Professional Development:
The International Journal of
Continuing Social Work Education

Historical and Contemporary Synopsis of the Development of Field Education Guidelines in BSW, MSW and Doctoral Programs

Journal:	Professional Development: The International Journal of Continuing Social Work Education
Article Title:	*A Content Analysis of Recidivism, Cost Efficacy, and Offender Success in Mental Health Court*
Author(s):	*Giang and Lam*
Volume and Issue Number:	*Vol.23 No.1*
Manuscript ID:	*231032*
Page Number:	*32*
Year:	*2020*

Professional Development: The International Journal of Continuing Social Work Education is published two times a year (Spring and Winter) by the Center for Social and Behavioral Research at 1923 San Jacinto, D3500 Austin, TX 78712. Our website at www.profdevjournal.org contains additional information regarding submission of publications and subscriptions.

ISSN: 1097-4911

URL: www.profdevjournal.org **Email: www.profdevjournal.org/contact**

A Content Analysis of Recidivism, Cost Efficacy, and Offender Success in Mental Health Court

Giang and Lam

Abstract

Mental health court (MHC) was created with the goal of deterring dual diagnosis offenders from the cycle of incarceration and into a full faceted diversion program. There are nearly 400 mental health courts (MHCs) throughout the country. The purpose of this content analysis is to offer an in-depth and comprehensive understanding of the effectiveness of MHCs in terms of recidivism rates, cost efficacy, and factors for participant success. Social workers, attorneys, therapists, probation officers, and judges need an understanding about dual diagnosis to better implement a successful treatment plan that participants will continue to follow after completion of the program and reduce their risk of recidivism. This article is a content analysis of previously established empirical research studies. Recommendations and implications offered are based on a review of empirical research on current and former MHC participants.

Introduction

Mental health court (MHC) is a strategy change by the criminal justice system to better serve criminal offenders who suffer from both mental illness and substance abuse; the point was to shift dual diagnosis offenders (DDO) towards the community mental health system (Broner, Lattimore, Cowell, & Schlenger, 2004). The goal was to prevent the recidivism of the offender as well as maintaining sobriety, stable mental health, and preventing further criminal behavior (Almquist & Dodd, 2009).

Peer review studies on the contributing factors that either promote or deter success in mental health courts are increasing, coinciding with the expansion of mental health courts in more jurisdictions. This study's purpose is the exploration of factors that affect recidivism, efficacy, and stability in mental health courts by answering the following questions:

1. Are mental health courts effective in regards to recidivism rates and cost-efficacy?
2. What characteristics promote compliance and lead to graduation for current and former mental health court participants?
3. What characteristics hinder compliance and lead to termination for current and former mental health court participants?

To assist components of the mental health court treatment team (Department of Probation, District Attorney's office, Public Defender's office, Sheriff's Department, Department of Mental Health), this literature review aims to take a comprehensive look that factors that promote success in mental health court among current and former mental health court participants. A better understanding of such factors will assist in explaining the likelihood of stable mental health, sobriety, and recidivism after completion of MHC.

Background

Broward County, Florida was the location of the country's very first MHC (Strong, Rantala, & Kyckelhahn, 2016). The court was developed in 1997 as a response to the exponential growth in prison and jail populations across the country (Strong et al, 2016). With the growth in the inmate population, there was also a growth in the number of offenders that suffer from severe mental illness (SMI). MHCs function similarly to many problem-solving courts but have the added component of DDO. It is important to understand the shift from incarceration towards a community mental health system, with the end goal of developing a self-sufficient individual (Bazelon Center of Mental Health Law, 2003; Goodale, Callahan, & Steadman, 2013). MHCs are funded through county, state, and federal grants (Frailing, 2010).

Today there are nearly 400 MHCs across the United States (Burns, Hiday, & Ray, 2013). Jails and prisons are known to house a large number of mentally ill inmates, with approximately 16% of

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their population, 350,000 inmates, suffering from SMI (Castellano & Anderson, 2013). However, depending on the jurisdiction, the SMI offender population in jail can range from 6-36% (Abram, Teplin, & McClelland, 2003; Kubiak, Beeble, & Bybee, 2012). The prison system is known as "the primary mental health institution in the nation" (Adams & Ferrandino, 2008, p. 913). Broward County modeled their MHC after other problem-solving courts like drug court. Court-supervised mental health treatment and jail sanctions are part of this model; the goal of this diversion program is to lessen the burden of the criminal justice system and jail/prison system to process mental health offenders and divert them to the community mental health system (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009).

There are many different problem-solving courts designed to serve a particular population; they include drug court, DUI court, veterans' court, homeless court, and juvenile court (Strong et al., 2016). MHC aims to treat those with SMI, such as schizophrenia, major depression, and bipolar disorder, with an emphasis on healing, helping, and recovery through therapeutic modalities (Casey & Rottman, 2003). Schizophrenia, bipolar, and major depression are the primary diagnoses that are a prerequisite during evaluation for entry into a mental health court program; however, each MHC has different criteria for enrollment.

MHC is typically 18 months and voluntary. The defendant is required to enter a guilty plea prior to the beginning of the mental health court process (Ray, Hood, & Canada, 2015). The participant will then be under the supervision of the MHC treatment team, which consists of a judge, district attorney, public defender, therapist, physician, and in some jurisdictions a probation officer (Berman & Feinblatt, 2005). The participant is mandated to follow the rules of MHC in order to stay in compliance or face a court sanction. The rules for compliance include random drug testing, no use of drugs or alcohol, curfew, self-help meetings, having a sponsor, engaging with providers, taking medication, and productive use of time (Brunette, Drake, Woods, & Harnett, 2001). Since participants in MHC are dual diagnosis, relapse prevention is an important component of MHC (Ray et al., 2015).

Each MHC has its own requirements for enrollment into the program; some MHCs will allow defendants with felonies, while some will only allow misdemeanors. Frailing (2010) says each MHC also has its own criteria for issuing sanctions for noncompliance as well as completion. A participant can opt-out of MHC and be transferred back to a traditional criminal court and serve their sentence at any time (Kubiak, Roddy, Comartin, & Tillander, 2015). The reasoning behind MHC is that through legal proceedings and mandated treatment the defendant can improve their psychological wellbeing while at the same time giving the defendant due process. Federal and state entities have poured millions of dollars in support of the belief that healing the participant will pay off later on in the form of savings in future arrest (Wolff, 2003).

Problem-solving courts have been around for 30 years; however, the benefits and return on investment has still remained unknown (Honegger, 2015; Quinn, 2009; Sarteschi, Vaughn, & Kim, 2011). Kubiak, Roddy, Comartin, and Tillander (2015) state the cost of MHC and the cost/saving of the criminal justice system are also unknown due to lack of research. Studies are currently being conducted on whether recidivism rates are lower due to MHC, as well as studies on the cost efficacy of MHC. The goal of MHC is for the participant to no longer engage in risky behavior, which may include criminal behavior and substance abuse. Stable mental health, as well as a support network through community mental health systems, are deemed as more cost-effective while also benefiting the wellbeing of the participant in the program.

Method

Study Selection and Sampling

The sample size of this study consists of twenty-one empirical research studies that report factors that may impact MHC participants. Empirical research includes studies on MHC functionality and the interactions between participants and the MHC treatment team. Studies of current and former MHC participants were included. Empirical research studies were conducted from numerous MHC locations. Two studies conducted are based on content analysis of the following: a) factors that affect MHC success: effectiveness, cost efficacy, and recidivism; and

b) factors that promote or deter participants' success: therapeutic treatment, probation, mandatory court hearings, individual predictors of participant successes and outcomes, and social networking.

Data Collection

Empirical data for this study utilized peer-reviewed articles from 2003-2019, primarily from journals relating to Law and Psychiatry, Offender Therapy, Law and Human Behavior, Offender Rehabilitation, Criminal Justice and Behavior, and Behavioral Sciences and the Law. The authors used online library databases such as Jstor, ScienceDirect, Wileyonlinelibrary, Sage, Elsevier, ResearchGate, as well as county, state, and federal documents to identify relevant variables for this study. During database searches, the authors used keywords: mental health court, dual diagnosis, drug court, and recidivism to find empirical research articles. Twenty-one studies, each addressing different variables of this study, were selected to conduct a content analysis that aims to address the three-research question identified by the author.

Content Analysis

This study utilized qualitative content analysis of twenty-one empirical research studies about current and former MHC participants as well as the effectiveness of MHC programs. The results of the content analysis are tabulated in two studies: a) factors of MHC success: effectiveness, cost efficiency, and recidivism; and b) factors that promote or deter participants' success: therapeutic treatment, probation, mandatory court hearings, individual predictors of participant successes and outcomes, and social networking. The purpose of this content analysis of these empirical research studies is to provide a comprehensive understanding about the functionality and efficacy of MHC as a whole and how each component of MHC factors towards how the participant will either be in compliance or non-compliance and whether they will be terminated or complete the program.

This section will present the findings of the content analysis of the twenty-one empirical research studies analyzed which examined different facets of the MHC system. Of the twenty-one studies, eight examined the effectiveness and recidivism rates of MHC participants, four examined the cost efficacy, and nine examined factors that promote or deter MHC participant success or failure. All twenty-one empirical studies include mental illness and the criminal justice system.

Effectiveness of Mental Health Court: Cost Efficacy

MHCs must be cost-efficient to justify funding for their programs. Components of MHCs are the completion of a treatment program, regular therapy appointments, regular psychiatrist appoints, probation supervision, regular court attendance, regular drug tests, and jail sanctions for non-compliance (Frailing, 2010). These services can be costly if the participant does not have the means to pay for services; services would be provided by the county and the participant pays fines, fees, and cost of probation. Treatment, court processing, and time spent in jail are large parts of MHC costs (Frailing, 2010). However, multiple arrests of DDO and SMI offenders, along with court processing and incarceration, can potentially be more costly in the long run; there is also the potential for high-level mental health services like psychiatric hospitalizations (Kubiak et al., 2015). Processing time for MHC participants when detained was an average of 70 days compared to 76 days in traditional criminal court; both are courts are limited to a year time frame (Almquist & Dodd, 2009; Redlich, Liu, Steadman, Callahan, & Robbins, 2012). However, SMI offenders were processed in 37 days, half the time for MHC participants (Redlich et al., 2012). There was a reduction in psychiatric hospitalizations indicating less need for intensive mental health services post-MHC (Frailing, 2010). "Recovery model" treatment does require consistent ongoing low-level treatment; this must be factored into cost analysis (Kubiak et al., 2015).

Cost savings can be accounted for in the number of dollars spent to process and incarcerate SMI offenders. The time spent in jail by MHC participants is less than a comparable group; MHC participants also spend less time in jail than when they were pre-MHC (Frailing, 2010). Over the course of being enrolled in MHC, MHC participants will be committing fewer offenses, and this trend will continue until after graduation, thereby saving the criminal justice system the

burden of processing their cases. The cost savings for participants of MHC compared to a comparison group are estimated to be $22,906 post-MHC graduation, greatly outweighing the cost of $16,964 (Kubiak et al., 2015). However, a lack of concrete studies on cost analysis and simply relying on technical reports limits the scope of further analysis (Kubiak et al., 2015). These data may vary depending on jurisdiction as well, due to each court's independence in operation (Kubiak et al., 2015).

Effectiveness of Mental Health Court: Reducing Recidivism

Reducing recidivism is the goal of MHC (Goodale et al., 2013). Low rates of recidivism of MHC graduates can be an indicator of MHC success. The empirical studies utilized for this content review studied recidivism using two methods: a) comparing statistical data of MHC against SMI offenders not enrolled in MHC, and b) comparing a participant arrest pre-MHC enrollment and recidivism after enrollment or termination. Hiday, Wales, and Ray (2013) suggest short-term recidivism is defined as one year postexit from MHC. Ray (2014) expresses that long-term recidivism is defined as a minimum of five years to a maximum of ten years.

According to the Bureau of Justice Statistics, 67.5% of prison inmates will be rearrested within three years after release (Langan & Levin, 2002). SMI jail inmates have a recidivism rate of 70% three years after release (Lovell, Gagliardi, & Peterson, 2002). Empirical research states that around year three is when offenders are most likely to recidivate (Kurlychek, Brame, & Bushway, 2007). 60.4% of MHC participants who graduated MHC did not recidivate within five years or more (Ray, 2014). MHC participants who terminated from the program were likely to recidivate with the first year (Ray, 2014). Of the MHC participants that did recidivate, they were more likely to be rearrested sooner than later; 46.1% have not been rearrested in this longer period of time (Ray, 2014).

A short-term recidivism study by Hiday, Wales, & Ray (2013) states that specialized supervision unit (SSU) offenders who are eligible but did not enroll in MHC have much higher arrest rates in traditional courts then MHC participants who have exited MHC for one year. MHC graduates have a 17.6% rearrests rate, MHC participants who are terminated had a rearrests rate of 41.2%, and SSU who are processed through traditional courts had a earrests rate of 37.3% (Hiday, Wales, & Ray, 2013). MHC participants showed a longer period of time until they reoffend and are 26% less likely to get rearrested or get charged with a new violent crime compared to comparable treatment as usual (TAU) groups one year after enrollment (McNiel & Binder, 2007). MHC graduates are 34% likely to be rearrested compared to 56% for comparable TAU individuals (McNiel & Binder, 2007).

Findings of recidivism are also favorable for MHC when evaluating pre-MHC and postexit MHC arrests. Lim and Day (2014) explain that research conducted on two MHCs suggests that courts are effective in reducing recidivism for participants. 60% of the MHC participant sample is stated to have less incarceration and recidivism two years postexit from MHC as compared to pre -MHC bookings (Burns, Hiday, & Ray, 2013). MHC graduate pre-arrest rates are 1.32 compared to 0.21 after; MHC noncompleters' arrest rates pre-MHC are 1.46 compared to 0.64 after; and SSU offenders' arrests pre-booking in traditional court arrest rate is 1.67 compared to 0.60 after (Hiday, Wales, & Ray, 2013). MHC participants have a significant reduction in the likelihood of getting rearrests compared to before they joined MHC. SSU offenders' and MHC noncompleters' rearrest rates are almost identical. Post-MHC enrollment, participants are 400% less likely to commit a crime than a year before enrolling in MHC (Herinckx, Swart, Ama, Dolezal, & King, 2005). Not only are MHC participants less likely to commit a new offense, they are also less likely to abuse substances compared to TAU groups (Slinger & Roesch, 2010).

While each MHC does have their own guidelines, with some courts being 12 months and others being 18 months, there is research regarding recidivism and the length of MHC. Lowder, Desmarais, & Baucom (2016) say that the longer time a participant spends in MHC, the greater the reduction in time spent in jail. Other empirical research has shown that 6 months is not sufficient a duration to provide adequate treatment and supervision for MHC participants; those who reoffend during this shortened time in MHC will likely reoffend within 5 months (Lim & Day, 2014).

Stakeholders of MHC are judges, attorneys, probation officers, case managers, mental health professionals, and administrators (McNiel & Binder, 2010). Jail is rarely used as a sanction according to stakeholders; incentives and other forms of sanctions are used to encourage MHC participants to succeed, as jail is seen as counterproductive (McNiel & Binder, 2010). Stakeholders say that MHCs lack direct control over access to treatment resources (see Table 1, p. 39-40).

Factors that Promote or Deter Mental Health Court Participant Success

Individual factors of MHC participants play a role in the determination of participants' successful completion of MHC. According to Verhaaff and Scott (2015), age, educational attainment, and gender do not have any effect on determining MHC participants' successful completion. Variables that potentially predicted MHC successful completion were employment, residential stability, and reporting of co-occurring diagnosis (Verhaaff & Scott, 2015). It has been commonly theorized that employment pre-MHC enrollment is an indicator of successful completion in MHC (Butzin, Saum, & Scarpitti, 2002). Research shows that employment prior to MHC enrollment may act as a barrier because they are focused on financial security and stability, thus hindering full focus on their treatment (Verhaaff & Scott, 2015). Housing security is another barrier that MHC participants face; the participant may have to opt-out of MHC due to instability with housing (Verhaaff & Scott, 2015; Reich, Picard-Fritsche, Lebron, & Hahn, 2015). Verhaaff and Scott's (2015) findings say that participants who report experiencing symptoms of SMI are more likely to complete MHC as opposed to MHC participants who did not report symptoms. Concurrent disorders and prior jail or prison sentences are an indicator of participant success; participants with a co-occurring disorder and previous arrest are more likely to not complete MHC (Verhaaff & Scott, 2015; Reich et al., 2015).

Empirical studies have been conducted on predictors of SMI offender compliance and rearrest. Four predictors of compliance are age, housing status, employment status, and previous arrest history (Reich et al., 2015). Age is not an indicator of MHC outcome (Verhaaff & Scott, 2015). However, younger participants are more likely to face in-program jail sanctions and be rearrested within two years of completion (Reich et al., 2015). Unemployed participants are more likely to receive in-program jail sanctions as well; however, they are more likely to complete MHC (Verhaaff & Scott, 2015; Reich et al., 2015). Interestingly, the specific diagnosis of SMI offenders is not a reliable indicator of involvement in the criminal justice system (Rezansoff, Moniruzzaman, Gress, & Somers, 2013).

Stakeholders of MHC are judges, attorneys, probation officers, case managers, mental health professionals, and administrators (McNiel & Binder, 2010). Jail is rarely used as a sanction according to stakeholders, incentives, treatment, and other forms of sanctions are used to encourage MHC participants to succeed, jail is seen as counterproductive (McNiel & Binder, 2010; Skeem, Encandela, & Eno Louden, 2003). The reduction in recidivism of MHC participants reflects the stakeholder's approach of fewer jail sanctions and more incentives. Regular court appearances are one of the sanctions MHC judges will use instead of jail (Redlich et al., 2010). Judges use Mandatory court appearances less frequently when MHC participants are doing well and in compliance with treatment (Redlich et al., 2010).

Probation officer supervision is an important characteristic of MHC. Probation is the most common way to supervise offenders, and SMI offenders are regularly supervised by probation departments (Eno Louden, Skeem, Camp, Vidal, & Peterson, 2012). MHCs have specially trained probation officers who have smaller caseloads and training in mental health issues; SMI is dealt with more often than criminogenic needs (Eno Louden et al., 2012). MHC participants benefit from evidence-based practice compared to TAU comparison groups, and MHC probation officers will work with probationers to build viable treatment plan (Eno Louden et al., 2012). Resource gathering from an internal and external source and problem-solving strategies are utilized in MHC compared to TAU probation (Skeem, Emke-Francis, & Eno Louden, 2006). Strategies MHC probation officers use are built around developing rapport, respect, personal, and approachability as opposed to a confrontational relationship (Skeem et al., 2003). TAU

probationers try to "get off probation" as soon as possible; MHC probationers seek assistance for SMI from their probation officer, and the relationship is seen as friendly and flexible (Skeem et al., 2003). Safety for the community and participant and obtaining services to help the participant become more functional and independent are general goals of MHC probation officers (Skeem et al., 2003).

Social networking is a factor that plays a direct role in promoting success in MHC. SMI offenders who surround themselves with individuals who adhere to probation are less likely to recidivate or relapse compared to participants who surround themselves with individuals who abuse substances (Skeem, Eno Louden, Manchak, Vidal, & Haddad, 2009). Similarly, SMI offenders who have small groups that provide positive support are more like to succeed (Skeem et al., 2008). Conversely, social undermining such as anger and criticism are detrimental towards success in MHC (Skeem et al., 2009). Another stakeholder for MHC participants is clinicians. Clinicians who have a high-quality relationship with participants tend to benefit the participant positively (Skeem et al., 2009).

MHCs lack direct control over access to treatment resources, which is a factor that hinders MHC participant success according to stakeholders (McNiel & Binder, 2010). Treatment resources such as housing options are a factor that hinders success (Verhaaff & Scott, 2015). MHCs do not have housing or treatment centers for their participants. Jail is a hindrance to success in MHC. Those who were incarcerated were more likely to recidivate, and those who have charges dismissed are less likely to recidivate (Ray et al., 2015) (See Table 2, p. 40-41).

Summary

MHCs are specialty problem-solving courts for DDO. SMI offenders represent 6-36% of the jail population (Abram et al., 2003). The goal of MHCs is to divert SMI offenders from the criminal justice system to the community mental health system; in the end, the process is aimed towards developing independent DDO (Bazelon Center of Mental Health Law, 2003; Goodale et al., 2013). MHCs have spread since the first MHC opened in 1997 (Strong et al., 2016). Each of the nearly 400 MHCs follow national guidelines but operates independently (Burns et al., 2013), each with their own criteria for enrollment and noncompliance (Frailing, 2010). MHCs have been deemed as beneficial for both DDO and the criminal justice system, hence the expansion of these specialty courts. MHC participants save the criminal justice system $22,906 when compared to a TAU group; the cost of MHC is estimated to be $16,964 (Kubiak et al., 2015). MHC is efficient because the money potentially saved by treating SMI offenders instead of incarcerating them. Statistics show that MHC participants will spend fewer days in jail once enrolled in MHC (Burns et al., 2013) and will be less likely to recidivate once they complete the program (Ray, 2014). Factors that promote success for MHC participants are fewer jail sanctions, being unemployed pre-MHC enrollment, incentives, therapeutic approaches to supervision in court dates and probation that encourage support and rapport building as opposed to confrontation, medication management, and trust with clinicians (Eno Louden et al., 2012; McNiel & Binder, 2010; Redlich et al., 2010). Factors that deter success in MHC are threats of incarceration, confrontational approaches to supervision, social undermining, concurrent disorder, and lack of stable housing (Eno Louden et al., 2012; McNiel & Binder; Skeem et al., 2009; Verhaaff & Scott, 2015)

Limitations

Limitations of this study are the limited availability of peer review research on MHCs (Kubiak et al., 2015). Of the studies available, there is no control variable to have an accurate empirical study. In empirical studies that compare MHC participants with other TAU SMI offenders, a diagnosis could not be verified (Hiday et al., 2013). Additionally, every MHC runs their court differently, but they follow recommended guidelines; because of that, no two MHCs operate in the same way. Limitations arise because each study only uses data from one court (Hiday et al., 2013). Nonrandom enrollment into MHC is another limitation; participants are screened for the likelihood of success in MHC (Hiday et al., 2013). MHCs in specific jurisdictions can potentially enroll based on

different criteria.

Implications

SMI offenders are 6-36% of the offenders that enter the jail system in the United States (Abram et al., 2003). MHC is a solution to deter the revolving door that is the criminal justice system (McNiel & Binder, 2005). DDO not only deals with criminogenic needs and substance abuse, but there is an added component of SMI (Broner et al., 2004). These offenders are at higher risk for recidivism (Lovell et al., 2002). What MHCs do is strip away the stigma of SMI. Once enrolled in the program, MHC participants have supervision through judges and probation to stay on track. Probation supervision and judicial sanction ensure that MHC participants are attending appointments, not committing new offenses, in compliance with medications, and maintaining their sobriety (Brunette et al., 2001). Abstinence from drugs and alcohol are a large factor in the wellbeing of DDO (Ray et al., 2015). MHC aims to shift the burden of constant incarceration to a lower level of care through the community mental health system (Broner et al., 2004). The end goal for MHC participants is for them to be a self-reliant and functional member of society (Almquist & Dodd, 2009). This process does not happen overnight; hence the program is typically 18 months (Ray et al., & 2015). The completion of MHC will pay off in dividends down the road by producing a functional contributing member of society that is no longer a drain on the criminal justice system (Wolff, 2003).

The implementation of a recovery model is more beneficial for DDO. Threats of incarceration as a criminal deterrent are seen as counterproductive (McNiel & Binder, 2010). Support, care, and rapport building from the treatment team are paramount towards the success of MHC participants (Skeem et al., 2003). The MHC participant has influence over the direction of their treatment plan regarding employment. An important aspect of MHC is to develop a treatment plan that the participant is will to continue after graduating from MHC. The goal is to prevent the participant from returning to the criminal justice system, so participants are encouraged to continue medication management and therapy through outside providers (Skeem et al., 2003).

Utilizing therapeutic models is of utmost importance. Caseworkers, clinicians, and specially trained probation officers must be flexible in their treatment plans (De Ruysscher, Vandevelde, Vanderplasschen, De Maeyer, & Vanheule, 2017), as no two treatment plans for MHC participants are the same. Other stakeholders, such as the attorneys and judges, are a part of the treatment team and are trained to be caring with their approach as opposed to punishing (McNiel & Binder, 2010; Skeem et al., 2003). MHC is a full faceted and multi-dimensional treatment plan with stakeholders who have sway over the participant's freedom. Applying similar rapport development and social networking strategies for SMI/co-occurring disorder individuals with no criminal justice background may be effective. Forming a social and support network that includes clinicians, therapists, caseworkers of community mental health agencies, and support from family and friends can assist in the growth and guidance of dual diagnosis individuals.

Recommendation

MHC seems to be a move in the right direction for DDO. MHC participants recidivate less and are cost-effective; however, there are recommendations on empirical research to further improve MHCs functionality. More empirical research needs to be done on MHCs to further answer different policy and practice modality questions that arise from MHCs. Some changes in the way MHCs function may be an improvement; if all MHCs operate in the same fashion then research would be much easier. However, since each demographic and population of the specific MHC is different, this may be difficult.

If MHCs were to be less selective on the evaluation and enrollment process, then MHCs would have a greater effect on procedural processes (Wolff, 2018). Another potential study can be conducted on more than one MHC location in one study to give a broader perspective of the effectiveness of the program. By expanding studies to include numerous geographic locations in various jurisdictions across the nation, more empirical studies conducted on recidivism rates of MHC participants in urban and suburban settings can be

utilized. Empirical studies can delve into the effectiveness of similar or different programs to see which one is most beneficial for the community and DDO (Ray et al., 2015). Reducing the caseload seems to be a practical way to improve practice for stakeholders of MHC participants (Skeem et al., 2003). The programs that are most beneficial for MHC participants can be refined and improved (Skeem et al., 2003).

Conclusion

MHCs are an effective solution for DDO who get tied up in the criminal justice system. By applying therapeutic modalities such as the recovery model, the judicial system, along with all the stakeholders, can assist DDO towards becoming self-sufficient. It has been 22 years since the first MHC was developed in Broward County, Florida. Most researchers attest that there are limitations to empirical studies on this topic and more empirical studies need to be conducted; the research available has seen that MHCs are cost-effective, help reduce recidivism, and most of the characteristics of MHC will assist MHC participants not only while they are enrolled in the program but for years after as well.

Table 1: MHC: Effectiveness and Recidivism

A. Author, Year	Effectiveness & Cost Efficacy	Recidivism
Burns, P. J., Hiday, V. A., & Ray, B. (2013)	-	Post-MHC arrest and time in jail is significantly less than pre-MHC
Frailing, K. (2010)	Rapport building between judge and participant is used instead of sanctions, building positive outcomes.	MHC participants have fewer days in jail than control group and their own pre-MHC
Herinckx, H. A., Swart, S. C., Ama, S. M., Dolezal, C. D., & King, S. (2005)	MHC reduced the number of individuals who committed crimes and the total number of crimes committed by MHC participants	MHC helped reduce probation violations and rearrest compared to pre-MHC
Hiday, V. A., Wales, H. W., & Ray, B. (2013)	-	MHC graduates were significantly less likely to recidivate compared to a comparison group
Kubiak, S., Roddy, J., Comartin, E., & Tillander, E. (2015)	Successful MHC cost -$16,964 Unsuccessful MHC cost - $32,258 Compare group cost - $39,870 Successful/Compare savings of M=$22,906 Unsuccessful/Compare savings of M=$7,612	-
Lim, L. & Day, A. (2014)	Low-risk offenders were more likely to succeed then high-risk offenders. Effectiveness is based on who is enrolled.	2-year recidivism study shows a positive impact on recidivism for MHC as a whole, not based on individual success

Lowder, E. M, Desmarais, S. L., & Baucom, D. J. (2016)	MHC participants spend less time in jail then TAU offenders. Longer time in MHC, greater reduction in jail	-
McNiel, D. & Binder, R. L. (2007)	Criminal behavior and violence in SMI offenders are reduced through MHC	MHC can help reduce recidivism and violence for SMI offenders
Ray, B. (2014)	MHCs can reduce criminal recidivism among SMI offenders; this effect is sustained for many years after graduation	53.9% of all MHC defendants will be rearrested within 15 months. MHC graduates are less likely to be rearrested (39.6% vs. 74.8%) and went on longer without being rearrested (17.15 months vs. 12.27 months).
Redlich, A. D., Liu, S., Steadman, H. J., Callahan, L., & Robbins, P. C. (2012)	MHC participants are processed much faster and tend to spend less time in jail, thereby saving in terms of processing and long-term benefits for the participant	-
Slinger, E. & Roesch, R. (2010)	MHCs are effective compared to traditional courts for SMI with substances abuse and recidivism	MHC participants were less likely to commit a new offense or abuse substances compared to TAU offenders
Wolff, N. (2018)	MHC is not target efficient because it does not target crime motivators, but is an anti-harm therapeutic approach	-

Table 2: Factors that Promote or Deter Participants Success:

A. Author, Year	B. Promote Success C. Deter Success	D. Recidivism
Eno Louden, J., Skeem J. L., Camp, J., Vidal, S., & Peterson, J. (2012)	**B.** Supervision revolves more around mental health and treatment. Support, direct, and affirm questions. Neutral strategies and support. Smaller caseloads. Building a treatment plan together with a probationer. **C.** Supervision involves less criminogenic need. Confrontation. Threats of incarceration.	**D.** -

McNiel, D. E. & Binder, R. L. (2010)	**B.** Incentives for compliance (treatment, supervision, medications) **C.** Jail sanctions, lack of direct treatment access	**D.** MHC reduced recidivism coincides with increased adherence to treatment, reduced psychiatric symptoms and substance abuse, reduced homelessness, and improved quality of life
Ray, B., Hood, B. J., & Canada, K. E. (2015)	**B.** - **C.** Greater number of prior arrests, the more likely they will be sent to jail	**D.** Those incarcerated were more likely to recidivate; those with dismissed charges are less likely to recidivate
Redlich, A. D., Steadman, H. J., Callahan, L., Robbins, P. C., Vessilinov, R., & Özdoğru, A. A. (2010)	**B.** Court appearances instead of jail sanctions **C.** Jail sanctions	**D. -**
Reich, W. A., Picard-Frische, S., Lebron, L., & Hahn, J. W. (2015)	**B.** – **C.** Jail sanctions were used for younger MHC participants, those who have prior arrests or incarceration, participants arraigned on property charges, and participants that are unemployed	**D.** Being younger, having prior arrest, and having co-occurring disorders are predicated to recidivate within 2 years of MHC
Skeem, J., Eno Louden, S., Manchak, S., Vidal, S., & Haddad, E. (2009)	**B.** Social networks were small and key relationships to clinicians and probation officers are satisfying. Positive networks and quality relationships with clinicians. **C.** Social undermining (criticism, blocking instrumental goals)	**D.** Social networks of individuals who do not adhere to rules of probation will more likely recidivate or abuse a substance
Skeem, J., Emke-Francis, P., & Eno Louden, J. (2006)	**B.** Exclusive SMI caseload, reduced caseload, sustained officer training, active integration of internal and external strategies, and problem-solving strategies **C.** TAU strategies	**D. -**
Skeem, J., Encandela, J., & Eno Louden, J. (2003)	**B.** Probation approach is friendly, providing resources, assisting in becoming functional and independent. Open communication. **C.** Less on self-reporting for compliance and threat of jail for violations	
Verhaaff, A. & Scott, H. (2014)	**B.** Unemployment is a predictor of more focused treatment in MHC **C.** Concurrent disorder and unstable housing deter success in MHC	

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