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Are mental health courts target efficient?

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1. Introduction to mental health courts

Since 1997, with the start of the first mental health court in Broward County, Florida, mental health courts have experienced unprecedented growth, with over 300 courts now operating in nearly all states (Strong, Rantala, & Kyckelhahn, 2016). This pattern of growth characterizes problem-solving courts in general which, over the past two decades, have grown in volume and type (including specialized courts for drug abuse, domestic violence, homelessness, juveniles with mental health problems, reentry, Veterans) (Strong et al., 2016). In practice, the "problem-solving" movement is an attempt to migrate certain problems present among offenders in the traditional criminal court system into an alternative court system that uses a different kind of processing approach; one where the emphasis is on healing, helping, and recovery through therapeutic intervention (Casey & Rottman, 2003).

The underlying presumption of the problem-solving movement is: there are special problems among offender groups that can be identified and more effectively and efficiently solved through treatment than punishment. Problem-solving courts, in effect, create a diversionary pathway to treatment in an effort to solve (not manage) problems among offenders that manifest as socially or criminally unacceptable behaviors (e.g., drug use, nuisance crimes, shoplifting). Advocates of this approach invoke the precepts of therapeutic jurisprudence (Winick, 1997). Here there is conceptual recognition that the law in its application (e.g., legal rules, procedures, roles of judges and lawyers) can have therapeutic and anti-therapeutic consequences. It is argued that how the law is exercised through legal proceedings has the potential to improve psychological wellness of the offender and/or cause unintended and unnecessary harm. As such, while preserving and adhering to principles of due process, efforts should be advanced to apply the law in ways that consider in the balance the intrinsic worth and psychological wellness of the individual, independent of the offending behavior.

Based on this reasoning, millions of federal and state dollars have been earmarked to support the unique structure of these courts, which includes a specialized docket, a collaborative, non-adversarial team inclusive of a judge, prosecuting attorney, defense attorney, and specialized case manager; an established connection with the treatment system; and some form of compliance monitoring (Wolff, 2003). These funding allocations were based on a belief that treating specific problems (e.g., mental illness) therapeutically would improve public safety by lowering rates of recidivism, while also reducing cases from traditional court dockets, jail overcrowding, and judicial budgets. Investing in innovation on speculation, however, has its risks. Indeed, after 30 years of experimentation with problem-solving courts, their return on investment remains largely unknown (Honegger, 2015; Quinn, 2009; Sarteschi, Vaughn, & Kim, 2011).

2. Research on mental health courts

2.1. Evidence on effectiveness

Most of the research on problem-solving courts has focused on: do these courts work? For mental health courts, the research has grown substantially but, as a body of evidence, it is far from compelling. In a recent meta-analysis, the majority of the 20 studies with a comparison group reported a positive and statistically significant reduction in recidivism (Anestis & Carbonell, 2014; Honegger, 2015). Yet the evidence is inconsistent regarding whether mental health courts improve access to behavioral health services or psychiatric function (Honegger, 2015). More generally, there is an absence of evidence suggesting that treatments for offenders with mental illnesses that address clinical conditions reduce recidivism (Martin, Dorken, Wamboldt, & Wooten, 2012; Morgan, Flora, Kroner, Mills, & Steffan, 2012). If access to behavioral health services or psychiatric symptoms is not substantively enhanced through these courts, then how do mental health courts achieve the favorable recidivism outcome? Answering this question is challenging because most of the effectiveness research lacks a conceptual model that (a) is neutral to criminalization hypothesis (i.e., that mental illness causes criminal behavior) (Abramson, 1972; Soros Foundation, 1996; Torrey, 1995); (b) guides the research design in terms of identifying and measuring a set of potential individual, court, and contextual factors that may mitigate or mediate the effect of the intervention; (c) standardizes and distinguishes among process variables, impacts, and outcomes; and (4) controls for confounding exogenous or endogenous change over the observation period (Wolff & Pogorzelski, 2005).

The lack of a demonstrable connection between treatment and recidivism has led some to posit that the functionality of mental health

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courts may be constrained by the availability of evidence-based treatment (Honegger, 2015; Sarteschi et al., 2011) and if there was access to evidence-based treatment, the connection might be validated (Boothroyd, Mercado, Poythress, Christy, & Petrila, 2005.). Others, however, have argued that instead of searching for evidence in support of the criminalization hypothesis, the research effort should change course and test the normalization hypothesis: offenders with mental illness are "normal" in their criminal behavior insofar as the same criminogenic risk factors that motivate offenders without mental illness also motivate those with mental illness (Skeem, Manchak, & Peterson, 2011). Emphasis on criminogenic risk factors as the cause of criminal behavior for the preponderance of people with mental illness, while not new (Draine, Salzer, Culhane, & Hadley, 2002; Fisher, Silver, & Wolff, 2006; Wolff, 2002) is gaining support. According to Skeem et al. (2011), interventions, like mental health courts, that "focus on psychiatric services may poorly match the policy goal of reducing recidivism" (p.110).

Research on mental health courts is at a crossroads and will likely splinter according to hypothesis adherence. One line of research, guided by the criminalization hypothesis, will continue its effort to validate the intervention by strengthening the mental health court's connection to evidence-based treatment. This research will likely show that for some court participants whose criminal behavior is the result of psychiatric symptoms, estimated at approximately 10% of the population (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014), symptom improvement may reduce recidivism. However the protective effect of treatment is likely to be selective and weak. This prognosis reflects the research on evidence-based community-based treatments, such assertive community treatment, which, while reducing psychiatric symptoms, have not prevented criminal justice encounters (Calsyn, Yonder, Lemming, Morse, & Klinkenberg, 2005; Clark, Ricketts, & McHugo, 1999; Essock et al., 2006; Wolff, Diamond, & Helminiak, 1997). Even without proving that treatment per se causes the reduction in recidivism, the evidence will be used to demonstrate the utility (i.e., reduced recidivism) of mental health courts to yield (potential) cost savings.

2.2. Evidence on cost savings

Mental health courts are expected to yield cost savings by substituting lower cost treatment for higher cost criminal justice episodes. The evidence on the cost saving of mental health courts is thin and mixed. Of the three studies, two studies found higher treatment costs offset reductions in criminal justice costs (Ridgely, Engberg, & Greenberg, 2007; Steadman et al., 2014), although average cost savings were detected when the study period was extended to two years of mental health court participation (Ridgely et al., 2007). A more recent study conducted by Kubiak, Roddy, Comartin, and Tillander (2015) estimated a cost saving of $1.4 million for mental health court participants in the 12-months post-MHC follow-up period.

What this cost saving evidence does not address is whether the actual costs of the mental health court (e.g., judicial and prosecutor time and effort, administrative processing, case management) are offset in ways that yield real budgetary savings. The "cost saving" measured in these studies represent the opportunity cost of resources used but not actual budgetary costs avoided. Supply-side rigidities in the criminal justice and behavioral health systems (e.g., union contracts, jail capacity, employment stickiness) constrain adjustments to micro changes in demand. Moreover, whether taxpayers receive a *reasonable* rate of return on their investment in mental health courts is not clear in part because other possible investments that might achieve a similar or better yield are not considered in the analysis. Presenting absolute (economic) cost savings without considering the cost of the investment (mental health court processing and supervision) and alternative investment options results in policy reform that is biased towards "satisficing" (Simon, 1991, 1979). This form of decision-making uses evidence, according to Spinak (2009), to "settle for an outcome that falls within an acceptable zone rather than maximizing our options" (p.22).

2.3. Evidence on procedural justice

Instead of expending resources to validate the criminalization hypothesis, some researchers are arguing for innovation and research that pursue the normalization hypothesis (Skeem et al., 2011). At its core, these researchers embrace the evidence showing that clinical variables (e.g., psychiatric symptoms) are poor predictors, while criminogenic variables (e.g., procriminal attitudes, antisocial personality, history of anti-social behavior) are more reliable predictors of long-term recidivism (Andrews & Bonta, 2010; Andrews, Bonta, & Wormith, 2006; Bonta, Blais, & Wilson, 2014; Bonta, Law, & Hanson, 1998). Accordingly, to reduce criminal justice involvement of people with and without mental illness emphasis is placed on rehabilitation that objectively assesses level of *risk* (i.e., supervision and treatment intensity), criminogenic *need* (factors with a proven association with criminal behavior), and *responsivity* (stylizing interventions to learning abilities) (Andrews & Bonta, 2015). This conceptualization of criminal behavior and its reduction is not anti-treatment. Rather, it sees medical and behavioral health treatment for co-occurring medical and psychiatric problems as a complement, not a substitute for criminologically-informed rehabilitative treatment that focuses on criminogenic risks and needs. It follows from the risk-need-responsivity (RNR) model that offenders with the greatest criminogenic risks and clinical need would receive the most intensive supervision and rehabilitation and treatment resources. The Good Lives Model (GLM) similarly focuses on rehabilitation but emphasizes holistically assessing the internal and external obstacles that limit offenders from living a good life and intervening in ways that help offenders build and practice skills, attitudes, and behaviors that will eliminate constraining obstacles (Birgden, 2002; Ward & Brown, 2004).

Assuming normalization challenges the directed therapeutic reasoning underpinning mental health courts: untreated or inadequately managed symptoms of mental illness drive criminal behavior and appropriate treatment supervised by a healing-oriented court will reduce psychiatric symptoms and problem behaviors and improve public safety and health. Yet even without this therapeutic reasoning, mental health courts have been justified on grounds that they reduce the anti-therapeutic consequences associated with traditional court and criminal processing. Because arrest, detainment, and prosecution are stressful events, they are likely to exacerbate psychiatric distress (Earley, 2007; Haney, 2001; Human Rights Watch, 2003; Selzer, 2005). Moreover, depersonalized and authoritative court processing may cause further psychological harm (Stefan & Winick, 2005), whereas the more relational approach associated with mental health courts may reduce such anti-therapeutic effects (Stefan & Winick, 2005; Wolff et al., 2013).

A more relationally-sensitive or procedurally-just approach is a cornerstone of therapeutic jurisprudence (King, 2009; Porter, Rempel, & Mansky, 2010) and, hence, its offspring, problem-solving courts. Normatively, the non-adversarial team comprising the problem-solving court adheres to the value that people have intrinsic value and deserve to be treated with dignity and fairness (Perlin, 2013). Treating people with dignity and respect, while also giving them voice and validation, is expected to improve self-worth and enhance legitimacy and adherence (Lidz et al., 1995; Monahan et al., 1995). A recent meta-analysis identified procedural justice as a potential active ingredient of mental health courts (Sarteschi et al., 2011). More specifically, the judge's interactional or relational style may be systematically influencing the participant's engagement with the court and perhaps their more socially appropriate behavior.

Several studies have found that participants of mental health courts experience procedural justice not experienced in traditional courts