

Predictors of Program Compliance and Re-Arrest in the Brooklyn Mental Health Court

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EXECUTIVE SUMMARY

Partnerships between the criminal justice and mental health systems have become common over the past 30 years, and mental health courts are one product of this partnership. Since the first mental health court was established in Broward County Florida in 1997, their number has grown to more than 300 across the United States. As a special case of “problem-solving courts” mental health courts seek to divert mentally ill offenders from conventional prosecution through a combination of community-based mental health treatment and intensive judicial oversight of the treatment process. The primary goal is to reduce recidivism and stop the “revolving door” for justice-involved people with mental illness.

A growing body of evidence has accumulated indicating that mental health courts are more effective than traditional criminal justice processing in reducing recidivism among participants. However, it is less clear which factors are related to successful program completion and reduced recidivism. While some criminogenic factors such as prior arrest have been consistently identified as predictors of post-mental health court recidivism, research has produced mixed evidence regarding the strength and direction of the impact of mental health diagnoses.

The current project seeks to add to the literature on mental health court outcomes—and more generally, the risk of re-offense among mentally ill populations—by examining factors associated with program compliance and recidivism in the Brooklyn Mental Health Court. In order to be eligible for the mental health court, potential participants must be diagnosed with an Axis I mental illness and be deemed legally eligible by the District Attorney’s Office. Misdemeanor, felony and violent felony defendants are all technically eligible. The Brooklyn Mental Health Court follows a post-plea model that requires participants to plead guilty in advance of participation and commit to a clinical treatment plan and regular court appearances. The court employs graduated sanctions, including jail, and positive incentives to encourage compliance with court mandates.

The present analysis is based on data tracked by the court and criminal justice data provided by the New York State Division of Criminal Justice Services for 654 participants who enrolled from 2002 through 2010. Specifically, the present study explored the influence of demographic, socioeconomic, clinical and criminal justice factors on several key outcomes, including mental health court graduation, program compliance (i.e., avoidance of in-program jail sanctions), and re-arrest.

Study Findings

- Impact of Demographic Characteristics: Younger participants were more likely than older participants to receive an in-program jail sanction and to be re-arrested within two years of program entry. Homeless participants were more likely than others to fail the program. Unemployed participants were more likely to receive a jail sanction.
- Impact of Criminal History: Having a prior arrest or incarceration record predicted worse outcomes on all three measures (jail sanction, program failure, and re-arrest).
- Impact of Current Charges: Arraignment on a property charge predicted receiving a jail sanction.
- Impact of Mental Health Diagnoses: Having a co-occurring substance use disorder diagnosis was positively associated with re-arrest. Specific diagnoses other than substance abuse (e.g., bipolar disorder, major depression, or schizophrenia) were unrelated to any outcome.

Two practical implications emerge from these results. First, the present findings support the practice of admitting into mental health court those arraigned on more serious (felony) offenses, as these participants were less, not more, likely to demonstrate poor compliance or re-arrest. Second, results suggest that additional resources be devoted to mental health court participants with the known criminogenic factor of substance abuse, both to facilitate their recovery and to reduce their risk for program failure.

1. Introduction

Historically, persons with serious mental illness have been overrepresented in the criminal justice system (Council of State Governments, 2002; Lurigio, 2012). As the prison system has grown, so has the population of incarcerated mentally ill. The scope of the problem led two recent authors to describe correctional facilities in the United States as “the primary mental health institutions in the nation” (Adams & Ferandino, 2008, p. 913). One recent estimate places the prevalence serious mental illness at 16% of those confined to American jails and prisons, or 350,000 inmates (Castellano & Anderson, 2013).

In response to the needs of this growing population, partnerships between the criminal justice and mental health systems have become common over the past 30 years. Mental health courts are one product of this partnership. The number of mental health courts has grown to more than 300 across the United States since the first one was established in 1997 in Broward County, Florida (Burns, Hiday, & Ray, 2013; Hughes & Peak, 2013). Mental health courts seek to divert offenders with a mental illness from conventional prosecution to individually supervised mental health treatment. Besides receiving community-based mental health treatment, program participants are typically required to appear in court for frequent judicial status hearings and are subject to court-administered sanctions, incentives, and clinical responses, based on their needs and progress to date. The primary goal is to reduce recidivism and stop the “revolving door” for justice-involved mentally ill persons (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009; Denkla & Berman, 2001). Programs may vary widely in terms of legal and clinical eligibility criteria and types and intensity of clinical treatment. Though not without critics (Kaiser, 2010; Miller & Perelman, 2009), mental health courts have been embraced by many overburdened criminal justice systems nationwide.

Mental health court policies and procedures have traditionally been grounded in the following assumptions: (1) untreated (or inadequately treated) mental illness can contribute to criminal behavior; (2) mental health treatment will help reduce the symptoms of mental illness and improve psychosocial functioning; (3) judicial monitoring will help offenders engage in community-based treatment, leading to improved treatment retention and outcomes; (4) improvements in symptoms and functioning levels will reduce criminal behavior; and (5) the combination of mental health treatment and judicial supervision will improve public safety. Successful completion of mental health court program requirements typically leads to dismissal or reduction of criminal charges, while failure to complete the mental health court mandate typically results in an alternative sentence of jail or prison that is predetermined at the time of the original plea.

To date, a body of evidence has accumulated indicating that mental health courts are more effective than traditional criminal justice sentences in reducing recidivism and increasing time to re-arrest among the mentally ill. Usually these studies employ single-group or quasi-experimental designs (Dirks-Linhorst & Linhorst, 2012; Hiday & Ray, 2010; Hiday, Wales, & Ray, 2013; McNiel & Binder, 2007; Sarteschi, Vaughan, & Kim, 2011; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011; but see Rossman et al., 2012 for a case-control study). Mental health courts are also effective at reducing jail time for participants without compromising public safety (Cosden, Ellens, Schnell, & Yamani-Diouf, 2005; Steadman &

Naples, 2005; Steadman et al., 2011). Recent research, however, raises doubts about some of the assumptions that have driven mental health court design due to a dearth of evidence directly linking mental health disorders, symptom change, and crime, and, as a result, the underlying logic of mental health courts is evolving from its original form (Osher, D'Amora, Plotkin, Jarrett, & Eggleston, 2012). Although mental health courts have been shown to increase access to mental health services, these courts have not been consistently successful in producing clinical improvement (Boothroyd, Mercado, Poythress, Christy, & Petrila, 2005; Cosden et al., 2005). Indeed, neither increased access to mental health services or symptom improvement been clearly associated with reduced recidivism (Keator, Callahan, Steadman, & Vesselinov, 2013; Skeem, Manchak, & Peterson, 2011).

If access to mental health services is not the “active ingredient” in mental health courts, there remains the possibility that other factors account for the positive impact these courts have had on participants (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014; Skeem, Manchak, & Peterson, 2011). Recent work has demonstrated that many mental health court participants’ perception of jurisprudence—knowledge of the court rules and procedures, experience of procedural justice in the court, and perceived voluntariness of the program—predicted compliance and, indirectly, successful mental health court completion (Redlich & Han, 2013). Qualitative and observational research suggests, consistent with Redlich and Han’s (2013) finding, that mental health court judges communicate key features of procedural justice—transparency, accountability, dignity and respect—in such a way as to avoid stigmatizing defendants (O’Keefe, 2006; Ray, Dollar, & Thames, 2011; Wales, Hiday, & Ray, 2010).

Relatedly, a less-than-clear picture emerges of the factors related to successful completion of mental health court. Not all mental health court participants fully adhere to their court-supervised treatment plans, and not all who do remain uninvolved in the criminal justice system. Indeed, there is wide variation in completion rates in mental health courts: Redlich et al. (2010), for example, reported failure rates between 17% and 36%, the only significant predictor of which was interim non-compliance with the court’s mandate prior to failure. Another study found that mental health court termination was more likely for males and racial minority members (Dirks-Linhorst, Kondrat, Linhorst, & Morani, 2011). Burns et al. (2013) showed that a prior arrest record and a co-occurring substance abuse and mental health diagnosis both predicted failure to graduate. Callahan, Steadman, Tillman, and Vesselinov (2013) found that participants charged with a drug (but not a person) offense were more likely to receive a jail sanction in mental health court.

Looking toward longer-term outcomes, research has shown that prior arrests, prior jail time, and not having received prior mental health treatment are predictive of post-enrollment re-arrest and re-incarceration among mental health court participants (Moore & Hiday, 2006; Steadman et al., 2011). Steadman et al. (2011) found that bipolar disorder and post-enrollment illegal drug use predicted a greater number of post-enrollment incarceration days. In non-mental health court samples, Yampolskaya and Chuang (2012) and Baillergeon et al. (2009) reported positive correlations between mental health diagnoses and recidivism (conduct disorder and bipolar disorder, respectively). Generally, however, the evidence is decidedly mixed regarding the strength and direction of the impact of mental health diagnoses on recidivism, in both mental health court and other justice-involved populations (Burns et al., 2013; Colins et al., 2011;

Herinckx, Swart, Ama, Dolezal, & King, 2005; Mallett, Fukushima, Stoddard-Dare, & Quinn, 2013; Stoddard-Dare, Mallett, & Boitel, 2011; Welch-Brewer, Stoddard-Dare, & Mallett, 2011; Wilson, Draine, Hadley, Metraux, & Evans, 2010). It is clear from a review of the literature that mental health court participants are a diverse subpopulation that researchers do not fully understand.

The Present Study

The present study seeks to contribute to the literature on mental health court outcomes by examining factors associated with lack of success in satisfying the conditions of mental health court participation (evidenced by jail sanctions and failure to graduate), and subsequent criminal involvement (two-year post-enrollment recidivism) in the Brooklyn Mental Health Court in New York City. The Brooklyn Mental Health Court opened in March 2002 as a joint demonstration project of the Center for Court Innovation and the New York State Unified Court System. During its more than 10 years of operation, it has enrolled more than 900 participants, including misdemeanor, felony and violent felony offenders. As of the end of 2012, approximately 73% of the court's closed cases ended in graduation. A recent evaluation found that participation in the Brooklyn Mental Health Court significantly reduced re-arrests compared to matched sample of incarcerated offenders with mental illness (Rossman et al. 2012).

Cases are typically referred to the Brooklyn Mental Health Court by a judge, defense attorney, or district attorney, and a dedicated assistant district attorney screens incoming defendants for eligibility. Participation is voluntary and contingent on a guilty plea. Eligibility is contingent on the presence of an Axis I psychiatric diagnosis—a serious and persistent mental disorder—as determined by a qualified mental health professional, that cannot be handled adequately in another traditional or alternative justice venue (Rossman et al., 2012). The court does not accept defendants who need hospitalization or who are incompetent to stand trial, since the court cannot be sure the potential participant is able to make an informed decision about participating in the program. Participation in Brooklyn Mental Health Court is voluntary and contingent on a guilty plea and acceptance of a treatment plan and an alternate disposition that is imposed if the conditions of the mandate are not met.

Psychiatric and psychosocial assessments take place at intake and are used to develop individualized treatment plans. Regular court appearances are required to track progress and provide an opportunity to deliver rewards (e.g., certificate and praise in the courtroom) or, if treatment program requirements are not being met, graduated sanctions. Sanctions include jail time, though in practice this is used only after multiple failures to comply (Rossman et al., 2012). More common are “clinical responses,” which are not intended to be punitive, but are designed to adjust the treatment plan in light of early compliance problems (see O’Keefe, 2006).

Method

All analyses were based on court administrative and treatment program data tracked by the Brooklyn Mental Health Court and criminal justice data provided by the New York State Division of Criminal Justice Services (DCJS). Specifically, data were drawn from the Brooklyn Mental Health Court database, developed specifically for this court, and the DCJS database,

which tracks criminal history and recidivism data statewide. Analyses cover participants enrolled in Brooklyn Mental Health court between March 2002 and December 2010 (N = 654).

Prior to requesting criminal history and recidivism data, we ran descriptive analyses to determine common variables that are routinely tracked (e.g., demographic, court outcome, treatment compliance and diagnostic data). Data were merged on common variables, and case level pseudo-identifiers were assigned to individual participants in the final dataset. Individual identifying data and pseudo-identifiers were used to link the data to statewide criminal justice data provided by DCJS.

2. Study Findings and Discussion

The analytic goal of the current study was to identify baseline characteristics among mental health court participants that make them more (or less) likely to comply with their mental health court mandate and avoid future criminal justice system involvement. Specifically, we sought to determine the demographic, socioeconomic, clinical, or criminal justice factors that were predictive of: receiving an in-program jail sanction; mental health court failure; and re-arrest within two years from program entry.

Sample Characteristics

Table 1 displays the demographic profile of the 654 participants in the sample. The majority of participants were African American and male. Nearly half of the participants were diagnosed with a mental illness and a comorbid substance abuse problem. All had a DSM-IV Axis I diagnosis and there were roughly equal numbers of participants with a diagnosis of bipolar disorder, major depression, and schizophrenia.

Table 2 shows the sample's criminal justice characteristics. The vast majority—more than eight in 10—of all arraignments were for felony charges, most commonly those involving a property offense. More than seven in 10 participants had at least one prior arrest. Notably, the Brooklyn Mental Health Court accepted a substantial number (55%) of violent offenders—a relatively recent (though now, not unusual) phenomenon in problem-solving courts (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). Table 2 also shows that 288 of 654 participants (44%) were issued a jail sanction during the course of their mental health court participation, 144 of 542 (27%) participants failed the mental health court program, and 263 of 631 participants (42%) were re-arrested within two years of mental health court program entry.

Table 1. Mental Health Court Demographics and Clinical Characteristics

Race	
Black/African-American	59%
White/Caucasian	20%
Hispanic/Latino	20%
Asian	2%
Sex	
Male	74%
Female	26%
Age	
25 and under	36%
26 - 40	35%
41 and above	29%
Unemployed	89%
Homeless	
Currently	12%
In past 12 months	20%
Education less than high school	79%
Primary Axis I Diagnosis	
Bipolar Disorder	25%
Major Depression	23%
Schizophrenia	24%
Schizoaffective Disorder	13%
Other	15%
Co-Occurring Substance Disorder	45%
Axis II Personality Disorder	5%

Table 2. Baseline Criminal Justice Characteristics

First time offender		29%
Felony arraignment		82%
	Property	42%
	Weapons	30%
	Assault	23%
	Drug Possession or Use	20%
	Violent felony charge	55%
Misdemeanor arraignment		18%
	Property	20%
	Weapons	18%
	Assault	18%
	Drug Possession or Use	4%
	Other Misdemeanor	40%
Number of prior arrests		
	Felony	3.45
	Violent felony	1.41
	Misdemeanor	4.71
Court program mandate length		
	9 – 12 months	2%
	12 – 18 months	67%
	18 – 24 months	18%
	Other	11%
Mental health court outcomes		
	Jail sanction	44% (n = 654)
	Failure ^a	27% (n = 542)
	Re-arrest within 2 years ^b	42% (n = 631)

^a Computed for those participants reaching final program status as of the analysis date.

^b Computed for slightly fewer participants than the full sample omitting a small number of cases whose recidivism data could not be located and merged from the DCJS database.

Predictors of Jail Sanction, Failure to Graduate, and Re-arrest

Table 3 displays the bivariate correlations between predictors and participant outcomes (jail sanction, failure, and two-year re-arrest). Particularly striking, although consistent with much of the prior literature, was the observation that specific mental health diagnoses (other than dual diagnosis, which involves substance abuse) were almost completely unrelated to participant outcomes.

Table 3. Bivariate Correlations Between Participant Outcomes and Court Site, Demographics, Criminal History, and Mental Health

	Jail Sanction ^a	Failed ^b	Re-arrest ^c
Demographics			
Age	-.15***	.01	-.23***
Male	.07	.11*	.03
Black/African American	.05	.11**	.07+
Post-high school education	-.11**	-.01	-.10**
Unemployed at intake	.12**	.05	.04
Homeless at intake	.12**	.16***	.03
Criminal History			
Any prior arrest	.25***	.19***	.18***
Any prior jail/prison sentence (yes/no)	.23***	.25***	.07
Any prior violent felony arrest (yes/no)	.18***	.17***	.10*
Instant case arraignment charge			
Felony (vs. misdemeanor)	-.02	.08+	-.10*
Violent felony	-.09*	-.12**	-.12**
Weapons	-.06	-.09*	-.08*
Property	.13**	.08+	.11**
Drug possession, use, or sale	.09**	-.01	.05
Assault	-.13**	-.09*	-.14***
Diagnosis			
Bipolar	-.01	.03	.05
Major depression	.01	-.03	-.04
Schizophrenia	.02	.00	-.02
Schizoaffective	.02	.07	.03
Axis II Personality	-.02	.08	.01
Co-occurring substance use disorder	.15***	.11**	.14***
Court program mandate length^d	.18***	.06	.02

a. N = 653 - 654; 630 for diagnosis variables.

b. N = 541 - 542; 527 for diagnosis variables.

c. N = 630 - 631; 607 for diagnosis variables.

Note. Re-arrest (1 = yes) at 2 years from program entry.

Note. * $p < .05$. ** $p < .01$. *** $p < .001$. + $p < .10$.

Table 4 shows the results of logistic regression analyses predicting participant outcomes by including all significant covariates shown in Table 3.^{1,2} Jail sanctions were more likely for younger participants, those who were currently unemployed, those with a prior history of arrest or jail/prison sentence, and those arraigned on property charges. Failure rates were higher for those with a prior jail/prison sentence and those who were homeless, and marginally for males, African-American participants, and those who were arraigned on a misdemeanor (vs. felony) charge. Being younger, having a prior arrest, having a co-occurring substance use disorder, and marginally being arraigned on a misdemeanor (vs. felony), all predicted a greater likelihood of re-arrest.

Table 4. Logistic Regression Coefficients Predicting Participant Outcomes

	Participant Outcome		
	Jail Sanction	Failed	Re-arrest
N	617	541	629
Male		.47 (.26)+	
Age	-.04 (.01)***		-.05 (.01)***
Black/African-American	.01 (.16)	.43 (.22)+	
Homeless	.20 (.27)	.61 (.30)*	
Post-high school education	-.06 (.23)		
Unemployed	.79 (.31)**		
Prior arrest	.85 (.24)***	.28 (.32)	.79 (.21)***
Prior jail/prison sentence	.56 (.21)**	.85 (.24)***	
Arrest charge			
Any felony		-.55 (.29)+	-.48 (.25)+
Violent felony	-.21 (.20)	-.20 (.28)	-.34 (.25)
Weapon		-.15 (.29)	-.07 (.24)
Property	.53 (.23)*		.26 (.21)
Drug	.37 (.27)		
Assault	-.09 (.28)	-.27 (.31)	-.35 (.27)
Co-occurring substance use disorder	.19 (.18)	.24 (.21)	.38 (.18)*
χ^2 / df	5.80 / 11	59.16 / 10	87.53 / 9
Nagelkerke R^2	.19	.15	.18

Note. Re-arrest (1 = yes) at two years from program entry.

Note. B coefficients with standard errors in parentheses.

Note. * $p < .05$. ** $p < .01$. *** $p < .001$. + $p < .10$.

Summary

Our multivariate analyses revealed the following results. Younger participants were more likely than older participants to receive an in-program jail sanction and to be re-arrested within two years of program entry. Participants who were homeless at program entry were more likely to fail, and unemployed participants were more likely to receive a jail sanction. Having a prior arrest or incarceration record predicted worse outcomes on all three dependent measures. Being arraigned on a property felony increased the likelihood of a jail sanction. A co-occurring substance use disorder diagnosis increased the risk of re-arrest. We further note the finding in the simple bivariate analyses that, in line with Callahan et al. (2013), receiving a jail sanction was *less* likely for those arraigned on a assault charge, and *more* likely for those arraigned on a drug charge. Finally, other than co-occurring substance use disorder, not a single mental health diagnosis was associated with any outcome. Yet schizophrenia and co-occurring substance use disorders appeared to increase the risk of program non-compliance among those with no prior arrest record.

Two of our predictors of mental health court outcomes—having a prior arrest record or prior jail or prison sentence, and having a co-occurring substance use disorder—are well-known in the literature on mental health and criminal justice outcomes (Bonta, Law, & Hanson, 1998). Prior involvement in the justice system has been found in several studies to predict recidivism among mental health court participants (Hiday & Ray, 2010; Hiday et al., 2013; Moore & Hiday, 2006; Steadman et al., 2011), and prior arrest and substance use diagnosis are both known to be predictive of receiving a mental health court sanction or failing to graduate (Burns et al., 2013; Callahan et al., 2013). Thus our findings add support to emerging literature that the strongest predictors of recidivism (i.e., “the revolving door”) are consistent across offender populations with and those without mental illness (Skeem, 2011; Steadman et al., 2011).

As there is to date no strong consensus on “best practices” for mental health courts, we tentatively offer two practical implications of our results. First, we concur with Dirks-Linhorst et al. (2011) in supporting the practice of admitting into mental health court those arraigned on more serious (felony) offenses. In fact, even those with violent felony offenses were less, not more, likely to demonstrate poor compliance or re-arrest. Second, we agree with Burns et al.’s (2013) suggestion that additional resources be devoted to mental health court participants with substance use issues, not only to address their clinical symptoms and facilitate recovery, but also to reduce their risk for program failure.

Endnotes

1. For each participant outcome, all significant bivariate correlates ($p < .10$) were then entered simultaneously into a logistic regression with the following exceptions. The instant case arrest charges were highly correlated with their corresponding arraignment charges, r s ranging from .67 to .94. Since the instant case arraignment charge correlations were slightly stronger with participant outcomes than were the instant case arrest charge correlations, we entered only the arraignment charge variables to avoid multicollinearity. For the same reason, white/Caucasian was not entered as a race variable because it was highly correlated with black/African American, $r = -.60$, and prior violent felony arrest

was not entered because it was correlated at $r = .56$ (and conceptually redundant) with prior arrest.

2. Although length of mental health court program mandate was significantly correlated with jail sanction, $r(578) = .18, p < .001$, and program failure, $r(481) = .13, p < .01$, it was not included in the multivariate model due to a fairly large proportion of missing data ($n = 76$, nearly 12%). A model including length of mandate did not substantively change the results: each main effect we report remained significant.

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