



# Cost analysis of long-term outcomes of an urban mental health court



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## ABSTRACT

Multiple studies have demonstrated decreased recidivism and increased treatment engagement for individuals with serious mental illness involved in Mental Health Courts (MHC). However, the limited availability of social and fiscal resources requires an analysis of the relationship between a program's effectiveness and its costs. Outcome costs associated with a sample of 105 participants discharged for more than 1 year – and grouped by completion status – were compared to an eligible sample not enrolled ( $n = 45$ ). Transactional costs analysis (TCA) was used to calculate outcomes associated with treatment, arrest, and confinement in the 12-month post-MHC. Total outcome costs for the Successful Group (\$16,964) significantly differed from the Unsuccessful (\$32,258) and Compare Groups (\$39,870). Costs associated with the higher number of arrests for those in the Compare Group created the largest differences. Total cost savings between Successful and Compare ( $M = \$22,906$ ) equated to \$916,240 and savings between Unsuccessful and Compare ( $M = \$7612$ ) were \$494,708. The total combined cost savings for participants in the 12-month post-MHC period was \$1,411,020. While it is important to understand that MHCs and the individuals that they serve vary and these results are for a felony-level court, policy makers and researchers can use these results to guide their decision-making.

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The number of people with serious mental illness (SMI) in jails ranges from six to 36% (Abram, Teplin, & McClelland, 2003; Kubiak, Beeble, & Bybee, 2012; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, Abram, & McClelland, 1996; Trestman, Ford, Zhang, & Wiesbrock, 2007). As one potential solution to this social problem, local jurisdictions have implemented various diversionary programs in which offenders with a mental illness are given an opportunity to substitute prosecution and incarceration for mandatory prescribed treatments. The mental health court (MHC) is an example of a post-booking diversion program that utilizes treatment and services available in a given community to decrease confinement and stem the frequency of mentally ill offenders' contacts with the criminal justice system. MHC are a type of problem-solving court (also called specialty courts or therapeutic courts), which are an alternative to traditional criminal court processing (Bazelon Center for Mental Health Law, 2003; Goodale, Callahan, & Steadman, 2013).

The explicit goals of the MHC are to decrease incarceration, increase treatment continuity, and enhance functioning of individuals with mental illness (Bazelon Center for Mental Health Law, 2003; Goodale et al., 2013). However, the implicit goals of MHC are to decrease the financial burden and oppressive court dockets of the courts and criminal justice system. While numerous studies have pointed to positive outcomes in terms of reduced recidivism (Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005; Hiday, Wales, & Ray, 2013; McNeil & Binder, 2007; Moore & Hiday, 2006; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011) and increased mental health treatment (Boothroyd, Poythress, McGaha, & Petrila, 2003; Herinckx, Swart, Ama, Dolezal, & King, 2005), there has been little analysis of cost savings or costs avoided as a result of MHC interventions (i.e. Ridgely, Engberg, & Greenberg, 2007; Rossman et al., 2012). The criminal/legal involvement of persons with mental illness of multiple arrests, court processing, and possible incarcerations is costly. Moreover, inconsistent treatment utilization or medication maintenance may result in high-level mental health services such as psychiatric hospitalization, whereas routine and low-level services associated with MHC (i.e., case management, med reviews) might prevent instability and potentially save costs.

To date, there has been little information about costs and/or savings attributable to MHC. However, limited availability of

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resources requires an analysis of the relationship between a program's effectiveness and its costs. Although there is some evidence that drug courts produce a cost savings (Carey & Finigan, 2004; Crumpton, Brekhus, Weller, & Finigan, 2004; Marchand, Waller, & Carey, 2006), there are few published cost analyses of MHC (Ridgely et al., 2007; Rossman et al., 2012). Moreover, cost analyses of problem-solving courts are generally conducted when the participant remains active in the program and under intense court supervision, so that the impacts on future expenditures are not quantified, leading toward an underestimate bias. This study examines a MHC in an urban Midwestern city, in operation since 2009, which focuses on individuals with SMI who have been convicted of felony offenses. Our primary interest in this study is the long-term effects of MHC, rather than the specific treatment or service costs attributable to the operation of the court. Many researchers (including the authors – see Online Appendix) have examined program costs and intermediate outcomes of MHC, however, very few have examined long term outcomes (see Hiday & Ray, 2010 for a study of 2-year outcomes), and no one to the best of our knowledge has examined if cost savings are sustained during the post-MHC period. Therefore, we utilize a treatment and comparison group sample in the first year post-MHC involvement. As specialty courts, such as MHC, drug court, veterans' court, etc., expand across the country, it is important to determine if the implicit goal of cost effectiveness is met.

## 1. Background

The emergence of specialty courts is commonly associated with the first drug court in Dade County, Florida in 1989 (Goldkamp, 1999; Nolan, 2001). The court was established to treat addiction among defendants who had been arrested on drug-related charges and who had a history of substance abuse. Observers lauded the drug court for its innovation and success and the model was quickly emulated in other jurisdictions and used as a framework for developing other types of problem-solving courts. In 1997, Broward County, Florida, started the nation's first official MHC after a judge observed the county's number of misdemeanor cases involving mental illness growing and leading to overburdened court dockets and overcrowded jails (Petrila, Poythress, McGaha, & Boothroyd, 2001). The Broward County MHC modified the key components of the drug court model to fit mentally ill offenders. Similar experiences in other jurisdictions led to the creation of MHCs, and today there are more than 300 MHCs in operation across the United States (Council of State Governments, 2014).

Similar to drug courts, MHCs use a mix of coercion and compassion in a team approach. Typically, a judge, prosecution and defense attorneys, mental health practitioners, probation officers, and other experts collaborate to link defendants to treatment and services (Berman & Feinblatt, 2003). Participation in MHC is voluntary. Individuals can opt-out at any time and have their case sent back to traditional criminal court for processing if enrollment is pre-adjudication or serve their sentences if enrolled post-adjudication. Once enrolled, the treatment team regularly evaluates compliance with treatment, services, and court mandates for behavioral change. If a participant is continually non-compliant, the treatment team ejects him/her from the MHC process and returns him/her to traditional court or to serve the sentence.

Since the first MHC in the late 1990s, a number of studies have examined criminal justice outcomes and generally find that mental health participants, especially those who complete the process, have fewer arrests and jail days while under supervision and post-MHC exit (see review by Sarteschi, Vaughn, & Kim, 2011). While some of these studies have had comparison groups of defendants from traditional criminal court (Christy et al., 2005; Hiday et al., 2013; McNeil & Binder, 2007; Moore & Hiday, 2006; Steadman

et al., 2011), others have examined criminal justice outcomes before and after MHC participation by court completion status (Burns, Hiday, & Ray, 2013; Dirks-Linhorst & Linhorst, 2012; Frailing, 2010; Herinckx et al., 2005; Hiday & Ray, 2010; Palermo, 2010; Trupin & Richards, 2003).

Studies assessing the influence of MHC on treatment involvement suggest that utilization of treatment increases with participation in MHC. While this greater involvement may signal an increase in costs, the logic of continual versus intermittent engagement in mental health services would suggest a greater number of less costly "low-level" services that would prevent the more costly "high-level" services. Boothroyd and colleagues (2003) did find significant differences when comparing the proportion of 116 individuals engaged in treatment at pre- to post-MHC involvement (36% pre-compared to 53% post-compared). In addition, the study included a comparison group and found a greater number of high-level services (i.e., residential and emergency treatment) for them when compared to the MHC treatment group, even though service encounters increased overall for the MHC group. Examination of the effects of MHC on treatment engagement generally assesses the period of time surrounding the enrollment date (e.g., year before compared to the year after), rather than the influence of MHC involvement after discharge. For example, Herinckx and colleagues (2005) found that compared with the year prior to MHC, low-level services (i.e., case management, medication management, and outpatient treatment) significantly increased and high-level services (i.e., crisis intervention and in-patient hospitalization) significantly decreased in the year after enrollment.

### 1.1. Cost-benefit analysis

Assessing the positive impact of a program on a particular population is insufficient in determining its social value. Limited resources for social programs require an analysis of the relationship between a program's costs and its effectiveness. Efficiency assessments – or cost-benefit analyses – should be considered an extension, rather than an alternative, to impact evaluation, providing a frame of reference for relating costs to program results (Rossi, Lipsey & Freeman, 2004). Although these types of analyses have historically met with some opposition due to unfamiliarity with the assessment procedures and/or a reluctance to assign monetary values to social program outcomes (Eddy, 1992; Zerbe, 1998) many researchers and policy analysts have undertaken the task and buffered these criticisms by employing robust methodology and explicitly stating their assumptions (Nas, 1996; Yates, 1996).

Cost-benefit analysis produces measurements that allow for comparison of the total costs of a program versus its total benefits. Cost-benefit analysis is a method for examining if the program's social benefits exceed the social cost and whether that return can be anticipated with reasonable probability. A common strategy utilized to assign costs to highly detailed data associated with problem-solving courts is TCA or transaction cost analysis (Carey & Finigan, 2004). TCA is a subset of cost-benefit analysis; it considers total costs and compares those costs to the cost savings inherent in prevention. This approach accommodates the complex nature of specialty courts where participants interact with multiple publically funded agencies, utilizing resources, or participating in transactions (Carey, Finigan, Crumpton & Waller, 2006). Use of the TCA approach, as adapted by Carey and Finigan (2004), differs from a more traditional form of TCA because it carefully identifies the level of resources provided by each agency, including both indirect and direct costs, so all resources can be determined and calculated into overall costs (Carey & Finigan, 2004). Although economists are concerned with marginal costs and benefits, there

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