VOLUNTARY, BUT KNOWING AND INTELLIGENT?
Comprehension in Mental Health Courts

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The number of mental health courts (MHCs) is steadily increasing. Although the courts are voluntary, it is unknown whether decisions to enter MHCs are made knowingly and intelligently. However, the ability to make these decisions is important given that MHCs are informal (and thus may lack built-in safeguards against constitutional violations) and given their rate of growth. Relevant research on other types of legal competencies suggests there may a substantial number of MHC participants who do not fully comprehend court processes and requirements. Furthermore, the level of comprehension at entry may predict future success or failure in the court. Thus, for both legal and practical reasons, the issue of MHC comprehension among its participants is critical.

Keywords: mental health courts, due process, legal decision making, voluntary

One of the most important developments in mental health law in the past decade is the mental health court (MHC). MHCs are criminal courts usually based on the notion of therapeutic jurisprudence (Winick & Wexler, 2003), which oversee cases of individuals with mental illness charged with misdemeanors and/or felonies. Often proposed as a strategy to stop the revolving door of repeated cycling through the criminal justice system (see Center for Mental Health Services [CMHS], 1995), MHCs were developed in response to the large number of persons with severe mental illness incarcerated in jails, their special needs while incarcerated, the difficulties courts face in effectively addressing mental illness issues, and the strains that involvement with the criminal justice system place on individuals with mental illness and their families. Despite little to no empirical data that MHCs are successful in obtaining their goals, the courts are proliferating at a fast rate (Steadman, Davidson, & Brown, 2001). Today, 100 MHCs in the United States exist (National GAINS Center for People With Co-Occurring Disorders, 2004) compared with only 2 in 1997, and recently Congress appropriated $7 million to the development of new MHCs (Public Law 106–515).

A precondition of all MHCs is that participation is voluntary. However, unlike other legal decisions, such as decisions to plead guilty, the concomitant components of MHC enrollment decisions being made intelligently and knowingly are rarely discussed. It is currently unknown to what degree persons who are being asked to partake in MHCs understand and appreciate the decision before them. Winick (1991) wrote, “Competency is one of the central questions of mental health law” (p. 169). Yet, as MHCs become increasingly important to mental

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health law, the comprehension of requirements and procedures among persons enrolling in these courts remains unexamined.

Another frequent characteristic of the courts is to require defendants to plead guilty as a condition of enrollment (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). However, in addition to taking responsibility for the crime, entering into an MHC includes agreeing to attend and engage in outpatient treatment, to take prescribed medications, and to adhere to all other orders from the judge, treatment providers, and probation officers. Noncompliance with these mandates can result in increased court supervision, jail time, expulsion from the MHC, and return to regular court processing and sentencing. Thus, the level of understanding of the contract into which a potential MHC client is being asked to enter may prove important to the ultimate success attained in the court.

The purpose of the current article is to review relevant information about the potential for MHC participants to make voluntary, knowing, and intelligent decisions about entry into the courts. These three constructs are used in the present article to define “MHC comprehension.” MHCs usually process cases quite informally and lawyers and judges have nontraditional roles (see Petrila, 2003). For example, regarding the Broward County (Florida) MHC, Petrila, Poythress, McGaha, and Boothroyd (2001) stated that “the proceedings are very informal, and there are few occasions where motions are filed or more formal ‘lawyering’ occurs” (p. 20). Thus, because of the level of informality inherent in MHCs, the potential for violations of due process, such as adjudicating defendants who do not understand proceedings or who are unaware of the voluntary nature of the court, may be enhanced.

Numerous factors may influence MHC decision making and comprehension. Such factors can include how (or whether) and when the MHC process and procedures were explained and who did the explaining. For example, if defense attorneys take the time to fully and appropriately inform their clients of MHC options, it can be surmised that understanding and awareness of the voluntary nature of the courts would be more likely. However, in MHC settings, it is not known how often or whether defense attorneys (or other court personnel) follow these practices. If MHCs are similar to drug treatment courts in this regard, there is reason to suspect that full explanations are not forthcoming (see Reisig, 2002).

Additional factors can include characteristics of the participants themselves, such as severity and type of mental disorder, age, and presence or absence of mental retardation. There is a large knowledge base (e.g., adjudicative competence) to draw from regarding the dispositional characteristics that may influence one’s ability to make valid MHC decisions. After a brief overview of MHCs, the factors that may contribute to deficits in MHC decision-making capacities are described. Evidence supporting the fact that deficient comprehension may lead to undesirable MHC outcomes is then presented.

MHCs

In the past, MHCs have been described as individualistic (Goldkamp & Irons-Guynn, 2000; Steadman et al., 2001). However, there are at least five commonalities that operationally define MHCs. First, MHCs are criminal courts with separate dockets exclusive to persons with mental illness. Some MHCs are
exclusive to persons with serious and persistent mental illness (SPMI, Axis I disorders). Other MHCs have less stringent criteria and only require demonstrable mental health problems (as opposed to diagnoses). Additionally, some MHCs tend to focus on persons with mental illness charged with misdemeanors, whereas others focus more on persons charged with felonies (Redlich et al., 2005).

Second, MHCs were developed as a mechanism to divert persons with mental illness from jail into community mental health treatment and to, therefore, reduce the detrimental cycle of revolving in and out of jail (CMHS, 1995; Torrey et al., 1992). Empirical outcome data from specific courts are just beginning to emerge (Boothroyd, Poythress, McGaha, & Petrila, 2003; Cosden, Ellens, Schnell, Yasmeen, & Wolfe, 2003; Trupin & Richards, 2003) indicating that MHCs can be somewhat successful in getting participants to engage in treatment and lessening recidivism. However, clear, consistent, and robust differences have not been found between persons in MHCs and comparable persons not in MHCs.

Third, all MHCs mandate and monitor community mental health treatment. Main requirements are that participants engage in treatment and take prescribed medications. Some MHCs have written contracts that participants must sign before being allowed to enroll (Goldkamp & Irons-Guynn, 2000). Although most MHCs state that they do not force participants to take their medications, participants are often disallowed from continuing in the MHC if they do not comply. That is, because a requirement of MHCs is taking prescribed medications, not taking them is grounds for dismissal. To gain compliance, there are usually incentives in place, such as having the initial charges dropped or reduced or the conviction vacated (in addition to avoiding jail/prison). Numerous other requirements are attached to MHCs, and these vary from court to court and from defendant to defendant. A usual first step for the courts is to set up individualized treatment plans at the onset of defendants’ participation (see Goldkamp & Irons-Guynn, 2000); complying with the preset treatment plans is central to graduating from MHCs. Other requirements include, but are not limited to, desisting criminal behaviors, attending scheduled court review hearings, meeting with vocational training officers, finding and maintaining employment, and following more idiosyncratic mandates (e.g., physical exercise, keeping one’s home clean, moving from a certain location).

All MHCs monitor participants’ compliance, of which the intensity of supervision can depend on the court and on the defendant. In this context, supervision refers to the responsibility of ensuring that MHC participants stay engaged in community treatment (e.g., go to therapy sessions, take their medication) and otherwise follow the court’s orders. Courts may have dedicated personnel responsible for supervision and reporting back to the judge (e.g., specialized probation officers, court monitors), may rely on community treatment providers indirectly linked to the court, or may use some combination of court and community providers (Griffin, Steadman, & Petrila, 2002).

Fourth, MHCs offer praise and encouragement for compliance and impose sanctions for noncompliance. MHCs generally work under the model of therapeutic jurisprudence (Winick & Wexler, 2003) and as such tend to recognize small and large successes. It is common for MHC judges to congratulate participants at status review hearings for accomplishments such as going to scheduled clinic appointments and maintaining the components of their treatment plans.
These review hearings may be weekly, biweekly, monthly, or even quarterly. It is also common for the entire courtroom to applaud participants’ efforts. After sustained periods of success and stability, participants graduate from MHC, which is the point at which the original charges may be dropped or convictions vacated and when connection with the criminal justice system ends.

In contrast to offerings of praise and encouragement for compliance is the utilization of sanctions for noncompliance. Commonly used sanctions include admonishments from the judge, increases in supervision and in the number of status hearings, and when necessary, placing people in jail. Courts differ on their use of jail as a sanction, but it is becoming more common as MHCs accept more felons under their purview (see Redlich et al., 2005). If noncompliance is ongoing, participants can be dismissed from the MHC and returned to regular criminal court processing and/or to their sentence of jail or prison. However, it should be noted that perfect performance is not expected in MHCs. As such, a hierarchy of sanctions is in place with jail usually as a later option when other penalties have failed. Thus, although most MHCs have lenient policies regarding noncompliance, all courts have mechanisms in place to counter nonadherence to mandates. Indeed, nonadherence is common and expected.

Fifth, a precondition standard across MHCs is that they are voluntary, referring to the fact that potential participants must choose to enroll in the court on their own accord. A report from Bazelon Center for Mental Health Law (2003) stated that “on its face, a defendant’s selection of a therapeutic court over one structured around determining guilt and meting out punishment would appear an obvious choice” (p. 5) but goes on to state that “further complicating the voluntary election of mental health court involvement is the fact that such decisions are made when the defendant is likely to be under considerable stress, having been arrested and taken into custody, and perhaps having spent some time in a jail cell, often without treatment of any kind” (p. 5). In addition to influencing the voluntariness of the decision, the stress associated with being arrested and jailed and nonmedicated is also likely to influence the level of understanding surrounding the MHC option.

The knowing and intelligent requirements attached to voluntary decisions are often neglected in MHCs. The three prongs of “knowing, intelligent, and voluntary” have a long history in the law. For example, waivers of Miranda rights and the right to a trial by jury must be done with a comprehension of and appreciation for the consequences as well as on one’s own volition. Similarly, guilty pleas are subject to the same test. Today’s MHCs more often than not require guilty pleas as a condition of enrollment (National GAINS Center for People With Co-Occurring Disorders in the Justice System, 2004; Redlich et al., 2005), although sentences are often deferred and convictions expunged on successful completion of MHC terms and conditions. Thus, a voluntary decision to participate in an MHC can include agreeing to plead guilty in addition to agreeing to comply with court orders, such as engaging in outpatient community treatment and taking prescribed medications for one’s mental illness. Noncompliance with court mandates is grounds for dismissal; thus, any part of a voluntary choice to enter in an MHC contract must include a full comprehension of court processes, mandates, and the consequences of not complying with the mandates.

In summary, among the 100 MHCs in the United States, there are several
common defining features. In brief, the courts are specialty criminal courts for persons with mental illness that mandate and supervise community treatment, offer encouragements and sanctions contingent on compliance, and are voluntary.

**MHC Decision Making**

**Voluntariness**

As mentioned, the processes of how the MHC option is portrayed and how persons make the decision to enter into MHCs have received little research attention. In particular, data are generally lacking about how voluntariness is assessed within MHCs, such as what information is explained to potential participants, who does the explaining, and whether mechanisms are in place to ensure that decisions are indeed voluntary and informed. Additionally, there is little to no information on whether potential MHC clients are “stable” (e.g., on medication, not intoxicated) and/or coherent when given the option to partake in the court.

However, there is some preliminary information on specific courts. Boothroyd et al. (2003) conducted a comprehensive study of the Broward County, Florida MHC, which included detailed court observations and the interviewing of MHC participants (as well as a comparison sample from another county). They reported that only 15.7% of MHC transcripts contained explicit discussions of the voluntary nature of the court, although a larger percentage of clients (53.7%; N = 65) self-reported knowing that the court was voluntary. However, 54.7% of the 65 clients indicated they were told about the voluntary nature of the court after their first hearing. Thus, 46.3% of clients claimed not to be aware at all that their participation was voluntary, and another 29% claimed not to know that their participation was voluntary until they had already participated.

Further information about choosing to enroll in an MHC comes from evaluations of two Seattle-based MHCs (Trupin & Richards, 2003; Trupin, Richards, Lucenko, & Wood, 2000). Trupin et al. were able to compare persons who opted into the MHCs versus those who opted out. Several findings stand out. First, somewhat large numbers of referred persons chose not to participate. Across the two MHCs, 128 people opted out compared with 96 people who opted in (Trupin & Richards, 2003). This is surprising because anecdotally it is believed that few people who are offered the option of MHC decline it. In one study, Steadman, Redlich, Griffin Petrila, and Monahan (2005) found that, across seven MHCs and 148 accepted referrals, only 1 defendant (less than 1%) chose not to enroll in the MHC. Furthermore, in other studies on MHCs (e.g., Boothroyd et al., 2003; Cosden et al., 2003), rates of those who opted out (of the MHC or the study) are not reported, which may suggest that the rates were trivial. Thus, is there something unique to how options to enroll in the Seattle MHCs are offered? In regard to this, Trupin and Richards (2003) stated that “defendants who expressed interest in considering participation were scheduled for an initial hearing, wherein the judge would evaluate the basis for their eligibility and confirm the defendant’s understanding of the MHC, particularly the fact that participation was voluntary” (p. 37).

The second noteworthy finding that Trupin and Richards (2003) reported was that, at baseline, the opt-ins sometimes differed from the opt-outs in meaningful ways. For example, the opt-outs tended to have less severe criminal charges...
pending and less severe mental health problems but more severe substance problems. Finally, Trupin et al. (2000) reported that the decision to enroll in an MHC was strongly influenced by defense attorney recommendations, and that defendants with insight into their mental illness were more likely to opt for enrollment compared with those with less insight or paranoid symptoms. Thus, in regard to these latter two findings, it appears that the MHC decision-making process was affected by personally relevant characteristics, which may additionally have affected understanding of the MHC option.

Related to issues of voluntariness are perceptions of coercion (Monahan et al., 1995). Although perhaps most studied in regard to (in)voluntary hospitalizations and persons with mental illness (e.g., Lidz et al., 1995; Morrissey & Monahan, 1999), the examination of coercion perceptions has been extended to outpatient commitment (OPC) mandates (Rain, Steadman, & Robbins, 2003; Swartz, Swanson, & Monahan, 2003) and MHCs (Poythress, Petrila, McGaha, & Boothroyd, 2002). Poythress et al. (2002) investigated whether awareness of the voluntary nature of the Broward County MHC was associated with perceived coerciveness of the court among a sample of its participants. They found that participants who claimed to be unaware of the voluntary choice to participate were significantly more likely to feel coerced than those claiming to be aware, even when severity of mental illness was considered. Further, Poythress and colleagues found that MHC procedural justice perceptions (e.g., having a voice, being treated fairly and with respect) predicted satisfaction with, and the emotional impact of, court hearings. Therefore, although all MHCs are voluntary, participants may still feel coercion, and these perceptions may prove important for future adherence to mandates. Clearly, court satisfaction and court impact can influence compliance with court orders.

In summary, available data on the MHC enrollment process indicate that (a) in one court, a significant proportion of clients claimed to be unaware of the voluntary nature of the court prior to participation, (b) criminal and mental health characteristics and insight into mental illness may be important to enrollment decisions, and (c) awareness of voluntariness and perceptions of coercion are negatively related. Awareness of the voluntary nature of the court and overall understanding may be greatly enhanced if attorneys take the time to explain MHC proceedings and requirements to their clients. However, as mentioned, whether attorneys do this as a regular practice is unknown, and the risk of this practice not occurring exists.

Several empirical questions remain: At what level do eligible MHC clients understand and appreciate the choice before them? What characteristics of defendants (e.g., age, mental health diagnosis) influence level of MHC understanding? To what extent does initial comprehension (or lack thereof) predict success or failure in MHCs? Therapeutic jurisprudence, which is the basis for and guiding principle underlying MHCs, predicts that participants who make treatment decisions knowingly and voluntarily will have better outcomes (Winick, 1997).

**Knowing and Intelligent**

MHC comprehension includes an understanding of and appreciation for MHC-related options (e.g., voluntary choice to stay in regular court processing),
MHC requirements (e.g., taking prescribed medications), and MHC procedures (e.g., attending status hearings). Mental illness itself is often characterized by deficits in attention, cognition, and other executive functions that contribute to comprehension generally and are likely to contribute to MHC comprehension specifically. Research focused on related topic areas, including adjudicative competence (competence to stand trial) and competence to make treatment decisions among persons with mental illness, has uncovered different rates of knowledge and understanding and has shown that variance in understanding stems from several factors, such as severity of mental illness, demographic, and criminal justice factors.

Based on the Dusky standard, Bonnie (1992) conceptualized adjudicative competence as comprising of two distinct dimensions: (a) competence to assist counsel and (b) decisional competence. In regard to both competencies, Bonnie delineated three related abilities, which included capacities for understanding (e.g., the charges, the adversarial nature of the court), for reasoning as it related to one’s case (e.g., recognizing pertinent information to tell lawyer), and for appreciating one’s situation as a defendant being prosecuted. Similarly, Appelbaum and Grisso (1995) included the three components of understanding, reasoning, and appreciation in their theory regarding competence to make treatment decisions.

In research on adjudicative competence and competence to make treatment decisions, a consistent finding has been that persons diagnosed with schizophrenia are more impaired than persons diagnosed with other mental disorders (and certainly more impaired than persons without any diagnosis). For example, Hoge et al. (1997) found that persons with schizophrenia had significantly lower competence to assist counsel and decisional competence scores than persons with affective disorders and other diagnoses. In addition, when adjudicative competence was dichotomized into impaired versus adequate, 72% of persons with schizophrenia were categorized as impaired compared with only 25% of those with affective disorders and other diagnoses. In addition, when adjudicative competence was dichotomized into impaired versus adequate, 72% of persons with schizophrenia were categorized as impaired compared with only 25% of those with affective disorders and other diagnoses. In addition, when adjudicative competence was dichotomized into impaired versus adequate, 72% of persons with schizophrenia were categorized as impaired compared with only 25% of those with affective disorders and other diagnoses. In addition, when adjudicative competence was dichotomized into impaired versus adequate, 72% of persons with schizophrenia were categorized as impaired compared with only 25% of those with affective disorders and other diagnoses. In addition, when adjudicative competence was dichotomized into impaired versus adequate, 72% of persons with schizophrenia were categorized as impaired compared with only 25% of those with affective disorders and other diagnoses.

By definition, the primary constituents of MHCs are persons with mental illness. Some MHCs will only accept persons with Axis I disorders. In a recent evaluation of seven MHCs, Steadman et al. (2005) found that 48% of referrals had been diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder. Further, having a serious mental illness was positively predictive of MHC acceptance. Insofar as MHC comprehension is reflective of other legal competencies, the potential exists for a significant portion of MHC clients not to fully comprehend the MHC mandates, their participatory roles, and the consequences of nonadherence.

In addition to diagnostic factors, criminological and sociodemographic variables have been found to associate with competency status. Specifically, Cooper and Zapf (2003) discovered that charge type significantly predicted clinicians’
ratings of competence, such that persons with a violent charge were less likely to be considered incompetent, but those with a miscellaneous charge (e.g., disorderly conduct) were more likely to be considered incompetent. In MHCs, criminal charges vary from low-level misdemeanors to serious, violent felonies. Cooper and Zapf also found employment status to be a significant predictor of competence status. Employment is often used to define socioeconomic status (SES), which has also been found to influence non-clinician-rated adjudicative competence (Hoge et al., 1997) and competence to make treatment decisions (Grisso & Appelbaum, 1995) among persons with mental illness. Although data on proportions of MHC clients who are employed versus unemployed are lacking, it can be presumed that at least some of the clients are employed (as is common among similar samples of persons with mental illness; see, e.g., Lamb, Weinberger, & Reston-Parham, 1996). Thus, individual difference factors found to influence types of legal competence are almost certain to exist in MHC populations. Whether these same factors will also influence MHC comprehension is unknown, but aspects that comprise adjudicative competence and competence to make treatment decisions may overlap with aspects relating to MHC comprehension. Research (Redlich, Silverman, & Steiner, 2003) has indicated that different forms of legal competence are positively related (i.e., comprehension of Miranda rights and adjudicative competence).

As mentioned, competence to stand trial and competence to make treatment decisions are operationally defined as including three common components: (a) understanding, (b) reasoning, and (c) appreciation (generally see Appelbaum & Grisso, 1995; Bonnie, 1992). This three-construct framework is also useful for defining MHC comprehension. In regard to understanding, there are numerous aspects that are important for potential MHC participants to comprehend, such as the guilty plea, the conditions of the contract they are entering into (e.g., agreeing to engage in outpatient treatment), and the consent to release their confidential records to the court. In regard to reasoning, participants should be able to consider the consequences of not enrolling in the MHC (e.g., going to jail for 3 months) versus the consequences of enrolling in the MHC (e.g., agreeing to take prescribed medications) as well as the ability to communicate their preferences about enrollment. In regard to appreciation, MHC participants, for example, should be able to appreciate what happens if they choose to disenroll, if they get expelled, and if they successfully graduate from the MHC. Overall, the three prongs of understanding, reasoning, and appreciation are highly relevant to MHC decision making, and utilizing such a framework would allow for theoretical comparisons between different types of legal abilities.

To summarize, the constructs that help to define adjudicative competence and competence to make treatment decisions can also operationally define MHC comprehension. Indeed, some of the individual components are the same, such as the concept of pleading guilty. Moreover, the variability in factors found to influence competence in the legal arena, such as diagnosis type and SES, will exist in MHC populations. Although it is currently unclear whether these same factors will influence MHC comprehension, comprehension would nevertheless be expected to vary on a continuum ranging from little to no understanding to complete understanding because of discrepancies in both situational (e.g., how much time was spent in explanation; whether the person was intoxicated and/or unstable at
the time) and dispositional (e.g., age, diagnosis) characteristics. An important next-step question is whether MHC understanding influences court outcomes.

MHC Comprehension and MHC Success

In the past, the links between legal comprehension and legal success have not received much attention. Competence at the time of adjudication, for example, which is narrowly defined, may or may not have applicable ramifications for future outcomes. To my knowledge, no one has studied this relation probably because adjudicative competence is specific to understanding the roles of attorneys, decisions to plead guilty, and appreciation of one’s situation at a certain point in time. That is, from an applied standpoint, it has not been worthwhile to examine whether impairments in competence to stand trial predict conformity to prison settings or compliance with probation, for example. It is more likely that factors that contribute to competence-related deficits are similar to factors that predict future compliance, such as on probation or in MHCs. However, in MHCs, the question of whether initial comprehension—both awareness of the courts’ voluntary nature and understanding of court procedures—predicts future success is relevant. Agreement to enter an MHC is explicit agreement to follow judicial orders, to engage in treatment, to take prescribed medications, and to obey all other mandates. It stands to reason that those who are unaware that entry into this agreement is voluntary and thus do not understand this agreement may be less likely to adhere to the agreement.

Although there has been little research linking legal understanding with legal performance, there are studies examining how persons with mental illness succeed with treatment mandates. These studies include ones on MHCs (Boothroyd et al., 2003; Cosden et al., 2003; Trupin & Richards, 2003), outpatient treatment and commitment (Centorrino et al., 2001; Steadman et al., 2001; Swanson, Borum, Swartz, Wagner, Burns, & Hiday, 2001; Swartz, Swanson, Wagner, Burns, Hiday, & Borum, 1999), and probation–parole (Solomon & Drain, 1995; Solomon, Drain, & Marcus, 2002). Typically, what these studies reveal is that (a) compliance with mandates/conditions varies between and within samples of persons with mental illness, and (b) there are certain factors that contribute to higher versus lower compliance and better versus worse mental health outcomes.

Mandated Treatment and Outcomes

In regard to the aforementioned fact—that compliance with mandates varies between and within samples—data are just starting to emerge on whether MHCs improve outpatient treatment adherence rates and outcomes (such as reducing recidivism). Across several studies, there is consistent, if not robust, evidence that MHC participants are better off than comparable non-MHC participants. More specifically, Trupin and Richards (2003) found in their examination of two Seattle-based MHCs that booking rates decreased, treatment referral and engagement increased, and overall functioning (Global Assessment of Functioning [GAF] scores) improved among MHC participants (see also Cosden et al., 2003). Similarly, Boothroyd et al. (2003) found that, compared with non-MHC defendants in another county, participants in the Broward County MHC were more likely to access services and, when services had been accessed, to have a higher
volume of service encounters. However, of importance, MHC outcomes also vary within samples of MHC participants. That is, even with established policies of leniency and expectations of and procedures for handling noncompliance, some MHC participants simply do not adhere to the courts’ orders. For example, of participants in an MHC linked with an Assertive Community Treatment team, 47% had been convicted of a new crime during a 12-month period of being in the court (Cosden et al., 2003). Thus, even with intensive case management, nearly half recidivated, although significantly less than the treatment-as-usual control group. Why MHCs are successful with some clients and not others has not been sufficiently addressed.

Similar studies have been conducted with OPC samples and with mentally disordered probationers and parolees (Solomon et al., 2002). In their study of the influence of OPC (in New York) on arrest and hospital days, Steadman et al. (2001) reported that, within the group on OPC, 18% had at least one arrest and 51% had at least one hospitalization. Another series of OPC (in North Carolina) studies, conducted by Swartz et al. (2001; Swartz et al., 1999, 2001), found that patients with nonaffective, psychotic diagnoses on OPC 6 months or longer and who had received intensive outpatient services had improved outcomes, such as fewer days in the hospital and fewer hospital admissions, and lower likelihood of being violent or victimized (Swartz et al., 2001). Patients with affective disorders (even those on OPC longer than 6 months), however, were comparable to the matched control group of non-OPC patients in terms of hospitalization rates and other outcomes.

To summarize, when outpatient treatment is mandated either through MHCs or outpatient commitment statutes, participating persons tend to do better than nontreatment control samples. However, within samples of mandated-treatment participants, improvement (as measured by standard outcomes like GAF scores and rearrest rates) is often conditioned on such factors as length of mandated treatment time and type of disorder. Researchers have started to investigate what predicts these differential outcomes. Two factors—insight and perceived coercion—have been examined and are discussed for their particular relevance to MHCs.

**Insight and Outcomes**

Insight into mental illness has been found to be associated with MHC enrollment decisions (Trupin et al., 2000) and competence to consent to treatment (Grisso & Appelbaum, 1995). Swartz et al. (2003) examined how insight toward (or endorsement of) OPC related to later OPC mental health outcomes (as measured by GAF scores and presence of hospitalizations and violence). They found that, of those patients with negative mental health outcomes 12 months later, 56.8% held negative endorsements at baseline (7.4% had changed from negative to positive and 49.4% remained negative). In contrast, of those patients with positive mental health outcomes 12 months later, only 42.1% had originally held negative endorsements (18.4% had changed from negative to positive and 23.7% remained negative). Thus, initial perceptions of the utility of OPC influenced mental health outcomes 1 year later, even when initial perceptions had changed from negative to positive.
Solomon et al. (2002) found further evidence linking beliefs about treatment and outcomes. Specifically, they discovered that mentally ill probationers who did not believe psychiatric medications were helpful were almost five times more likely to be arrested for new charges and more than three times more likely to be jailed on technical violations than those who believed them to be helpful. Because insight has been linked to MHC entry decision making and competence to make treatment decisions, insight may also be linked to MHC comprehension. Indeed, recognizing one’s mental illness would be important to an understanding of MHC participation. Furthermore, patients entering into treatment with full knowledge and on their own volition have better treatment-related outcomes (Winick, 1997). Thus, initial deficits in MHC comprehension may predict less favorable future outcomes regardless of whether understanding improves over the course of court participation.

**Perceived Coercion and Outcomes**

Several studies have examined the relations between perceived coercion among persons with mental illness and future treatment adherence, although no published studies have involved MHC samples. In general, findings have been mixed. Rain, Williams, et al. (2003) did not find significant associations between perceptions of coercion at time of hospital admission and adherence to mental health treatment at discharge. However, other researchers (Kaltiala-Heino, Laippala, & Salokangas, 1997) found that patients who initially felt coerced were less likely to take medications, use mental health services, and show improvement in functioning and symptoms.

Rain, Steadman, and Robbins (2003) also investigated how initial perceptions of coercion influenced later OPC adherence. At baseline, higher perceptions of coercion regarding hospitalization were significantly associated with higher likelihood of self-reported adherence to outpatient treatment and taking injected medications. At the 1-month follow-up, perceptions of coercion about medication and outpatient treatment were still positively correlated with adherence to injected medications, but at subsequent follow-ups (5 and 11 months), these relations were not found. Finally, Swartz et al. (2003) examined how perceptions of coercion, mental health outcomes, and personal endorsement of OPC were related. An interesting interaction effect was found: Among OPC participants who felt coerced, 53.3% with a positive mental health outcome at 12-month follow-up had originally endorsed OPC’s benefits compared with only 16.7% of those with a negative mental health outcome. Among participants who felt less coercion, a significant difference by mental health outcome did not emerge. Thus, in the Swartz et al. study, perceptions of coercion influenced later outcomes. In MHCs, perceptions of coercion and voluntariness have been linked (Poythress et al., 2002), and although perceived voluntariness and MHC comprehension have yet to be linked, it is likely that persons who understand that their participation in the court is voluntary may also have a better understanding of the court as a whole, especially if time is taken to ensure that potential court clients know their participation is voluntary and they understand what participation involves (e.g., Trupin & Richards, 2003).

In summary, some preliminary evidence supports the theory that initial MHC
comprehension is predictive of future success or failure in the court. Clearly, research needs to be conducted to assess the level of comprehension among MHC clients and then determine whether understanding at onset predicts later outcomes.

Conclusions

The issues raised here suggest several pressing research and policy questions. First, from a purely clinical (and nonlegal) standpoint, are considerations of competence to consent to MHCs even salient in therapeutic jurisprudence settings? That is, within less adversarial settings in which the “best interests” of the client are foremost, does it matter if potential clients do not fully comprehend the contract into which they are being asked to enter? If MHCs can fulfill their intended promises of improved mental health and criminal justice outcomes, perhaps understanding at entry is a contrary concern. However, as raised previously, if understanding influences outcome, than understanding cannot be overlooked. In addition, certainly from a legal standpoint, MHC participants—especially those that are required to plead guilty—are constitutionally protected against proceeding sans decisions that are knowing, intelligent, and voluntary. Second, what are the legal ramifications of having MHC clients participate without full comprehension? Because of their novelty, there exists no legal standard specific to MHCs, although certainly extant standards, such as the Dusky standard apply. To date, I am not aware of any legal contests regarding MHCs, but it may only be a matter of time before they are challenged. Related to this, because of their informality, MHCs often have wide discretion and thus potentially run the risk of discounting constitutional safeguards standard in regular court processing (such as adjudicative competence requirements). Juvenile justice courts, which are often cited as one of the first specialty courts (Petrila, 2003), were once labeled as “kangaroo courts” (In re Gault, 1967) generally because of their broad discretion and lack of formality. Resultant from this was the creation of a more adversarial system with explicitly stated constitutional protections for juveniles. Will MHCs follow a similar path of the juvenile justice courts?

Although new and controversial, MHCs are proliferating at a fast rate. The empirical and practical issues surrounding voluntariness, knowingness, and intelligence, as well as numerous other issues (such as whether judicial mandates improve treatment adherence), have yet to be addressed. Extrapolating from relevant research on other legal competencies suggests that the very types of people MHCs were designed for may be the people who do not fully comprehend the purpose, requirements, and roles in the courts. Future research should examine the situational and dispositional factors influencing MHC comprehension as well as whether comprehension predicts success or failure in the courts. Indeed, if initial comprehension is predictive of success, MHCs would be better able to fulfill the goals of improving the lives of persons with mental illness in the criminal justice system.

References


In re Gault, 387 U. S. 1 (1967).


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**Call for Nominations**

The Publications and Communications (P&C) Board has opened nominations for the editorships of *Behavioral Neuroscience, JEP: Applied, JEP: General, Neuropsychology, Psychological Methods*, and *Psychology and Aging* for the years 2008–2013. John F. Disterhoft, PhD; Phillip L. Ackerman, PhD; D. Stephen Lindsay, PhD; James T. Becker, PhD; Stephen G. West, PhD; and Rose T. Zacks, PhD, respectively, are the incumbent editors.

Candidates should be members of APA and should be available to start receiving manuscripts in early 2007 to prepare for issues published in 2008. Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations also are encouraged.

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Deadline for accepting nominations is **January 20, 2006**, when reviews will begin.