagnoses of enrollees varied with some heavily in the schizophrenia spectrum and others more in the depression/bipolar spectrum. All courts had enrollees with rates of co-occurring substance use disorders in the 75% to 90% range.

On-site researchers approached newly enrolled MHC participants for participation in the study. Baseline interviewers were conducted with MHC participants within 30 days of enrollment in the court. The comparison TAU sample was drawn from similar jail detainees matched as closely as possible to the MHC sample first on sex and criminal charges, and then on race, age, and diagnosis. On-site researchers approached eligible jail detainees for study participation and conducted baseline interviews within 30 days of admission to jail. All approach procedures, informed consent procedures, and data collection instruments were approved by a federally assured institutional review board (IRB) and by local IRBs where required. As part of their participation in the study, respondents agreed to be interviewed at two periods and allowed researchers access to their mental health and criminal justice records.

Table 1. Characteristics of Study Respondents

	San Francisco		Minneapolis		Indianapolis	
	MHC (*n* = 106)	TAU (*n* = 135)	MHC (*n* = 94)	TAU (*n* = 144)	MHC (*n* = 96)	TAU (*n* = 107)
Female (%)	27.4	23.7	48.9	22.9	50.0	65.4
Average age (years)	38	40	38	38	36	34
White (%)	36.8	41.5	53.2	41.0	54.2	74.8
Diagnosis						
Schizophrenia (%)	54.7	20.7	37.2	14.6	30.2	17.8
Bipolar Disorder (%)	9.4	5.2	36.2	18.1	27.1	41.1
Depression (%)	14.2	72.6	19.1	28.5	7.3	39.3
Other (%)	21.7	1.5	7.4	38.9	35.4	1.9

Data Collection

Study respondents were interviewed at baseline and 70% completed a 6-month follow-up interview. Study enrollment began in September 2005 and was concluded by September 2007. Objective outcome data were collected on each respondent by accessing his or her criminal justice and mental health treatment records through a number of federal, state, and county agencies. In most cases, the outcome data were provided by means of electronic transfer of information, but some data were abstracted from on-site records such as in the jails.

Data Analysis

The sample used for this article includes MHC participants ($n = 296$) and TAU ($n = 386$) from San Francisco County, Hennepin County, and Marion County. Santa Clara County was excluded because of insufficient length of time for which community treatment data were available. Characteristics of the study sample are presented in Table 1.

Variables used for analysis in this article include the following: *study sample* (MHC, TAU); *time period* (pre- or postenrollment); *type and amount of community mental health treatment*, which includes Medicaid-funded services categorized as crisis, intensive, and therapeutic services, 18 months before and after enrollment. *Crisis* includes contacts with crisis services and emergency room visits. *Intensive* includes inpatient days at short-term psychiatric facilities, 24-hour residential care, and detox services. *Therapeutic* includes community-based treatment and support services such as day treatment and individual and group therapy, medication management, case management, and other support services. Excluded from community mental health treatment are services received while in jail or prison, treatment in a state psychiatric

hospital, and treatment for non-mental-health-related services as the data were incomplete across the sites. *MHC outcome* is their program status at 12 months—graduated, terminated, or still in the program. *Annualized arrest rate* is their number of arrests per 365 days "at risk" for being arrested, that is, not in prison or jail.

Results

The two major research questions for this analysis were the following: (a) Does participation in MHC produce higher rates of treatment participation than processing through the regular criminal court system? and (b) Is the amount of treatment received related to subsequent arrests? We first examined the percentage of our sample that accessed community-based mental health treatment in the 1 year prior to enrollment. To create an indicator of community mental health treatment utilization, we used self-report data from the baseline interviews and the objective records. All records that matched (no–no, yes–yes) were coded accordingly. We used self-report data and collateral sources to code records for which we were unable to find any objective treatment data.

MHC and TAU Linkage to Community Mental Health Treatment

Overall, most of the MHC (73.6%) and TAU (55.5%) samples accessed treatment services in the pre enrollment year ($\chi^2 = 22.78$, 1, $p < .001$). This result was a bit unexpected since an assumption underpinning mental health courts is that their target group is primarily individuals who have resisted or have not had access to services. As this result indicates, the vast majority (73.6%) of MHC enrollees have had services in the year prior to their enrollment.

In the 12 months postenrollment, 84.2% of the MHC and 55.8% of the TAU sample received at least some mental health treatment ($\chi^2 = 60.32$, 1, $p < .001$). The specific amount by type of community treatment MHC and TAU individuals accessed both pre- and postenrollment is presented in Table 2. MHC participants accessed significantly more crisis and therapeutic services in the 12 months immediately prior to enrollment when compared with the TAU participants. In the 12 months following enrollment, the MHC participants continued to have more therapeutic treatment episodes, now had more intensive treatment episodes, and no longer had more crisis treatment episodes than the comparison sample. This was expected given their MHC enrollment with its treatment plan and judicial supervision.

As part of examining access and connections to community treatment, we examined the average length of time to first service contact by calculating the number of days between release from jail for the target stay and the first community treatment service contact. Respondents for whom we did not have community treatment records (6.6% of sample) or who did not receive treatment in the 12 months following release from jail were excluded from this analysis. MHC participants accessed community treatment much sooner than their TAU counterparts following release from their target

Table 2. Amount and Type of Community Treatment Pre- and Postenrollment by Sample

	12 months pre-enrollment					12 months postenrollment				
	MHC (n = 292)	TAU (n = 355)	F	df	p	MHC (n = 292)	TAU (n = 355)	F	df	p
Crisis episodes	1.9	0.86	8.89	1	< .01	0.78	0.48	3.12	1	.076
Intensive Tx episodes	13.8	10.2	1.31	1	.25	31.2	13.6	17.56	1	< .001
Therapeutic Tx episodes	77.7	35.2	17.34	1	< .001	111.8	32.6	48.83	1	< .001
Therapeutic Tx hours	189.9	263.8	0.626	1	.43	267.2	238.3	0.113	1	.737

Table 3. Average Amount and Type of Postenrollment Community Treatment for MHC Participants by Program Status at 12 Months

	Graduated (n = 126)	Still In MHC (n = 42)	Terminated (n = 92)	F	df	p
Crisis episodes	0.56	1.11	0.44	2.06	2	.130
Intensive Tx episodes	26.74	52.71	14.39	7.77	2	.001
Therapeutic Tx episodes	117.60	129.19	61.12	3.48	2	.032
Therapeutic Tx hours	282.36	356.67	129.45	1.13	2	.324

jail stay, with a median of 7 days for MHC enrollees compared to 64 days for the comparison group ($p < .001$). Therefore, after being released from jail, persons enrolled in the mental health courts accessed more community treatment services and more quickly than similar individuals who were not in a mental health court program in the same community.

Community Mental Health Treatment and Mental Health Court Outcome

Next, we examined the relationship between the type and amount of community treatment accessed by MHC participants—crisis, intensive, and therapeutic—and MHC outcome at 12 months—graduated, still in program, and terminated (Table 3). It should be noted that we had all of their treatment records, not just the treatment that was directed by the court. Therefore, even if someone graduated (or was terminated) before the 1-year mark, we had records for the treatment they received beyond his or her graduation or termination date. We found that the MHC participants who were still

Table 4. Average Number of Annualized Arrests and Average Jail Days Months 7 to 18 Postenrollment by Community Treatment Services

	Community treatment services Months 1 to 6 postenrollment								
	No			Yes					
	M	*SD*	*n*	*M*	*SD*	*n*	*F*	*df*	*p*
Average number of annualized arrests (*n* = 291)	1.12	2.17	58	1.81	4.32	233	1.38	1	.241
Average number of subsequent jail days (*n* = 292)	35.55	80.40	58	36.49	73.91	234	.007	1	.933

in the court program at 12 months had significantly more intensive and therapeutic episodes than those who graduated or were terminated at 12 months. Our interpretation of this result is that those who graduated during their first year of MHC enrollment had reduced levels of activity over time and needed less intensive service; those who had not graduated within the first year required more intensive services during that time, and the court saw this need for more intensive services as a reason to retain them under supervision.

Community Treatment and Public Safety Measures for MHC Participants

One important public policy measure of the effectiveness of MHCs is whether arrest rates and jail days decline after enrollment in the treatment court and linkage to community treatment. By calculating the number of days that respondents are at risk of being rearrested, for an annualized rate, we can give a more accurate picture than simply noting if they are arrested or even how many times. For example, two people who both have no subsequent arrests may each indicate very different outcomes. One may have been released to the community for, say, 9 of the 12 months and be a success story. The second may have been incarcerated for 10 of the 12 months after release, meaning only 2 months of "success" versus the 9 of the first person. These represent very different levels of success. For this analysis, we used receipt of community treatment services during Months 1 to 6 postenrollment in the court and examined the relationship with the annualized rate of arrest in Months 7 to 18 postenrollment in the court. Although all MHC enrollees would have been expected to receive treatment, the reality is that because of resistance, lack of case management follow-through, or long incarceration, some enrollees did not receive any treatment. We found no significant differences in the rate of annualized arrests in Months 7 to 18 postenrollment for the MHC participants who did receive treatment and those who did not receive treatment in the first 6 months postenrollment (Table 4).

We then retested the effect, controlling for linkage with treatment prior to enrollment in the court and time in the community, or the "opportunity" to access community treatment services during the first 6 months postenrollment. The relationship between postenrollment community-based treatment and rearrest in Months 7 to 18 could be affected by prior relationships with community treatment providers. We also placed an additional contingency on the sample, requiring that the participant had been in the community for a minimum of 30 days during the first 6 months postenrollment for there to be an opportunity for receipt of treatment services. These controls made no difference in the analysis outcome, and we found no relationship between receipt of community treatment services in Months 1 to 6 and annualized arrest rates during Months 7 to 18 postenrollment in the MHC.

The second public safety outcome measured was the effect of MHC participation on subsequent jail days. We conducted the same analysis described above, first without controls and second with the two control variables. Again, we found no significant difference in the number of subsequent jail days for those MHC participants who did receive community treatment during Months 1 to 6 and those who did not receive treatment (Table 4). There is much variation in the groups, as evidenced by the reported standard deviation.

Although the average annualized arrest rates for these two groups of MHC participants may appear quite different (1.81 and 1.12, respectively), there is much variation in the group as evidenced by the reported standard deviation. Before discussing possible reasons for this apparent difference, or lack of a statistically significant difference in the rearrest rates and incarceration days reported in Table 4, it should be noted (as reported elsewhere) that the MHC group for this study had lower annualized rearrest rates and fewer incarceration days when compared with a TAU group (Steadman et al., 2011). There were some differences within the MHC group—graduates had lower rearrest rates than did participants who were terminated from the program, and all participants had fewer arrests while under MHC supervision (Steadman et al., 2011). So although the annualized arrest rates reported in Table 4 may seem to indicate that MHC participants receiving community-based treatment services in Months 1 to 6 had more arrests in Months 7 to 18, this relationship is not statistically significant. What this seems to indicate, particularly given the previously reported results, is that measuring treatment in the aggregate without measuring treatment quality, responsivity to services provided, or whether the services are appropriately matched to the client is inadequate. The implications of these data and recommendations for future research are reported in the discussion section.

Discussion

The results show that MHC participants were more likely to receive community treatment services in the years before and after enrollment in the mental health court when compared with the TAU sample. Whether it is prior relationships with treatment providers or the influence of the MHC, participants accessed community treatment

services more quickly than their TAU counterparts on release from their target jail stay. MHC participants accessed more therapeutic and intensive treatment services compared to their TAU counterparts. It is not surprising that participants still in the court 12 months postenrollment were high service users with a complicated array of behavioral health and criminogenic needs who appeared to require continued, extended court supervision. In each of the four measures of treatment, the group still under court supervision at 12 months had twice as many crisis and intensive treatment episodes than the group that graduated.

We found little support for a relationship between receipt of community treatment services by the MHC participants and subsequent annualized arrests, number of arrests, and number of jail days. We found similar results in models without controls and multivariate models controlling for differences among the groups. As described earlier, the often-stated intention of MHCs is to reduce recidivism through the facilitation of access to treatment services and the oversight of the court to ensure participation in these services. Although we found little support for the relationship between treatment services and increased public safety, the relationship between treatment and increased public safety in MHCs is not necessarily invalid. When we examine the types of treatment received by MHC enrollees, it is apparent that most are targeting standard behavioral health goals such as reduced symptoms, higher functioning, and satisfactory living standards. What emergent research has demonstrated is that to achieve public safety goals, treatment must focus on criminogenic risk factors. If the reality were that the treatment mandated by MHCs was focused on both mental health and criminogenic factors, one would expect to find a relationship between receiving treatment and reduced arrests and jail days. What our results clearly indicate is that this is a direction that MHCs need to begin taking to meet their core assumption of engaging enrollees in meaningful treatment that achieves both public health and public safety goals. MHCs depend on the delivery of effective treatment services in conjunction with the therapeutic jurisprudence role of the court to achieve their results. If the services provided are evidence based but the evidence base consists of symptom reduction, increased functioning, and increased quality of life but not reduced recidivism as validity criteria, one would not expect to achieve the public safety outcomes MHCs are expected to provide.

Beyond the policy and practice implication of these findings, there are methodological challenges in studying the relationship between treatment and public safety in some jurisdictions—a primary tenet of MHCs. Measuring receipt and dose of services is insufficient as these do not capture what we are beginning to understand about the relationship between services and outcomes—behavioral health and public safety. The growing body of literature on evidence-based services demonstrates that correct use of these services can increase the likelihood of achieving positive behavioral health outcomes for individuals with serious mental illness, and often co-occurring substance use disorders. Forensic adaptations of these evidence-based services—assertive community treatment and intensive case management, for example—are available and

have been shown to achieve similar results with justice-involved populations. The critical issue for future research is determining how to best measure services targeting behavioral health needs—in particular those services that are evidence based—and services aimed at reducing or mitigating criminogenic risk factors. It is not enough to record a one-hour therapy session. Was some type of cognitive behavioral therapy provided? Was any content meant to reduce criminal thinking and improve problem solving, for example? Just counting units of generic services will not answer the questions of what works for whom under what circumstances. Until then, the true nature of the relationship among treatment, individual behavioral health outcomes, and public safety will remain unknown.

Beyond difficulties with measuring quality and appropriateness of treatment interventions, there are methodological issues with collecting community treatment data given the variety of funding sources. Although we were fortunate to have access to a variety of self-report and objective data sources, enough that we were able to dichotomously code receipt of community treatment for nearly 94% of our sample, we are fully aware that there were gaps in the treatment data records given alternative sources for accessing treatment. For example, a number of MHC participants received treatment services through their local Veterans Administration Health Care Office or Indian Health Affairs Office. In addition, state psychiatric hospitalizations—an important piece of this puzzle in some jurisdictions—were not available as part of the Medicaid-funded treatment databases. Furthermore, because peer-based services are usually not reimbursed by Medicaid, despite the growing evidence that many are effective modalities, we could not study the role of peer-based services as we relied on Medicaid databases. Capturing all of these services and measuring the quality of the services would greatly enhance any analysis of the relationship between treatment and outcomes.

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