

Mental Health Courts

EVIDENCE BRIEF

Ninety-one percent of prisoners have been diagnosed with either a substance abuse or mental health disorder over their lifetime. International evidence concludes that Mental Health Courts (MHC) help to reduce offending. This approach works best for those that have committed more serious offences.

OVERVIEW

- New Zealand does not have MHCs.
- MHCs divert offenders who are experiencing mental illness away from typical court processing and sentencing into court-mandated and monitored community-based treatment.
- Most evaluations show a moderate association between MHC participation and reduced recidivism.
- However, given the wide variation in MHC design and that the amount of research is still limited, there remains uncertainty in how to best implement MHCs. As most of the studies are from the United States, care is needed in applying these findings to the New Zealand context.
- Indications are that more successful MHCs provide more tailored treatment and support, have good compliance monitoring, and deal with non-compliance more decisively.
- Better outcomes from participation in a MHC tend to occur with those who:
 - are older
 - have bipolar disorder (rather than schizophrenia or depression)
 - have committed serious offences but have few previous convictions
 - have experienced no or little previous treatment for their mental health difficulties.
- Mental illness is common amongst offenders processed through New Zealand's criminal justice system.
- MHCs are relatively expensive. If it was to be examined, an MHC might be best focused on diverting those that have committed serious offences from more expensive sentences into community-based treatment, where appropriate.

EVIDENCE BRIEF SUMMARY

Evidence rating:	Fair
Unit cost:	Unknown
Effect size (number needed to treat):	MHCs are estimated to reduce recidivism rates by 25 percentage points. For every 4 people who receive treatment, one fewer will reoffend.
Current justice sector spend:	-
Unmet demand:	Small to Moderate

DESCRIPTION OF MENTAL HEALTH COURTS

MHCs were established in the 1990s in the United States and Canada in response to the large number of people with mental illnesses being processed through the courts.

MHCs are characterised as problem-solving courts that focus on addressing the underlying drivers of offending by offenders who are mentally ill. Their primary aim is to reduce the likelihood of an individual's future involvement with the criminal justice system. This is done by diverting mentally ill offenders from typical court processing and sentencing into court-mandated and monitored community-based treatment.

MHCs in different countries share a number of elements:

- defendants are selected for a programme by a screening process against entry criteria (e.g., clinical criteria, guilty plea, etc)
- eligible defendants are given the option of participating in the mental health court
- a multidisciplinary team, typically made up of justice and mental health professionals, works with the court to develop a community-based programme for addressing the defendant's mental health and other needs (e.g. drug addiction)
- implementation of a wide range of services including medications, counselling, substance abuse treatment, financial benefits, housing, crisis intervention, peer supports, and case management
- community supervision which may be the responsibility of treatment providers, probation officers, mental health court personnel, or other criminal justice agencies
- progress is monitored through regular status hearings by a judge who may use a range of sanctions and incentives to encourage programme completion

- the programme is completed only when a participant meets a set of specified individualised criteria.

A large proportion of MHC participants have co-occurring substance abuse disorders. The most effective programmes provide coordinated treatment for both mental illnesses and substance abuse problems. Thus, MHC should connect participants with co-occurring disorders to integrated treatment approaches whenever possible.ⁱ

MHCs differ across jurisdictions in terms of eligibility criteria, compliance monitoring and how they sanction participants.

Some MHCs, for example, restrict eligibility to certain offence types and levels of seriousness, and will only accept people with treatable disorders.ⁱⁱ For example, approximately 75% of MHCs in the US handle felony cases (i.e., imprisonable for over a year), 20% handle violent felony cases and only 1% handle seriously violent felony cases.ⁱⁱⁱ Some courts require a guilty plea prior to entry, while others delay adjudication until the participant completes the programme or is removed from it.

There are now over 300 MHCs in operation in the United States across the adult and youth jurisdictions.^{iv}

Australian jurisdictions including Queensland, Tasmania, South Australia and Victoria have initiatives that share many MHC characteristics. These characteristics include multidisciplinary teams, treatment programmes and community monitoring. Approximately two-thirds of their clients have either mental illness or drug/alcohol dependency with more than 40% having both conditions.^v

ARE MENTAL HEALTH COURTS EFFECTIVE?

Do MHCs reduce reoffending?

There is still limited research on how MHCs reduce reoffending. The overall assessment is one of cautious optimism. The majority of evaluations show that MHC participation is associated with reduced recidivism.

The only one published meta-analysis of MHCs^{vi} examined the effectiveness of adult mental health courts in the United States.^{vii} Eighteen studies met criteria for inclusion in the meta-analysis, of which nine were categorised as high quality.

Findings from the meta-analysis indicated that mental health courts are moderately effective at reducing recidivism. It found an overall effect size equivalent to a reduction of reoffending from 50% to 25%.

These results parallel findings from narrative reviews^{viii}, and evaluations^{ix} completed since the meta-analysis.

Despite the overall positive assessment of MHCs, some individual evaluations have not found MHCs to reduce recidivism. In addition, some researchers have indicated that once the court supervision has finished, the positive impact of the MHC tends to decrease^x, but this point is contested.^{xi}

Methodological issues such as non-representative samples and poor selection of variables have undermined many of the earlier evaluations of MHCs. However, research that has employed more robust methodologies has also produced positive results.^{xii}

Early evaluations of Australian court mental health diversion initiatives, including Hobart's Mental Health Diversion List and the South Australian Magistrates Court Diversion

Programme, have found participation in the programmes to be associated with reduced reoffending. However, the generalisation of these findings is limited due to the small sample sizes used.^{xiii}

Recent analysis of the South Australian diversion programme found that the programme reduced the rate and severity of recidivism. Successful completion of the programme was the strongest predictor of not engaging in re-offending, followed by low frequency of pre-programme offending, female gender, and co-morbid substance use. Minor offenders were more likely to successfully complete the programme than those with more serious offences.^{xiv}

Do MHCs improve an individual's mental health?

The small number of studies that have sought to answer this question have found that MHC participation is associated with:

- a higher proportion of offenders with mental health needs accessing treatment services and
- improved social functioning.^{xv}

While some studies have found an association between MHC participation and reduced psychiatric symptoms, the evidence for this effect overall has been mixed, and remains ambiguous.^{xvi}

What makes mental health courts effective?

MHC participation is expected to reduce recidivism by linking offenders with mental health needs to treatment services, which reduces psychiatric symptoms, improves social functioning, and thereby reduces risks of reoffending. As stated in the previous section, there is some evidence that supports this broad hypothesis.

Some argue, however, that the link between mental illness and offending is not causal.

Another suggestion is that MHCs might work via the same processes as problem solving courts, which include^{xvii}

- coerced treatment - a growing research consensus suggests that this can be as effective as voluntary treatment
- increasing perceptions of fairness and legitimacy for the offender – in turn increasing their willingness to comply
- specific deterrence - making the consequences of non-compliance more certain and meaningful
- encouraging social learning - through positive reinforcement.

OTHER CONSIDERATIONS

Design considerations

Methodological shortcomings and variation in the design of MHCs across different studies have made it difficult to decide which approach to MHC design works best.

However, research has begun to identify what key factors make MHC successful:

- involvement of criminal justice, mental health, and community stakeholders
- adequate community treatment capacity
- screening that selects people most likely to benefit from participation in a MHC process
- clear terms of participation and informed choice
- linkages to services that can respond to the needs and risks of the courts' clientele
- appropriate information sharing
- a team of criminal justice and mental health staff that are appropriately trained
- good compliance monitoring
- data feedback to inform continuous improvement of the court's operation.^{xviii}

A recent study compared the features of poor and well-performing MHCs, and found that successful MHCs, in particular:

- offered more tailored treatment and support
- had better compliance monitoring
- clearly dealt with non-compliance (though not necessarily in the most severe way).^{xix}

These findings replicate other studies, particularly the observation of the need for well-tailored programmes.^{xx}

Context considerations

The criminal justice system and mental health service context in which MHCs operate also affect a MHC's outcomes.

In order to be successful, a MHC requires appropriate and effective services to be available to divert offenders to in the community.^{xxi}

Eligibility considerations

Different MHCs restrict eligibility to certain disorders, primarily disorders that are known to be treatable. Mental health conditions and their treatment needs vary substantially which may result in different MHC outcomes. For example, the evidence to date (although limited) suggests that people who are more likely to have the best outcomes from participation in MHCs include those with a diagnosis of bipolar disorder rather than schizophrenia or depression.^{xxii}

Other offender characteristics associated with better MHC outcomes include:

- a more serious offence
- less serious offending histories
- less severe mental health difficulties which do not require intensive mental health treatment on admission.^{xxiii}

A key area of debate is whether MHCs should also address substance abuse problems. MHCs appear to be less effective for people with substance abuse disorder.^{xxiv} This is a serious limitation as people with both substance abuse and mental health problems form a significant part of MHC participants.

To address this issue some MHCs were initiated to deal with drug-dependent offenders whose mental health problems made them particularly difficult to manage under the standard drug court process.

Cost-effectiveness

Even if MHCs are effective, that is not to say they are necessarily the most cost-effective response to the offending population.

MHCs are relatively expensive, but can be cost effective.^{xxv} That said care needs to be taken in when drawing conclusions for New Zealand from MHC cost-benefit analyses conducted in other countries given the range of factors which vary considerably across jurisdictions.

A MHC approach is likely to be more cost effective if focused on diverting those that have committed more serious offences from long and expensive custodial sentences into community-based treatment. However, risk to the community needs to be carefully considered on a case-by-case basis.

Cheaper options, such as treatment with standard probation supervision may be more cost efficient for low level offences.

SCALE AND TYPE OF PROVISION IN NEW ZEALAND

Mental health difficulties are much more prevalent in New Zealand's criminal justice system than in the general population.

Research has found that people who had used mental health services (excluding substance abuse services only) in the preceding 12 months represented:

- a quarter of people charged in court
- 28% of people starting a community sentence.^{xxvi}

Prisoners are up to three times more likely to have a mental disorder^{xxvii} and are about three times more likely to require specialist mental health services.^{xxviii}

Approximately half of these populations have co-occurring substance abuse needs.

Appropriate treatment for convicted offenders with mental health needs is identified during a mental health screening test administered shortly after admission to a prison. Based on the screening results, a prisoner may be treated within the prison or referred to DHB forensic psychiatric services for a comprehensive assessment.

Within all prisons and selected Community Corrections sites, a new integrated care service is being introduced for offenders with mental health issues. Psychiatric, psychological and forensic clinicians work together to ensure the best possible outcomes for offenders.

A prisoner who becomes acutely mentally ill while in prison will be assessed and, if necessary, transferred to a psychiatric facility for treatment.

In the community, offenders are assessed at the commencement of their sentences by the probation officer. Although formal mental health

screening is not conducted, offenders with mental health issues on Supervision, Intensive Supervision or Home Detention sentences can be referred for specialist assessment and to community mental health treatment services, under general sentence conditions as directed by the probation officer.

New Zealand does not have Mental Health Courts, and the Alcohol and other Drug Treatment Court pilot excludes people with serious mental health conditions.

Two homelessness courts include mental health needs in their eligibility criteria:

- Te Kooti o Timatanga Hou (The Court of New Beginnings) in Auckland and
- the Special Circumstances Court in Wellington.

These courts have been operating for a short period of time (since 2010 in Auckland and 2012 in Wellington) and deal with small caseloads of homeless people. Evidence regarding their effectiveness is limited, and not necessarily representative as homeless people form a comparatively small proportion of the mentally ill offender population.

A review of Te Kooti o Timatanga Hou found a range of positive effects on justice sector outcomes, such as re-arrest. However, the small sample size (21 participants and 27 professionals) and other limitations make it difficult to generalise from this one case study.

New Zealand has also has a range of measures to divert people with mental illness (among others) towards treatments and away from the criminal justice system at different points:

- pre-charge – e.g., via a warning
- post-charge – e.g., those with serious mental illness may be not fit to plead, and less serious offenders can be diverted to treatment via the Adult Diversion Scheme

- pre-sentence - the adjournment mechanism can be used to enable an offender to undertake measures to reduce their sentence (as per the Drug Court pilot)
- as part of sentencing - mentally ill defendants who are sentenced to imprisonment can be ordered to be detained in a hospital, or instead to undergo treatment.

It is widely acknowledged that community mental health services are overloaded throughout New Zealand (more so in some DHB regions than in others). As a consequence, it may not be possible for persons suffering from non-life threatening forms of mental disorder to gain timely access to relevant services.

The situation is even more acute with in-patient hospital care.^{xxix} This may limit the number of services and placements which offenders appearing before MHCs can be realistically referred to for treatment and rehabilitation. Consequently, this would likely affect the feasibility of the MHC implementation within New Zealand, as least in the short to medium term perspective.

EVIDENCE RATING

Each Evidence Brief provides an evidence rating between Harmful and Strong.

Harmful	Robust evidence that intervention increases crime
Poor	Robust evidence that intervention tends to have no effect
Inconclusive	Conflicting evidence that intervention can reduce crime
Fair	Some evidence that intervention can reduce crime
Promising	Robust international <i>or</i> local evidence that intervention tends to reduce crime
Strong	Robust international <i>and</i> local evidence that intervention tends to reduce crime

According to the standard criteria for all Evidence Briefs,¹ the appropriate evidence rating for MHCs is Fair.

As per the standard definitions of evidence strength outlined in our methodology, the interpretation of this evidence rating is that:

- there is some evidence that interventions can reduce crime
- it is uncertain whether interventions will reduce crime even if implemented well
- interventions may be unproven in New Zealand or subject to conflicting research
- interventions may benefit from trial approaches with a research and development focus
- robust evaluation is needed to confirm interventions are reducing crime and to aid in detailed service design.

MHCs are unlikely to be a cost-effective approach on their own. MHCs could be a good

¹ Available at www.justice.govt.nz/justice-sector/what-works-to-reduce-crime/

area for further exploration as part of a broader approach to dealing with mental illness in the justice system given:

- the evidence suggests MHCs can have moderate impact
- mental illness is prevalent in both the community sentence and prison populations
- New Zealand has a range of processes already in place to divert people with mental illnesses into treatment
- Individuals who have offended seriously but do not have a serious-enough mental illness to be considered not fit to plead are unlikely to be eligible for diversion
- there is scope to also deliver wider health benefits, particularly for Māori who are over-represented both in the mental health and prison populations.

If such an approach was to be tested, it may be suited to a randomised controlled trial approach. Positive finding from a robust New Zealand study could lift the evidence rating for this investment class to Strong.

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FIND OUT MORE

Go to the website

www.justice.govt.nz/justice-sector/what-works-to-reduce-crime/

Email

whatworks@justice.govt.nz

Recommended reading

Sarteschi, C., Vaughn, M., Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative review, *Journal of Criminal Justice*, 39.

Rossman, B, Willison, J., Mallik-Kane, K., Kim, K., Debus-Sherrill, S., and Downey, P. (2012). *Criminal Justice Interventions with Mental Health Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn*, New York, Urban Institute.

Honegger, L. (2015). Does the Evidence Support the Case for Mental Health Courts? A Review of the Literature. *Law and Human Behaviour*, Vol. 39, No. 5.

Citations

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- ⁱ Thompson et al, 2007
 - ⁱⁱ Almquist and Dodd 2009
 - ⁱⁱⁱ Schug and Fradella, 2015
 - ^{iv} Ibid.
 - ^v Sowerwine and Schetzer, 2013
 - ^{vi} Sarteschi et al, 2011
 - ^{vii} Another unpublished meta-analysis was identified, that of Cross (2011), but was excluded given uncertainty of its robustness.
 - ^{viii} Almquist and Dodd, 2009; Rossman et al, 2012; Frank and McGuire, 2012; DeMatteo et al, 2013; and Honegger, 2015
 - ^{ix} Steadman et al, 2011; Rossman et al 2012
 - ^x Almquist and Dodd, 2009
 - ^{xi} Lim and Day, 2014; Ray, 2014
 - ^{xii} McNeil and Binder, 2007; Steadman, et al., 2011
 - ^{xiii} Sowerwine and Schetzer, 2013; Lim and Day, 2014
 - ^{xiv} Lim and Day, 2014
 - ^{xv} As summarised in Honegger, 2015
 - ^{xvi} Almquist and Dodd, 2009; Sarteschi et al 2011; Honegger, 2015
 - ^{xvii} Rossman et al, 2012
 - ^{xviii} Thompson, et al., 2007
 - ^{xix} Bullard and Thrasher, 2016
 - ^{xx} For example, Lim and Day, 2014
 - ^{xxi} Sowerwine and Schetzer, 2013
 - ^{xxii} Steadman et al, 2011
 - ^{xxiii} Ibid.
 - ^{xxiv} Ibid.
 - ^{xxv} Aos and Drake, 2013
 - ^{xxvi} Ministry of Justice, 2015
 - ^{xxvii} Indig et al, 2016
 - ^{xxviii} NHC 2010
 - ^{xxix} Ministry of Health, 2015

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APPENDIX ONE: SUMMARY OF EFFECT SIZES REPORTED IN META-ANALYSES

Treatment type	Meta-analysis	Reported average effect size on crime	Number of estimates meta-analysis based on	Assuming 50% untreated recidivism		Assuming 20% untreated recidivism	
				Percentage point reduction in offending	Number needed to treat	Percentage point reduction in offending (to prevent one person from reoffending)	Number needed to treat (to prevent one person from reoffending)
Mental Health Court	Sarteschi et al 2011	d=0.61*	18	0.25	4	0.12	8

* Statistically significant at a 95% threshold

OR=Odds ratio

D=Cohen's d or variant (standardised mean difference)

NA=Not applicable (no positive impact from treatment)