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Why do mental health courts work? A confluence of treatment, support & adroit judicial supervision

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ABSTRACT

The article contributes to the understanding of 'what works' in mental health courts (MHCs). There are now almost 400 MHCs in the US and more worldwide. A substantial body of evidence demonstrates that MHCs can succeed in reducing recidivism among offenders who suffer mental disorders. This article argues that MHCs succeed when they have achieved the right confluence of essential elements, including providing evidence-based treatment and psychosocial supports and using adroit judge-craft. After a brief review of some of the studies demonstrating MHC success, this article discusses the research into the necessary foundations of rehabilitation programs. It is argued that, although treatment and psychosocial services should be supplied within an evidence-based framework, neither of the two leading conceptual models – Risk–Needs–Responsivity and the Good Lives Model – are empirically proven with offenders who suffer from mental disorders. Despite the absence of proof, the Good Lives Model is argued to be appropriate for MHCs because it is normatively consonant with therapeutic jurisprudence. The MHC judge is another essential element. The judicial role is assayed to elucidate how it functions to promote the rehabilitation of offenders with mental disorders. It is argued that the role of the MHC judge during supervisory status hearings is to establish a therapeutic alliance and practice motivational psychology with each MHC participant.

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1. Introduction

An adage gaining currency in the problem-solving field is "when you've seen one mental health court, you've seen one mental health court" (Castellano & Anderson, 2013, p. 170). The adage reflects the diversity of models of problem-solving dockets that have been applied to the problem of offenders with mental disorders and their notorious over-representation among the offender population (Ogloff, Davis, Rivers, & Ross, 2006; Steadman, Osher, Robbins, Case, & Samuels, 2009). The first mental health court (MHC) in modern times commenced in Florida in 1990 (Denckla & Berman, 2001, p. 7). Since then, their proliferation has been remarkable. A recent systematic survey established that in 2013 there were 346 adult MHCs and 51 juvenile MHCs in the US alone (Goodale, Callahan, & Steadman, 2013, p. 299), with more in Australia (Richardson & McSherry, 2010), Canada (Slinger & Roesch, 2010), and England (Winstone & Pakes, 2010).

The problem-solving model is now well established. MHCs use a therapeutic jurisprudence orientation to seek to reduce recidivism. As demonstrated by the adage, there is considerable variation among the models, but, generally, charges are adjourned while offenders are engaged with services designed to reduce offending and to improve health and psychosocial functioning. A judge supervises a multi-disciplinary team that determines the most appropriate interventions for the offender, who is required to report back to the court at periodic status hearings. If the offender successfully engages in those interventions to the judge's satisfaction, then, usually, the sentence is reduced or discharged altogether (Almquist & Dodd, 2009; Thompson, Osher, & Tomasini-Joshi, 2007). Most problem-solving courts, especially in the early years, were judicial initiatives (Hora, 2002, p. 1483) and it is the hands-on involvement of a judge that is common to all MHCs and makes this process unique as a rehabilitative mechanism.

There is a growing body of evidence (some of which is discussed below) that appropriately designed and resourced MHCs can produce favorable recidivism outcomes for offenders with mental disorders. What is less well understood is *how* MHCs are able to achieve these results (Canada & Watson, 2013, p. 212). The diversity of MHC design makes for challenging meta-analysis. Some of the dimensions of MHC variation concern offender eligibility (nature/severity of index offense and/or offending history; nature/severity of mental disorder); pre-sentence/post-sentence operation; frequency of status hearings and the level of involvement of the judge; the composition of the court team (dedicated prosecutors and public defenders or not; dedicated psychologist/case manager/probation officer/social worker or not); the range and quality of services; and the funding model used for service delivery. Many experts in the MHC field have opinions about why this justice innovation has been able to reduce recidivism, but there has

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been little in the way of research. Indeed, the variation in MHC design and the confluence of legal, medical, psychosocial and psychological elements would make the isolation of elements responsible for positive outcomes a challenging task.

A growing number of judges are calling for problem-solving approaches to be deployed in mainstream courts for offenders with a diverse range of problems and offending profiles. For a sample, see: Hora (2002), Jones (2012), King (2007), Schmer (2000), Warren (2008), Popovic, (2007), Cannon (2008), and Spencer (2012). If a problem-solving approach is to be usefully employed in mainstream courts in relation to offenders with mental disorders, courts will benefit from improved understandings of how the amalgam of MHC elements – psychiatric treatment, psychosocial supports, adroit judge-craft, and techniques of applied psychology – interact to achieve rehabilitative effects with targeted offenders. The same information will also be invaluable within MHCs, especially in areas where resources are stretched.

This article will contribute to the understanding of what works for offenders with mental disorders and why by attempting to tease out the confluence of important elements that support successful MHCs. Section 1.1 of this article will briefly review the evidence that supports the claim that MHCs are effective in achieving reduced levels of recidivism among offenders with mental disorders. Section 2 starts to unpack the important elements by examining the 'what works' research. In relation to offenders with mental disorders, is treatment enough, or should treatment be supplemented with psychosocial supports? In an environment of shrinking resources, how can MHC decision-makers determine the types of services that will most effectively support desistance from offending? It is argued that MHCs should implement evidence-based practice and MHC directors and judges should understand the theoretical underpinnings of offender rehabilitation to ensure that overall programs and individual intervention plans are implementing best practice. Section 3 reviews the role of the MHC judge, including the style of judicial/offender interaction and the use of sanctions. It is argued that the evidence suggests that the role of the judge is a critical factor to the rehabilitative success of a MHC, but judges too must apply evidence-based methods to their practice. Arguably, it is the confluence of elements that work together to underpin a successful MHC. Those elements are provision of appropriate treatment and psychosocial supports and adroit judge-craft, including the adept use of motivational and rehabilitative psychology.

1.1. Do MHCs 'work'?

For many years, researchers have been saying that much more research is needed into the effectiveness of MHCs (King, Freiberg, Batagol, & Hyams, 2009, p. 153; Rossman, Willison, Mallik-Kane, Kim, & Downey, 2012, p. 19; Sarteschi, 2009, p. 123) and, in particular, more longitudinal studies (Almquist & Dodd, 2009, p. 21). However, there is now a significant body of research into MHC outcomes from the US and Australia which collectively demonstrates that MHCs are effective in reducing recidivism (for example, see: Cosden, Ellens, Schnell, & Yamini-Diouf, 2004; Frailing, 2010; McNeil & Binder, 2007; Newitt & Stojcevski, 2009; O'Keefe, 2006; Petrila, 2002; Rossman et al., 2012; Sarteschi, 2009; Skrzypiec, Wundersitz, & McRostie, 2004; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011; Trupin, Richards, Wertheimer, & Bruschi, 2001). Only the most cautious researchers continue to argue that the research remains deficient (Rossman et al., 2012, p. 19).

To support the premise that MHCs are effective, this section briefly catalogs the evidence. There have been numerous evaluations of individual MHCs that have shown positive recidivism outcomes. There are too many to cite, but among those from the past decade are: Frailing (2010), Newitt and Stojcevski (2009), Moore and Hiday (2006), O'Keefe (2006), Cosden et al. (2004), and Skrzypiec et al. (2004). Most recently, Rossman et al. (2012) positively evaluated the Bronx and Brooklyn MHCs in a study that examined recidivism over a three-year period. Studies of individual MHCs are supported by various meta-studies that have critically reviewed the collective and individual findings. Almquist and Dodd (2009) established an advisory group of leading researchers and practitioners to review a number of peer-reviewed studies. Sarteschi (2009) conducted a quantitative meta-analysis. Both studies concluded that MHCs do reduce rates of recidivism. Almquist and Dodd (2009, p. 23) concluded further that the recidivism-reduction effect might continue beyond the period of court supervision.

A number of longitudinal studies have also delivered positive findings about MHC effectiveness (Burns, Hiday, & Ray, 2013; Hiday & Ray, 2010; McNeil & Binder, 2007; Rossman et al., 2012; Steadman et al., 2011). The most comprehensive was Steadman et al.'s (2011) multi-site study of four MHCs. His team compared participants with matched controls over an 18-month follow-up period. Steadman concluded that participants in MHCs had better recidivism outcomes than the control group across a range of measures (Steadman et al., 2011).

Taken together, the body of MHC research supports the conclusion that recidivism among offenders with mental disorders can be reduced with appropriately designed MHC programs. Some researchers have been prepared to throw caution to the wind. Goodale, for example, has declared that there is now "ample evidence demonstrating that MHCs reduce recidivism" (Goodale et al., 2013, p. 298).

2. 'What works'?

In the 1970s, Martinson (1974) conducted what was then the largest ever meta-analysis of offender rehabilitation studies. Notoriously, Martinson's disheartening conclusion was that 'nothing works'. He reported that "[w]ith few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism" (p. 25). Martinson opined that rehabilitation programs failed because they were underpinned by a theory that characterized criminality as a disease, the cure for which could be forced onto unwilling offenders (p. 49).

Martinson (1979) subsequently recanted, but his study (and the 'nothing works' movement it spawned) remains a cogent reminder that rehabilitative initiatives must be based on more than good intentions and expert intuition. Experts now agree that rehabilitative programs can indeed reduce recidivism, but programs must be founded on evidence-based models of offender rehabilitation (Birgden, 2002, p. 180; Ogloff & Davis, 2004, p. 230; Skeem, Manchuk, & Peterson, 2011, p. 121; Thomas, 2010, p. 63).

Section 2 examines the scientific framework within which MHC services are delivered. It is argued that MHC performance will be optimized if the MHC uses evidence-based practices. Section 2.1 discusses the importance of both treatment and psychosocial supports to the recovery of offenders with mental disorders. Section 2.2 argues that those services should be delivered within a coherently designed programmatic framework and that MHC judges should have a general understanding of the rehabilitative theories underlying that framework.

2.1. Treatment and psychosocial supports — are both necessary?

Since Martinson's time, forensic psychology and offender rehabilitation programs have become more sophisticated. However, according to some, despite the well-understood over-representation of people with mental disorders among offender populations (Fazel & Danesh, 2002; Ogloff et al., 2006; Steadman et al., 2009), targeted rehabilitation programs for this cohort are still too few, conceptually under-developed, poorly implemented and generally under-evaluated (Blackburn, 2004, p. 297; Morgan et al., 2011, p. 14).

There have been, however, a number of studies that indicate that community-based programs for offenders with mental disorders can be effective at reducing recidivism. If the crime-as-disease model is flawed, then, *ex hypothesi*, more is needed than treatment interventions alone.

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