Mental Health Courts: Do they work?

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Introduction

- History
- Why were they created?
- What do they do?
- How well do they do it?
- What is the agent(s) of change, if any?
- Ethical issues in research in this field

History

- Problem-solving courts exist in various domains
  - Drug treatment courts
  - Mental health courts
  - Domestic violence courts
- The first Mental Health Court appeared in 1997, in Broward County Florida
- There are now more than 250 such courts in the US, and one in every jurisdiction in Ontario (but only one is full-time)

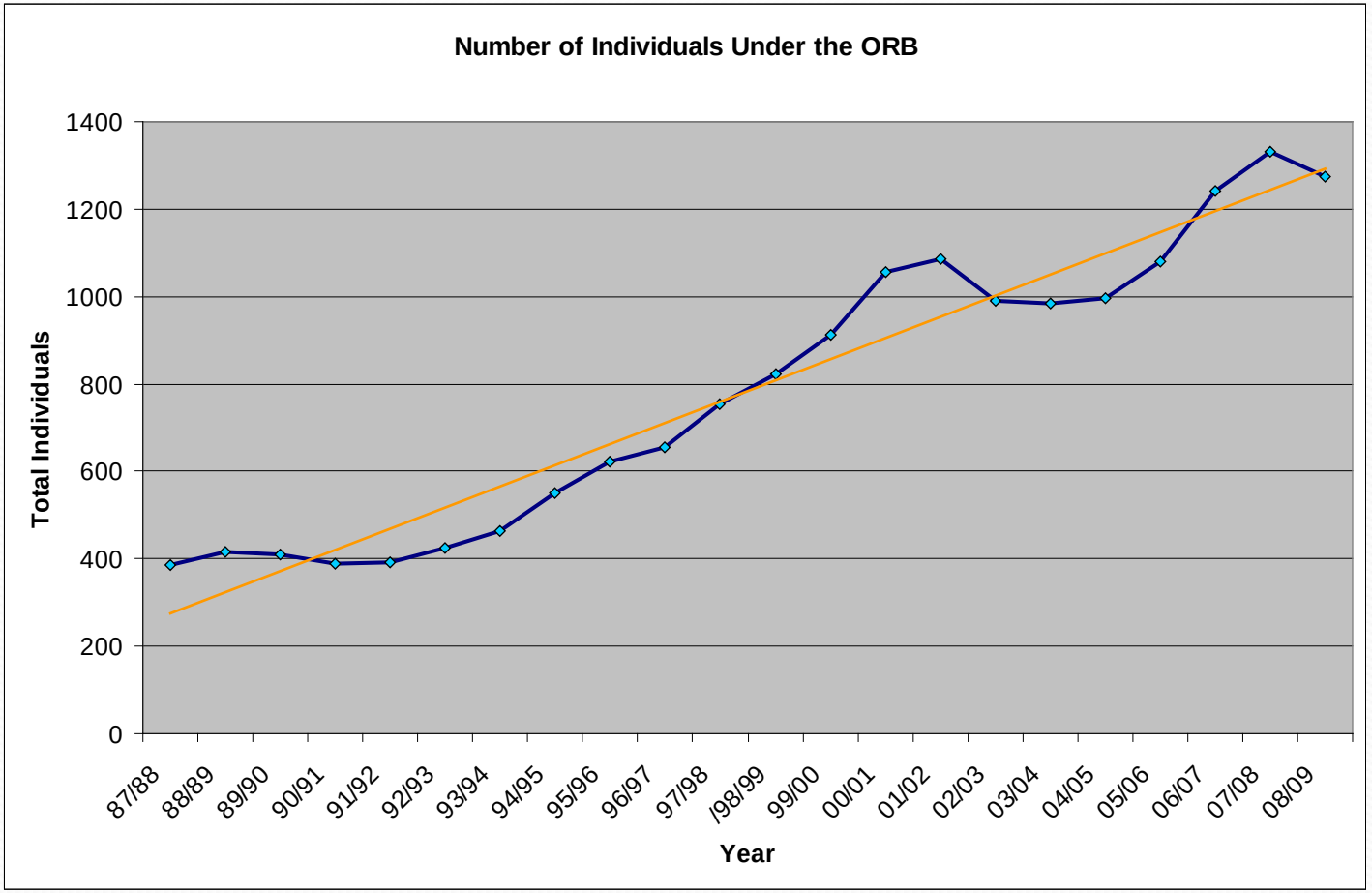
What is a Mental Health Court?

- A specialized court whose intention it is to move persons out of the criminal justice system, and into the community mental health system, without compromising public safety
- That being said, there are many variations on this theme
- Usually, the judge, Crown counsel, and defence counsel have a special interest in the area
- Mental health court support staff, and other health professionals, are key variables
- Part of post-booking diversion; others are jail-based, and regular court-based. There is also post-incarceration diversion

Why were they created?

- With de-institutionalization, the numbers of mentally ill persons in the criminal justice system increased
  - Now about 6% of the remand population (this figure is quite variable, depending on the definition of mental illness)
  - 2-3% of the general population
- General psychiatric services resist taking on treatment of offenders
- Hospitals are pushing for ever shorter LoS
- Contemporaneously, civil statutes became more libertarian
- Many are repeat offenders, who offend largely due to mental illness, and whose crimes are not grievous
- A general sense that these clients could and should return to mental health services in the community

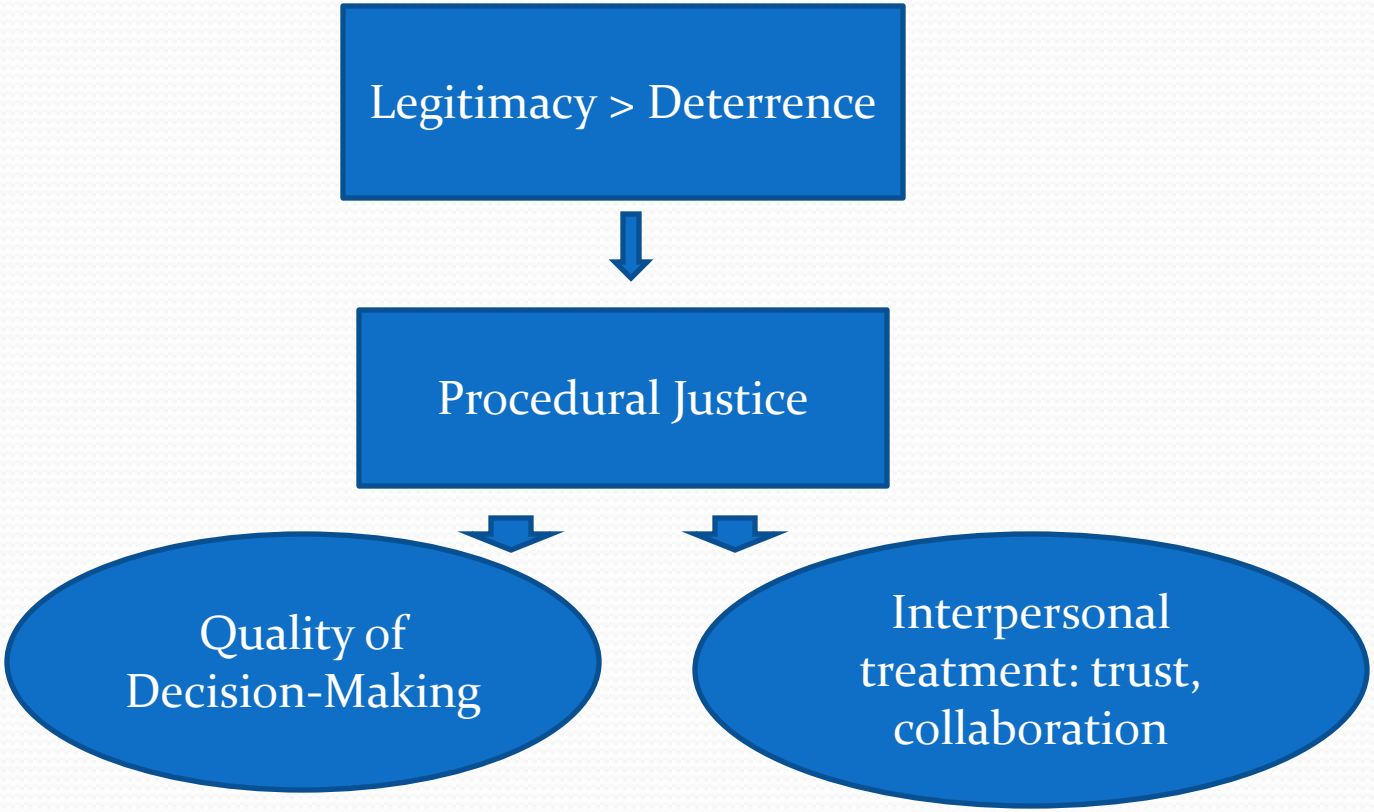
Forensic Patient Numbers in Ontario: Now over 1400



What do they do?

- Mental health courts differ from conventional courts in the following ways
  - The emphasis is on rehabilitative response/therapeutic jurisprudence, as opposed to general and specific deterrence
  - They thus offer individualized response
  - They are collaborative with the community
  - They seek to address the root cause of a person's offending
  - One team (Judge, Crown, defense counsel) manage all the cases, thus they are less adversarial
  - They are generally voluntary, and involve compliance with a treatment program (eg diversion)
  - The quality of outcome is related to the quality of community services; the programs are intended to increase service use.

What do they do?



Kenora-Rainy River MHC

- Forensic Psychiatric Services provide psychiatric assessments for individuals charged with a criminal offence(s) and/or convicted persons in the Kenora Rainy River Districts.
- The purpose of this service is to serve the Court, and the mental health needs of the client

Services Provided

- Consults for professionals working with individuals diagnosed or suspected as having a mental illness and/or cognitive impairments who are involved in the criminal justice system
- When appropriate the program will also provide psychiatric follow up for clients who have been previously assessed

Criteria for Referral

- Involvement with the Criminal Justice System (this also includes clients who have had a criminal history but are not currently charged with an offence)
- Individuals who are suspected of having or have been formally diagnosed with a major mental illness

Referrals

- Accepted from mental health & addictions professionals, officers of the Court (Judge, Crown, and defence), Probation & Parole, Kenora District Jail
- Referrals are made through the Mental Health Diversion Program
- Mental Health Diversion Worker identifies with the referring agent what type of assessment is warranted

Types of assessments

- Fitness to stand trial
- Criminal Responsibility
- Risk Assessment
- Sexological Assessment
- Diagnostic Assessment

All assessments highlight recommendations for treatment planning

Privileged Status

- When lawyers refer to the Forensic Psychiatry Program they are able to elect that the report requested is done on a ***PRIVELEGED*** basis
- When the client is cautioned at the beginning of the assessment the psychiatrist will inform the client that the assessment is ***ENTIRELY*** confidential and if the lawyer and client agree to release the report to other parties written consent from both the lawyer and the client is required

Key Partners

- CMHA, Kenora Branch: Sara Dias
- Ontario Court of Justice Judicial Officers: Judge Hoshizaki & Judge Fraser
- Crown Attorney: Will Scutt
- Defence Council: Greg Iwasiw and all other lawyers that have any cases that require mental health court intervention
- Kenora Courtoffice: Barb Brazao, Rolanda Peacock
- Kenora District Jail: Kathy Kinger
- Psychiatrists: Dr. Klassen, Dr. Pearce, Dr. McMaster
- Police
- All community agencies that offer support to individuals

How well do they do it?

- Available evidence suggests several domains of improvement over conventional courts, in this population
  - Higher levels of satisfaction/lower sense of coercion by accused persons
  - Less days in jail
  - Decreased recidivism
  - Decreased homelessness, substance abuse, increased level of function

Overview of outcome studies to 2011

- Boothroyd (2003, 2005)
  - Significant increase in service use, no decrease in symptomatology
- Christy (2005)
  - Similar number of arrests, but less violence, and fewer days in jail
- Ferguson (2008)
  - Fewer arrests, less substance use, better QoL, but no decrease in hospitalization
- Frailing (2010)
  - Fewer days in jail, fewer positive urine tests for substances
- Hiday and Ray (2010)
  - Fewer arrests
- Herinckx (2005)
  - More outpatients services, fewer inpatient days
- McNeil and Binder (2007)*
  - Reduced recidivism
- Moore and Hiday (2006)
  - Fewer arrests, less violent ofending
- Steadman (2010)
  - Arrests, days in jail halved
- Trupin (2001, 2003)
  - Inceased treatment utilization, decreased re-incarceration

Mental Health Court Effect

Lange et al, 2011

Recidivism	+++
Fewer days in jail	++
Improved mental health	++
Increased service use	+++
Reduced substance use	++
Increased QoL	+

MENTAL HEALTH COURT

TABLE 3. Average Effect of Mental Health Court Participation on the Probability of a New Charge for Criminal Defendants With Mental Disorders Participating in Mental Health Court or Receiving Treatment as Usual

	Probability of New Charge				Average Mental Health Court Effect				
	Mental Health Court Group		Treatment as Usual Group						
Months of Follow-Up	Mean	SD	Mean	SD	Average Effect[a]	SD	SE	t	95% CI[b]
Months after entry									
Any new charge									
6 months	0.23	0.19	0.30	0.13	−0.08	0.18	0.009	−8.11	−0.09 to −0.06
12 months	0.34	0.24	0.46	0.15	−0.12	0.21	0.004	−30.64	−0.13 to −0.11
18 months	0.42	0.26	0.57	0.15	−0.15	0.23	0.003	−55.34	−0.16 to −0.15
24 months	0.46	0.27	0.63	0.15	−0.17	0.23	0.003	−64.73	−0.17 to −0.16
New violent charge									
6 months	0.03	0.07	0.05	0.03	−0.02	0.07	0.001	−26.57	−0.02 to −0.02
12 months	0.04	0.10	0.08	0.04	−0.04	0.10	0.001	−36.60	−0.04 to −0.04
18 months	0.05	0.12	0.11	0.05	−0.06	0.12	0.001	−44.72	−0.06 to −0.06
24 months	0.07	0.15	0.17	0.08	−0.10	0.15	0.002	−58.08	−0.10 to −0.09
Months after graduation									
Any new charge									
6 months	0.26	0.35	0.34	0.13	−0.07	0.34	0.015	−4.80	−0.10 to 0.04
12 months	0.31	0.37	0.47	0.14	−0.16	0.35	0.006	−25.25	−0.17 to −0.15
18 months	0.34	0.38	0.56	0.15	−0.22	0.36	0.004	−49.98	−0.23 to −0.21
24 months	0.36	0.39	0.61	0.15	−0.25	0.36	0.004	−60.71	−0.26 to −0.24
New violent charge									
6 months	0.04	0.15	0.06	0.03	−0.02	0.15	0.002	−9.35	−0.02 to −0.01
12 months	0.05	0.18	0.10	0.05	−0.05	0.18	0.002	−21.85	−0.05 to −0.04
18 months	0.06	0.19	0.13	0.07	−0.07	0.20	0.002	−29.94	−0.07 to −0.06
24 months	0.07	0.20	0.15	0.08	−0.08	0.21	0.002	−35.66	−0.09 to −0.08

What is the agent(s) of change?

- Studies suggest the following
  - Quality of the leadership of the Presiding Judge
  - Dose effect (longer in the process is better)
  - Clients who graduate have better outcomes

What is the agent(s) of change?

Table 2
Intercorrelations of variables.

	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. Completion Status	.59***	−.35***	−.29***	−.01	.05	.16**	.07	−.03	−.09
2. Compliance		−.27***	−.27***	.03	.01	.20***	.05	−.06	−.15**
3. Judicial Supervision			.26***	.01	−.12**	−.17***	−.04	−.02	−.16***
4. No. of BWs Issued/Stayed				−.04	.04	−.12*	−.03	.10*	.02
5. Age					−.04	.00	.14***	−.05	.06
6. Female						.13***	−.04	.16***	.12*
7. White							.16***	.10*	.06
8. Education								.05	−.08
9. Most severe diagnosis (lower numbers = more severe)									.11*
10. Most serious target arrest (lower numbers = more severe)									

Notes. * $p<.05$; ** $p<.01$; *** $p<.001$.

Cosden et el, Beh. Sci. Law, 2005

(the only study to randomize)

Results: fewer charges, less substance use, better psychosocial functioning, but no difference days incarcerated

Table 3. Average number of bookings, convictions and jail days for participants in MHTC and TAU 24 months prior and 24 months after entering treatment

	MHTC		TAU	
	Mean	SD	Mean	SD
0–24 months prior to treatment				
Number of bookings	2.97	4.42	3.88	6.13
Number of convictions	1.84	2.19	2.32	2.54
Number of days in jail	39.44	62.87	47.30	71.86
0–24 months in treatment				
Number of bookings	5.33	6.14	3.89	5.12
Number of convictions	1.82	2.04	2.04	2.93
Number of days in jail	24.55	39.08	37.51	45.11

Cosden et el, Beh. Sci. Law, 2005

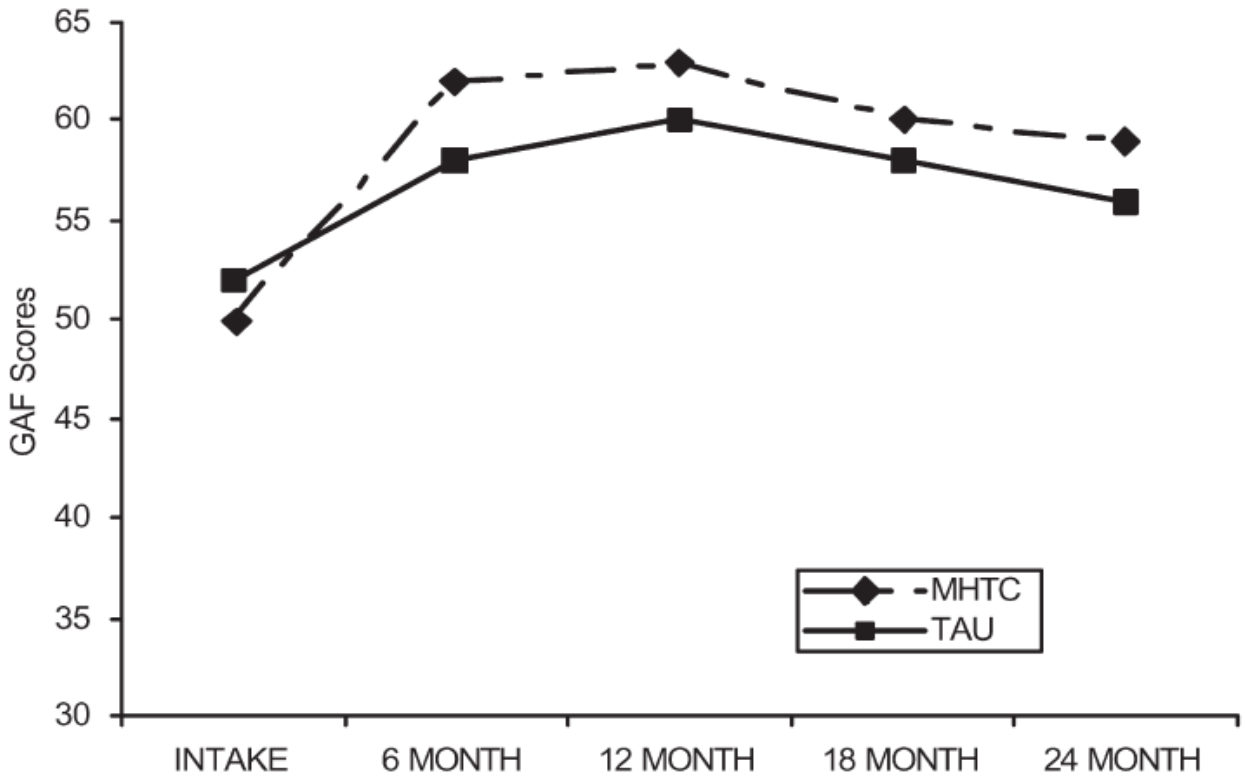


Figure 1. GAF scores over time for MHTC and TAU participants.

Steadman et al, 2011: 4 sites

Table 1. Characteristics of Study Subjects

Characteristics	No. (%)									
	SF		SC		MN		IN		Total	
	MHC (n=108)	TAU (n=146)	MHC (n=136)	TAU (n=198)	MHC (n=104)	TAU (n=144)	MHC (n=99)	TAU (n=112)	MHC (n=447)	TAU (n=600)
Female	30 (27.8)	37 (25.3)	61 (44.9)	77 (38.9)	48 (46.2)	33 (32.9)	48 (48.5)	74 (66.1)	187 (41.8)	221 (36.8)
Average age, mean (SD), y	37.5	39.8	38.1	34.7	38.1	38.0	36.3	34.0	37.5	36.6
Hispanic	8 (7.4)	20 (13.7)	37 (27.2)	81 (40.9)	2 (1.9)	1 (0.7)	0 (0.0)	0 (0.0)	47 (10.5)	102 (17.0)
White	42 (38.9)	66 (45.2)	103 (75.7)	147 (74.2)	54 (51.9)	56 (38.9)	54 (54.5)	84 (75.0)	253 (56.6)	353 (58.8)
Diagnosis										
Schizophrenia	61 (56.5)	31 (21.2)	44 (32.4)	46 (23.2)	37 (35.6)	22 (15.3)	38 (38.4)	20 (17.9)	180 (40.3)	119 (19.8)
Bipolar disorder	10 (9.3)	7 (4.8)	33 (24.3)	52 (26.3)	36 (34.6)	28 (19.4)	47 (47.5)	46 (41.1)	126 (28.2)	133 (22.2)
Depression	17 (15.7)	106 (72.6)	32 (23.5)	76 (38.4)	25 (24.0)	52 (36.1)	11 (11.1)	44 (39.3)	85 (19.0)	278 (46.3)
Other	20 (18.5)	2 (1.4)	27 (19.9)	24 (12.1)	6 (5.8)	24 (29.2)	3 (3.0)	2 (1.8)	56 (12.5)	70 (11.7)
Target crime										
Person	58 (53.7)	50 (34.2)	28 (20.6)	35 (17.7)	19 (18.3)	51 (35.4)	34 (34.3)	26 (23.2)	139 (31.1)	162 (27.0)
Property	28 (25.9)	41 (28.1)	28 (20.6)	64 (32.3)	52 (50.0)	40 (27.8)	32 (32.3)	42 (37.5)	140 (31.3)	187 (31.2)
Drug	21 (19.4)	46 (31.5)	72 (52.9)	73 (36.9)	8 (7.7)	16 (11.1)	13 (13.1)	12 (10.7)	114 (25.5)	147 (24.5)
Minor	1 (0.9)	9 (6.2)	8 (5.9)	26 (13.1)	25 (24.0)	37 (25.7)	20 (20.2)	32 (28.6)	54 (12.1)	104 (17.3)

Abbreviations: IN, Indianapolis; SC, Santa Clara; SF, San Francisco; MHC, mental health court; MN, Minneapolis; TAU, treatment as usual.

Steadman et al, 2011

Table 2. Annualized Arrests by Sample and Site

	MHC (n=447)			TAU (n=600)		
Sample	Pre–18-mo	Post–18-mo	Change, %	Pre–18-mo	Post–18-mo	Change, %
SF (n=254)	3.1	1.9	–39	2.7	2.5	–7
SC (n=334)	2.7	2.0	–26	3.6	2.9	–19
MN (n=248)	1.3	.6	–54	2.0	.9	–55
IN (n=211)	1.1	.6	–45	1.9	1.5	–17
Total, mean (SD) (n=1047)	2.1 (3.0)	1.3 (3.0)	–38	2.6 (6.1)	2.0 (8.8)	–23

Abbreviations: IN, Indianapolis; MHC, mental health court; MN, Minneapolis; SC, Santa Clara; SD, standard deviation; SF, San Francisco; TAU, treatment as usual.

Steadman et al, 2011

Table 3. Average Incarceration Days Before and After 18 Months

	MHC (n=447)			TAU (n=600)		
	Pre–18-mo	Post–18-mo	Change, %	Pre–18-mo	Post–18-mo	Change, %
SF (n=254)	128	149	+16	74	187	+243
SC (n=334)	110	113	+3	102	183	+79
MN (n=248)	21	41	+95	51	101	+98
IN (n=211)	17	12	−30	56	116	+107
Total (n=1047)	73	82	+12	74	152	+105

Abbreviations: IN, Indianapolis; SC, Santa Clara; SF, San Francisco; MHC, mental health court; MN, Minneapolis; TAU, treatment as usual.

Scientific and Ethical Issues

- Science: Data on mental health court outcomes is limited
  - There are few studies with comparison groups
  - Persons taken into mental health court/diversion tend to be lower risk
  - Follow up times tend to be short (1-2 years)
  - Only one study has used randomization
  - Outcomes are contingent not just on court function, but service availability and willingness
  - There is real variability between courts
  - Not clear who benefits most
  - Cost-benefit research is in it`s infancy
- Ethics: Is there a place for randomization in forensic milieux/with offenders?

Thanks you!

- Questions?