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The impact of judge–defendant communication on mental health court outcomes

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ABSTRACT

Previous research has shown that mental health courts have been successful in reducing the rates of recidivism among mentally ill offenders. However, none of these studies, to date, have examined exactly what aspects of the courts reduce these rates of recidivism and what makes them successful. The current study utilized a sample of 291 mentally ill criminal offenders participating in a mental health court to examine whether those participants who were addressed by and communicated with the judge had a reduction in recidivism rates and the severity of new charges in comparison to those who did not. The hypotheses regarding greater judge–defendant communication and recidivism were not supported. This suggests that communication in and of itself is not sufficient to reduce recidivism. Future research of a qualitative nature is essential to identify if the frequency, tone, and valence of the communication results in improved outcomes. In addition, these results may indicate a necessity for more stringent training and guidelines for the maintenance of Mental Health Courts. Results of the current study suggested differences between genders, such that females were spoken to by the judge more frequently than were men.

1. Introduction

Over 30% of female and 14% of male jail inmates have a mental illness (Steadman, Osher, Robbins, Case, & Samuels, 2009). Many mentally ill defendants are arrested as a direct result of his or her mental illness (Bernstein & Seltzer, 2003; Council of State Governments, 2002). Research indicates that police often arrest mentally ill individuals because they believe it may lead to reduced homelessness and better access to treatment (Seltzer, 2005; Thompson, Reuland, & Souweine, 2003). However, Watson, Ottati, Draine, and Morabito (2011) recently reported that in jurisdictions with a large number of police officers with mental health training (Crisis Intervention Team; CIT), more mentally ill offenders are referred for treatment than to the criminal justice system (Watson et al., 2011). Of those offenders who are convicted, mentally ill inmates serve sentences, on average, between 12 and 15 months longer than other inmates without mental illnesses (Ditton, 1999; Stefan & Winick, 2005). Furthermore, research indicates higher rates of recidivism among mentally ill offenders than criminal offenders without a mental illness (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009; Belcher, 1988; Ditton, 1999). In 1997, specialty courts, called mental health courts, were developed to try to reduce these inflated recidivism rates by matching the needs of mentally ill offenders with treatment services (Steadman, Davidson, & Brown, 2001; Stefan & Winick, 2005).

It has been hypothesized that the implementation of mental health courts can break the cycle of mentally ill criminal offenders being arrested and rearrested in part by providing mental health treatment (Bernstein & Seltzer, 2003; Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003; Stefan & Winick, 2005). The primary purpose of these courts is to reduce rates of recidivism, which is significantly different from the traditional adversarial system of criminal justice. However, based on the current literature, it is difficult to determine what aspects of these courts have an impact on recidivism.

1.1. Characteristics of mental health courts

The primary goal of mental health court is to divert the mentally ill offender out of the legal system and into treatment, in the hopes that this will reduce recidivism rates among this population. This treatment focus is different from the traditional adversarial system of criminal justice, in that the primary goal is not to prosecute the offender but to provide him or her with mental health services and hold him or her accountable for his/her compliance with treatment (Bernstein & Seltzer, 2003; Cosden et al., 2003; Stefan & Winick, 2005). "Mental health court is an alternative to the criminal justice system that many with mental illness may find more desirable than typical criminal processing of their minor (or even more serious) offenses" (Stefan & Winick, 2005, p. 511). This alternative is also beneficial for the court system as defendants with mental illnesses often require more of the judge's time than can be offered in traditional court proceedings (Thompson et al., 2003). However, additional time with the judge may not be sufficient assistance for these individuals.

Despite the fact that there is no single model for mental health courts, there are several similarities that often exist among these courts. Mental health courts have one docket with a single judge presiding,

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often the judge, prosecutor, and defense attorneys have received training in mental health issues, and the courts will only take defendants with a documented mental illness or developmental disability (Bernstein & Seltzer, 2003; Thompson et al., 2003). Mental health courts order participants to engage actively in community mental health treatment (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). Many mental health courts require a guilty or "nolo contendere" plea as a term of participation in the court (Bernstein & Seltzer, 2003). Individuals have the right to opt-out of mental health court and be transferred to the regular trial division where they could accept a plea bargain or have a trial by jury. However, Redlich, Hoover, Summers, and Steadman (2010) reported that defendants are not always aware of this right. These researchers studied two mental health courts to determine if defendants knew of the voluntary nature of the court and results indicated that over half of the defendants reported they had not been made aware of the voluntary nature of the court and did not know that they could opt-out of the court at any time. This calls into question the level of communication and understanding between defendants and the court. Individuals in mental health courts often have adjudication withheld and at the conclusion of their time in mental health court, many defendants may have their charges dropped or their sentences deferred if s/he has fully complied with the treatments recommended by the judge (Watson, Hanrahan, Luchins, & Lurigio, 2001).

One way that mental health courts differ from traditional courts is an individual in mental health court will have numerous hearings spanning over the course of his/her participation. These hearings are used to determine the best treatment options for the defendant, to check on the defendant's competency, and to ensure progress is being made and maintained. While numerous hearings are beneficial in determining best treatment options and check on progress, they can substantially increase the length of time a defendant has to be supervised by a court. A study by Redlich, Liu, Steadman, Callahan, and Robbins (2012) compared defendants in mental health courts to a sample of mentally ill, treatment as usual, defendants in traditional criminal courts to study the length of time between the instant offense arrest date and the date of adjudication or case diversion. Findings from this study indicated that the defendants enrolled in mental health court were retained in the court, on average, for 70 days, while defendants with a mental illness in traditional criminal courts were adjudicated in just 37 days. This led the authors to conclude that diversion is not always "swift" in mental health courts. Some courts also employ the use of sanctions for defendants who have a difficult time complying with the court's terms. Sanctions can include jail time, house-arrests, or fines which may hinder the therapeutic nature of the court.

1.2. Mental health courts and recidivism

Mental health courts have been shown to reduce the number of new crimes committed, reduce psychological and legal distress, reduce the number of days spent in jail, and improve quality of life (Cosden et al., 2003; Frailing, 2010; Herinckx, Swart, Ama, Dolezal, & King, 2005; McNiel & Binder, 2007; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011). In addition to helping the offender, mental health courts have the potential to provide protection for the community by treating mentally ill offenders (Bernstein & Seltzer, 2003). It has also been reported that, in addition to reducing new arrests, mental health courts also decrease the severity of new arrests of those participating in the court (Moore & Hiday, 2006; Steadman, Redlich, Griffin, Petrila, & Monahan, 2005).

Mentally ill criminal offenders who participate in mental health court have reported improvements in their drug problems, life satisfaction, independent functioning, and psychological distress; more so than a treatment as usual comparison group (Cosden et al., 2003). The average number of arrests of those who participate in mental health court is substantially lower and there is a reduction in the number of violations of probation (Herinckx et al., 2005).

A multisite study by Steadman et al. (2011) examined four mental health courts to determine the effect the courts had on recidivism rates in the 18 months following enrollment in the court. Results from this study indicated that defendants who were enrolled in mental health courts had lower arrest rates, had fewer arrests, and were incarcerated for fewer days than those in the treatment as usual group, 18 months following enrollment. In this study, defendants with fewer numbers of arrests prior to enrollment in mental health court, defendants with a diagnosis of bipolar disorder, and defendants who did not use illicit substances were shown to have better outcomes in the mental health court.

When compared to a treatment as usual group, defendants in mental health courts have been shown to be less likely to be convicted of new crimes but more likely to receive sanctions for violations of probation (Cosden et al., 2003). Cosden et al. explained that this finding could be due to the increased scrutiny of defendants in mental health court and the use of jail time as a therapeutic sanction. McNiel and Binder (2007) found that those defendants who participated in mental health court went longer without incurring new charges than those defendants who did not participate. Additionally, survival analysis indicated that these results became more robust over time. A similar study by Hiday and Ray (2010) examined 99 mental health court defendants in North Carolina. In the two years following the completion of the court, both the number of defendants re-arrested and the number of new crimes committed were significantly lower than the two years preceding enrollment in the court. These findings also applied to defendants who had not successfully completed the court, suggesting that even non-completion exposure to the court was effective at reducing recidivism rates in this population.

Another study by Steadman et al. (2005) has shown that while defendants who participated in mental health court were arrested more often for technical probation violations, those who were eligible, but did not participate in mental health court, were likely to be arrested for more serious crimes. Again, this finding may be explained by the increased amount of scrutiny in mental health court in that defendants in mental health court are seen much more frequently than those in traditional court proceedings and are continuously monitored by members of their treatment team. In addition to reducing recidivism, participants of mental health court experience a decrease in the number of days spent on inpatient treatment units and fewer hours of crisis management (Frailing, 2010; Herinckx et al., 2005). Having regular contact with mental health professionals could reduce the need for crisis stabilization inpatient treatment.

1.3. Treating defendants with dignity and respect

Ronner (2002) reported that the legal system has a therapeutic effect when defendants believe they are being treated with dignity, fairness, and respect. Ronner (2002) further states that "the three Vs," that is empowering defendants to have a voice, to feel validated, and that their participation is voluntary, are core components of this therapeutic effect (p. 94). Tyler (2000) also reported that conflict resolution is most successful when individuals are treated with dignity and respect by authority figures. Additionally, people who are allowed to participate in such resolutions and provide suggestions report feeling more fairly treated (Tyler, 2000). This conflict resolution work can likely be easily translated to individuals involved in the criminal justice system. Mental health courts generally operate under the principle of treating defendants with mental disorders with respect and dignity, something that is perhaps missing from traditional court proceedings (Stefan & Winick, 2005). Specifically, there are elements of mental health courts that are believed to act as therapeutic agents in their own right, such as the non-adversarial atmosphere, the relationship between the judge and defendant, and the use of sanctions and treatment referrals. Having a "voice" may not be enough to constitute a therapeutic effect