International Journal of Law and Psychiatry xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Exploring the relationship between criminogenic risk assessment and mental health court program completion

Natalie Bonfine *, Christian Ritter, Mark R. Munetz

Department of Psychiatry, Northeast Ohio Medical University, PO Box 95, Rootstown, OH 44272, USA

ARTICLE INFO

Available online xxxx

Keywords:
Mental health court
Criminogenic risk assessment
Clinical services

ABSTRACT

The two primary goals of mental health courts are to engage individuals with severe mental illness in the criminal justice system with clinical mental health services and to prevent future involvement with the criminal justice system. An important factor in helping to achieve both goals is to identify participants' level of clinical needs and criminogenic risk/needs. This study seeks to better understand how criminogenic risk affects outcomes in a mental health court. Specifically, we explore if high criminogenic risk is associated with failure to complete mental health court. Our subjects are participants of a municipal mental health court (MHC) who completed the Level of Services Inventory—Revised (LSI-R) upon entry to the program ($N = 146$). We used binary logistic regression to determine the association between termination from the program with the total LSI-R. Our findings suggest that, net of prior criminal history, time in the program and clinical services received, high criminogenic risk/need is associated with failure to complete mental health court. In addition to providing clinical services, our findings suggest the need for MHCs to include criminogenic risk assessment to identify criminogenic risk. For participants to succeed in MHCs, both their clinical and criminogenic needs should be addressed.

1. Introduction

Research on mental health courts (MHCs) shows promise that such programs are effective at meeting the needs of at least some of the participants served. Research has shown that MHCs are effective at reducing violent crimes (McNiel & Binder, 2007); reducing the severity of offenses (Moore & Hiday, 2006); increasing the time before a new charge (Hiday & Ray, 2010; Hiday, Wales & Ray, 2013; McNiel & Binder, 2007) and reducing the number and likelihood of arrests after completion of the program (Dirks-Linhorst & Linhorst, 2012; Herinckx, Swart, Ama, Dolezal, & King, 2005; Hiday & Ray, 2010; Hiday et al., 2013; McNiel & Binder, 2007; Moore & Hiday, 2006; Ray, Kubiak, Comartin, & Tillander, 2015; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011; Trupin & Richards, 2003). However, the limited amount of existing research that has compared criminal justice outcomes by completion status (i.e. completers or graduates, compared to non-completers or terminates) reports that MHCs have the best outcomes for those participants who successfully complete the program (Dirks-Linhorst & Linhorst, 2012; Herinckx et al., 2005; Hiday et al., 2013; Moore & Hiday, 2006; Ray et al., 2015).

Because those who successfully complete MHC are less likely to recidivate, and given that the reported rate of termination from MHC ranges from 9 to 60% (Burns, Hiday & Ray, 2013; Dirks-Linhorst, Kondrat, Linhorst, & Morani, 2013; Herinckx et al., 2005; Hiday et al., 2013; Hiday, Ray, & Wales, 2014; McNiel and Binder, 2007; Moore & Hiday, 2006; Redlich & Han, 2013), some research now seeks to better understand factors that influence the likelihood of graduation or termination. To our knowledge, however, only 7 studies have examined predictors of program completion status (Burns, et al., 2013; Dirks-Linhorst et al., 2013; Hiday et al., 2014; Ray & Dollar, 2013; Ray et al., 2015; Redlich et al., 2010; Redlich & Han, 2013). Such research finds that persistent non-compliance (i.e. failure to appear for MHC hearings; positive drug tests; missing treatment appointments; not taking medications) negatively affects the likelihood of graduation (Hiday et al., 2014; Redlich et al., 2010). Aspects of therapeutic jurisprudence are associated with graduation (Redlich & Han, 2013), while factors associated with termination include prior jail days (Burns et al., 2013) and the presenting offense (Dirks-Linhorst et al., 2013; Ray et al., 2015). Personal characteristics of MHC participants are also associated with termination, including history of substance abuse or substance abuse diagnoses (Burns et al., 2013; Dirks-Linhorst, et al., 2013), minority status (Dirks-Linhorst, et al., 2013; Hiday et al., 2014; Ray & Dollar, 2013) and being male (Dirks-Linhorst, et al., 2013; Ray & Dollar, 2013).

While research suggests that MHCs are effective at reducing recidivism, at least for graduates, additional research is needed in two areas to better understand those factors that contribute to participants' success or failure in the program. First, research is needed on criminogenic risk within MHCs. With the exception of examining past criminal behavior, the presenting offense and substance abuse (Burns et al., 2013; Dirks-Linhorst et al., 2013; Hiday et al., 2014), no study has examined the degree to which a participant's level of criminogenic risk, as

* Corresponding author. Tel.: +1 330 325 6182; fax: +1 330 325 5970.
E-mail address: nbonfine@neomed.edu (N. Bonfine).

http://dx.doi.org/10.1016/j.ijlp.2016.02.002
0160-2527/

measured by a standardized risk assessment tool, is a potential factor that may impact MHC completion.

A second needed area of research is in understanding how clinical services received during MHC impact program completion. Some studies suggest that MHC participants received fewer crisis services, more medication management, case management and outpatient services, and accessed community treatment more quickly than a comparison group (Keator, Callahan, Steadman, & Vesselinov, 2013; Luskin, 2013; Steadman et al., 2011), and received more services after enrolling in the program than before (Herinckx et al., 2005). Additional research is needed to better understand the array, intensity and duration of clinical services provided within MHCs, and the impact that such services have on participants' likelihood of success or failure with the program. This paper is an initial attempt to address these gaps in the literature by examining if areas of criminogenic risk are associated with program completion status, and if clinical services received during MHC affect this potential relationship.

1.1. Mental health courts and the criminalization hypothesis

MHCs and other jail diversion programs were developed with the goals of connecting individuals to an effective mental health treatment system to prevent future involvement with the criminal justice system (Epperson et al., 2011; Epperson et al., 2014; Goodale, Callahan & Steadman, 2013; Munetz & Griffin, 2006; Munetz, Griffin & Kemp, 2013; Rotter & Carr, 2011; Wolff et al., 2013). MHCs, as originally conceived, are grounded in the assumptions of the criminalization hypothesis which states that people with mental illness become involved with the criminal justice system because of criminal behavior stemming from symptomatic mental illness. This result is viewed as a failure of the mental health system to engage at risk individuals (Fisher, Silver & Wolff, 2006; Lamb & Bachrach, 2001; Lamb & Weinberger, 2013). The criminalization hypothesis represents a shift in the mechanism of social control from the mental health system to the criminal justice system (Fisher et al., 2006; Lamb & Weinberger, 2013). For MHCs, the court system is used not only to resolve legal disputes but also to address mental illness that may be associated with recidivism (Winick, 2002). To the extent that the index crimes associated with entry to MHC are caused directly by symptoms, linkage with mental health treatment alone may deter future criminal justice involvement.

The criminalization hypothesis has recently been challenged. Recent studies suggest that only 4–18% of criminal behavior committed by individuals with serious mental illness resulted directly from symptomatic mental illness (Junginger, Claypoole, Laygo & Crisanti, 2006; Peterson, Skeem, Hart, Vidal, & Keith, 2010; Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014; Skeem, Manchak & Peterson, 2011). Other research suggests that criminal thinking is prevalent among individuals with severe mental illness who are in jails and prisons (Morgan, Fisher, Duan, Mandracchia, & Murray, 2010; Wilson, et al., 2014), and that common factors for offenders with and without mental illness contribute to recidivism (Bonta, Law & Hanson, 1998; Epperson et al., 2011; Epperson et al., 2014; Peterson et al., 2010). Central criminogenic factors include: criminal history, antisocial behavior, antisocial personality, antisocial cognition and antisocial associates, as well as substance abuse, family or marital conflict, low levels of education or unemployment, and a lack of appropriate recreational activities (Andrews & Bonta, 2010; Andrews, Bonta & Hoge, 1990; Gendreau, Little & Goggin, 1996; Rice & Harris, 1992).

As offenders with mental illness tend to share the same central criminogenic risk factors as non-mentally ill offenders, it is important to not overlook the influence that criminogenic risk may have on MHC completion. Prior criminal history is static and cannot change, but other criminogenic risk factors, such as antisocial behavior or criminal thinking, are mutable, or dynamic, and interventions may reduce recidivism risk. Increasingly, mental health and criminal justice professionals are implementing targeted interventions to address dynamic factors that relate to an individual's risk of recidivating (Epperson et al., 2011; Heilbrun et al., 2011; Wolff et al., 2013).

1.2. Conceptualizing criminogenic risk within mental health courts

One common approach to conceptualizing criminogenic risk is the risk–need–responsivity (R–N–R) model (Andrews & Bonta, 2010; Andrews, Bonta, et al., 1990; Andrews, Zinger et al., 1990). In this model, the risk principle emphasizes identifying risk factors for recidivating and appropriately matching intensity of supervision services with the intensity of the risk (Andrews & Bonta, 2010; Guastaferro, 2012; Osher, D'Amora, Plotkin, Jarrett, & Eggleston, 2012). Ideally this intensive supervision would integrate clinical mental health services with interventions to address dynamic criminogenic risk factors (Aos, Miller & Drake, 2006; Osher et al., 2012). The needs principle suggests that those factors that contribute to the likelihood of reoffending must be addressed, and responsivity factors are those that impact receptiveness to supervision and treatment (e.g. mental illness) (Heilbrun et al., 2011; Osher et al., 2012).

A focus on criminogenic risk factors is not a new one for criminal justice professionals, yet it represents a paradigm shift for mental health professionals (Bonta et al., 1998; Gendreau et al., 1996). Criminal justice professionals primarily adopt a public safety approach and the foremost concern is reducing criminal activity. Mental health professionals have primarily a public health approach and focus on reducing impairment and potential harm to self or others (Osher et al., 2012). Their goal is not to prevent future crime but rather to stabilize individuals, prevent relapse and promote recovery. Most mental health professionals have either not been trained to assess the risk of reentering the criminal justice system or incorporate treatment programs that address such risk, or lack confidence in their ability to reduce criminal risk (Osher et al., 2012; Wolff et al., 2013). Clinical treatment itself may decrease symptoms and improve quality of life, but if it does not specifically address criminogenic risk factors it is unlikely to effectively reduce recidivism (Epperson et al., 2014; Ferguson, Ogloff & Thomson, 2009; Goodale et al., 2013). Unfortunately, such approaches may need to be adapted for people with severe mental illness, and widespread implementation is lacking (Edgely, 2014).

The process of assessing criminogenic risk has evolved from an examination based strictly on professional judgment and opinion to standard tools used to assess static and dynamic areas of criminogenic risk and guide service delivery (Andrews, Bonta & Wormith, 2006; Gendreau, et al., 1996). The Level of Services Inventory—Revised (LSI-R) is a widely used criminogenic risk/need classification instrument with demonstrated reliability and validity (Andrews & Bonta, 2000; Bonta, 2002; Holsinger, Lowenkamp & Latessa, 2006). The LSI-R is not designed to guide delivery of services as the revised Level of Service/Case Management Inventory (LS/CMI), does. However, the LSI-R does provide a score of criminogenic risk in comparable areas to the LS/CMI (e.g. companions, alcohol/drug problems) and has predictive validity for recidivism (Ferguson et al., 2009; Holsinger et al., 2006).

The LSI-R assesses ten domains and provides a composite score of criminogenic risk/need (Andrews & Bonta, 2000). The LSI-R assesses static and dynamic factors, suggesting that there is potential for the LSI-R to be used to identify criminogenic risk/needs and to guide service delivery within MHCs. The extent to which this is done is unknown, and it is beyond the scope of this paper to assess criminogenic risk assessment practices across MHCs. However, this study is among the first to examine whether criminogenic risk is associated with success or failure in MHC.

The purpose of this study is to explore the effects of criminogenic risk and the clinical services received during MHC on termination from the program. Our research questions are: 1) Is high criminogenic risk associated with termination from MHC? 2) Are clinical services received associated with termination from MHC? and 3) How do clinical

Please cite this article as: Bonfine, N., et al., Exploring the relationship between criminogenic risk assessment and mental health court program completion, *International Journal of Law and Psychiatry* (2016), http://dx.doi.org/10.1016/j.ijlp.2016.02.002