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Prior Mental Health Treatment and Mental Health Court Program Outcomes

Introduction

People with severe mental illness face particular difficulties within the criminal justice system. They are overrepresented in prisons and jails at rates of three to six times higher than the general population (Prins, 2011). In response to the high volume of persons with mental illness involved in the criminal justice system, mental health courts have emerged as an alternative to incarceration for these individuals. Mental health courts (MHC) were created as diversion programs from the traditional court system for those with mental illnesses to receive court-supervised treatment as an alternative to prison or probation. Previous research regarding MHC's has focused on the effectiveness of these programs and specific factors, such as employment status or type of diagnosis, that are associated with likelihood of successful completion of the program (Honegger, 2015; Sarteschi, Vaughn, & Kim, 2011; Verhaaff & Scott, 2014; Redlich & Han, 2014; Wales, 2014). However, prior treatment history has not been studied as a factor that may affect a participant's ability to successfully complete the program.

Past studies regarding prior treatment history suggest that those with a history of prior treatment are more likely to be selected for evaluation, are more likely to agree to participate, and are more likely to be enrolled in a MHC program than "treatment naïve" participants, or patients with no prior treatment history (Bernstein, 2008; Tate, 2011; Gu, 2014). Although these relationships regarding prior treatment history of MHC participants have been studied previously, it is still unknown whether there is a relationship between prior treatment history and successful MHC program completion. This is an important relationship to study, because non-completion of a MHC program is a strong predictor of poor outcomes and recidivism (Ray et al.,

2015). The purpose of this study is to determine whether or not there is a relationship between previous mental health treatment and MHC program completion. This was examined by conducting an archival analysis of previous MHC participants at Brooklyn LINK, a large alternative to incarceration program located in Brooklyn, New York.

Mental Health Courts: History and Previous Research

In the 1990's, MHC's were created as a diversion program for offenders with severe mental illness to receive monitored treatment as an alternative to incarceration (Honegger, 2015). As of 2013, there were an estimated 347 MHC's in the United States. Although MHC's throughout the United States have the common goals of improving mental health outcomes and reducing recidivism, it is also important to note that there is large variation among MHC programs and they may vary based on their selection criteria, program requirements, type of crime committed by the offender, as well as other variables.

In order to be selected into a MHC program, participants must first either be referred or apply (usually while detained after arrest), and then they go through a three-stage application process in which many factors are considered. The first stage includes a screening by the MHC team coordinator and district attorney. The MHC team usually consists of criminal justice and psychology professionals from multiple agencies. The central focus at this stage is determining if the individual meets severe mental illness eligibility criteria. The second stage includes a more thorough review of the applicants by the MHC team, examining behavioral issues including criminal behavior such as co-occurring substance abuse disorders, personality disorders, past treatment history, past violence and outstanding charges or warrants. Participants are more likely to be accepted if they have a history of mental health treatment and if they do not have any behavioral issues, current substance abuse, personality disorders, or any outstanding charges or

warrant (Luskin & Ray, 2015). This suggests that these factors are viewed as desired traits for participants during the selection process, since space is limited in MHC programs. Some other factors that may play a role include the applicant's internal motivation to participate, low symptom severity, and a diagnosis other than depression. It has been suggested that this may be the case due to the perceived less severe nature of a depression diagnosis compared to diagnoses such as bipolar disorder or schizophrenia, leading MHC officials to not perceive a diagnosis of depression to be associated with diminished capacity to appreciate the wrongfulness of their crime (Luskin & Ray, 2015). Once participants are chosen, the final stage includes approval by the MHC judge and informing the applicant of the program requirements. Upon receiving judge approval, participants can decide whether to opt-in to the program. Although there are many benefits associated with participation in a MHC program - such as avoiding incarceration and receiving treatment - there are many factors that can lead to a participant to elect to opt-out. These factors include negative perceptions of stigmatization and effectiveness of treatment, homelessness, and prior inpatient treatment (Bernstein, 2008; Edlund et al., 2002). Another reason clients may choose not to participate is due to the time commitment required. The programs typically takes at least a year to complete, while this can often times be a longer time commitment than the punishment one might receive if they plead guilty.

Most studies have found MHC programs to be generally effective in reducing recidivism so long as participants opt-in and successfully graduate from them. Honegger (2015) reviewed 20 studies of MHC effectiveness and found a significant relationship between MHC participation and reduced recidivism rates. Sarteschi, Vaughn, and Kim (2011) conducted a meta-analysis revealing an overall significant relationship between MHC's and recidivism reduction. Although these studies clearly show that MHC programs are overall effective at reducing recidivism, these

studies have also been criticized for their design, as it is nearly impossible to randomly assign participants to MHC's, and samples are not always representative of the population of interest. While an experimental design would be able to show causality between mental health courts and recidivism reduction, it is likely not ethically feasible to employ such a design.

Although it has been found that successful graduation from MHC programs is associated with reduced recidivism, unfortunately not all participants graduate from programs successfully. It is estimated that approximately 45% of those that enter a MHC program do not end up completing it (Ray, Hood & Canada, 2015). However, there are specific factors that have been tied to successful graduation of the program. Verhaaff and Scott (2014) found employment status had a significant effect on successful program completion, with unemployed participants being more likely to successfully complete programs than employed participants. A finding by Redlich and Han (2014) showed the importance of therapeutic jurisprudence, or the voluntary desire for participants to attend and succeed in these programs. It was found that this positive regard for the program is correlated with positive outcomes, ultimately leading to more successful completion.

The biggest predictor of non-completion of MHC programs is believed to be "non-compliance" (Wales, 2014). Generally, any resistance or non-adherence to the treatment requirements specified by the MHC may be considered non-compliance; the most common of which include missed treatment sessions, failed drug tests, and re-arrest. If a participant does not complete the MHC program, they return to traditional court where they either are sentenced to incarceration, receive probation, or their charges are dismissed. In one study, those who returned to traditional court and had their charges dismissed had a recidivism rate of 39% while those who were incarcerated had a recidivism rate of 79.2% (Ray et al., 2015).

In order for MHC programs to be most effective, it is important to have participants successfully complete them. Although many factors have been considered, treatment history has not been explored as a factor of mental health court outcome or completion. This is an important factor to examine as individuals with severe mental illness may go years without being diagnosed or treated until they come into contact with the criminal justice system. This is seen especially in cities with large homeless populations such as New York City, where there are many barriers that prevent these individuals from seeking mental health care (Brubaker, 2009).

Current literature regarding prior mental health treatment in MHC participants is scarce, revealing a strong need for more research in this area. A study regarding prior mental health treatment suggested that prior inpatient treatment significantly increased participant's willingness to enter a MHC program (Bernstein, 2008). In a sample of participants in a Florida MHC, 52.7% of participants had received prior outpatient or inpatient treatment, while 40.9% had not received any prior treatment (Tate, 2011), while, in a sample of MHC participants from Queens, NY, 78.6% of those accepted to the program had a history of prior treatment (Gu, 2014). This shows that most participants that are chosen to participate in mental health court programs do have a history of prior mental health treatment and they are more willing to participate; however, significant portions also do not have prior treatment histories, and the relationship between lack of prior treatment and outcomes remains unknown.

Study Overview

There has been a significant amount of research conducted examining the effectiveness of MHC programs nationwide. However, the majority of this research focused on who was selected and who decides to participate, as well as certain factors that may affect program completion, including employment status and non-compliance. The current study examined

whether prior treatment has an effect on the participant's outcome within the program. Based on the literature, it was expected that participants with a history of prior mental health treatment would have better outcomes in MHC programs, including more compliant behavior and more successful completion of the program than participants with no history of prior mental health treatment. This is supported by the tendency for those with prior treatment history to be more willing to enter MHC programs than those with no prior treatment. In order to test this, the archival records of previous MHC participants from Brooklyn LINK were studied and participants' history of mental health treatment, as well as their outcome in the program, was examined. The findings of this research can be used in order to help MHC programs better accommodate all participants regardless of their treatment history. This information may be used to create additional services for specific individuals in order to improve their completion rates.

Methods

Research Design

An archival analysis of existing data from the Brooklyn LINK Mental Health Court program was conducted. This analysis examined treatment history (no treatment, prior inpatient treatment, prior outpatient treatment) in relation to MHC program completion (completion, non-completion). Archival analysis was chosen for its non-invasive nature, time efficiency, and high ecological validity.

Participants

The charts of 66 female (15.8%) and 351 male (84%) past participants in Brooklyn LINK were reviewed. Data regarding the first 155 participants was received through an online database system. In order to obtain more data, the paper charts were reviewed systematically, selecting every other chart alphabetically by last name from A to Z. The sample consisted of 246 African

American participants (58.9%), 71 Hispanic participants (17%), 56 White participants (13.4%), 9 Asian participants (2.2%), and 20 participants identified as other or multiple races (4.8%). The ages of participants ranged from 16 - 76, with a mean age of 37.98 and a standard deviation of 12.26. 200 (47.8%) of participants reported a primary diagnosis of a psychotic disorder, 142 (34%) reported a primary diagnosis of bipolar disorder, 51 (12.2%) reported a primary diagnosis of mood disorder, 8 (1.9%) reported a primary diagnosis of anxiety disorder, 10 (2.4%) reported an unknown or no diagnosis, and 6 (1.4%) reported another diagnosis. 57 (13.6%) participants successfully completed the program, 49 (11.7%) were discharged due to receiving duplicate services, 124 (29.6%) were discharged due to being missing or absconded, 29 (6.9%) refused services, 1 (.2%) was transferred to a different jurisdiction, 2 (.5%) were transferred to a higher level of care, 3 (.7%) moved out of New York City, 28 (6.7%) were hospitalized, 65 (15.6%) were incarcerated, 54 (12.9%) didn't meet criteria for the program, 2 (.5%) were deceased, and 4 (1%) were discharged for other reasons. Those that were hospitalized, deceased, didn't meet criteria, received duplicate services, and refused services were excluded from the analysis. After excluding these participants, 251 participants remained. These participants were enrolled in the program from 14 days – 791 days, with a mean of 210 days and a standard deviation of 134 days. In order to gain access to the archival data, approval was obtained from Brooklyn LINK. All charts dated from 2015-2016 were included in the chart review.

Procedure

After receiving IRB approval from the City University of New York as well as approval from Brooklyn LINK, the charts of prior mental health court participants were systematically randomly selected, reviewed, and coded. This data was collected from the participants upon entering and was updated throughout the program. The charts were never removed from the

Mental Health Court facility, as researchers traveled there to code the data. Demographic information was first collected from the intake paperwork administered by Brooklyn LINK staff prior to the start of the program. These variables include gender, age, race, level of education, marital status, employment status, total time enrolled, as well as number of prior arrests, incarcerations, convictions, and violations. History of treatment and diagnosis as well as discharge reasons were reviewed and coded. Discharge reasons was dichotomized into successful or unsuccessful completion, excluding those that did not choose to participate in the program, did not meet criteria, or were discharged for reasons unrelated to their participation in the program.

Materials

In order to measure treatment history and outcome, the intake paperwork administered by Brooklyn LINK was reviewed for questions that were relevant to our research question. All 18 questions of interest are listed in Appendix A. These questions included demographic questions such as age, race, date of enrollment, and time enrolled. These variables were examined to determine if any of them are acting as covariates related to successful program completion, which may alter the relationship between prior mental health treatment and successful completion. Other questions that were included were, “Have you ever been hospitalized for a psychiatric illness?” “Has client ever seen a mental health professional?” Also, questions regarding the client’s arrest history and their outcome in the program were included. These questions were included because they directly relate to the program outcomes and history of mental health treatment. The variables of interest were coded and entered into a secure excel spreadsheet.

Results

Once all participant charts were reviewed and coded, the data with no identifying information was analyzed and interpreted using a Chi Squares Test of Independence as well as a binomial logistic regression in order to determine if specific factors are significant predictors of successful completion. The Brooklyn LINK patient charts were analyzed to reveal the effects of prior mental health treatment as well as other demographic characteristics on mental health court graduation. Of the 251 participants from Brooklyn LINK from 2015-2016 included in the analysis, 59 (23.5%) successfully graduated and 192 (76.5%) did not complete the program. Among the participants that didn't complete the program, 124 (63.9%) were missing, 65 (33.5%) were incarcerated, 3 (1.5%) moved out of New York City, and 2 (1%) were transferred to a higher level of care. A descriptive analysis of the time of program completion reveals that the program took approximately 20 to 791 days to successfully complete ($M = 286.40$, $SD = 138.30$); those that did not complete the program were enrolled for anywhere between 14 to 640 days ($M = 186.50$, $SD = 123.20$).

Chi-Squares Test of Independence

The results of the Chi Squares analyses looked at the differences between MHC completers and non-completers (see Table 1). Results showed that those who completed the MHC program were more likely to be White or Asian, female, and had less prior inpatient mental health treatment than those who didn't complete the program. There were no differences between those who previously received mental health treatment among those who did and did not complete the MHC program.

Table 1

Sample Characteristics of Participants by Graduation Status

| Characteristic | Non-completer | | Graduate | | Total | | Chi - Square | |
|----------------------------|---------------|-------|----------|-------|-------|-------|--------------|----------|
| | Mean | S.D. | Mean | S.D. | Mean | S.D. | χ^2 | <i>p</i> |
| Age | 38.65 | 12.23 | 38.63 | 12.99 | 38.64 | 12.39 | | |
| Gender | N | % | N | % | N | % | 4.43 | .035 |
| Male | 168 | 87.5% | 45 | 76.3% | 213 | 84.9% | | |
| Female | 24 | 12.5% | 14 | 23.7% | 38 | 15.1% | | |
| Race | | | | | | | 15.01 | .01 |
| African American | 121 | 63% | 27 | 45.8% | 148 | 59% | | |
| Hispanic | 31 | 16.1% | 12 | 20.3% | 43 | 17.1% | | |
| White | 20 | 10.4% | 16 | 27.1% | 36 | 14.3% | | |
| Asian | 1 | .5% | 1 | 1.7% | 2 | .8% | | |
| Other or Multiple | 8 | 4.1% | 1 | 1.7% | 9 | 3.6% | | |
| Treatment History | | | | | | | 1.51 | .471 |
| No Prior Treatment | 3 | 1.6% | 4 | 6.8% | 5 | 2% | | |
| Prior Inpatient Treatment | 173 | 90.1% | 46 | 78% | 219 | 87.3% | 6.60 | .010 |
| Prior Outpatient Treatment | 183 | 95.3% | 55 | 93.2% | 221 | 88.0% | | |

The results of the Chi Squares analyses examining differences between participants with no history of prior mental health treatment, history of prior outpatient treatment, and history of inpatient treatment (see Table 2) showed that those with and no prior hospitalizations had more favorable outcomes in the program, with more participants successfully completing the program and less participants discharged due to whereabouts unknown, $\chi^2 (df = 5, N = 250) = 19.84, p = .001$. Those with no prior mental health treatment at all, however, had less favorable outcomes in the program, with more participants being incarcerated or transferred to a higher level of care, $\chi^2 (df = 5, N = 245) = 24.34, p = .000$.

Table 2

Sample Characteristics of Prior Treatment

| Variable | No Prior Tx | | Prior Outpatient Tx | | Prior Inpatient Tx | | Total | | Chi - Square | |
|------------------|-------------|-------|---------------------|-------|--------------------|-------|-------|-------|--------------|----------|
| | M | S.D. | M | S.D. | M | S.D. | M | S.D. | χ^2 | <i>p</i> |
| Age | 33.60 | 11.39 | 39 | 11.99 | 38.74 | 12.51 | 38.64 | 12.39 | | |
| Gender | N | % | N | % | N | % | N | % | .08 | .779 |
| Male | 4 | 80% | 22 | 84.6% | 186 | 84.9% | 213 | 84.9% | | |
| Female | 1 | 20% | 4 | 15.4% | 33 | 15.1% | 38 | 15.1% | | |
| Race | | | | | | | | | 1.54 | .908 |
| African American | 4 | 80% | 15 | 57.7% | 129 | 58.9% | 148 | 59% | | |
| Hispanic | 0 | 0% | 2 | 7.7% | 41 | 18.7% | 43 | 17.1% | | |
| White | 1 | 20% | 6 | 23.1% | 29 | 13.2% | 36 | 14.3% | | |

| | | | | | | | | | |
|-------------------|---|----|---|------|---|------|---|------|--|
| Asian | 0 | 0% | 1 | 3.8% | 1 | .5% | 2 | .8% | |
| Other or Multiple | 0 | 0% | 0 | 0% | 9 | 4.1% | 9 | 3.6% | |

Correlation

Correlational analyses were then conducted examining associations between successful completion and background characteristics. Analyses showed there was a significant positive correlation between successful completion and level of education and length of program stay. There was a significant negative correlation between successful completion and number of previous arrests, number of previous convictions, and number of previous incarcerations. There was no correlation between successful completion and age and number of violations. There were no significant correlations between previous mental health treatment and all other variables, however there was a significant correlation between previous inpatient mental health treatment and education. This indicates that participants with a history of previous inpatient mental health treatment were more likely to have a lower education level than participants with no history of previous inpatient treatment.

Table 3

Correlational Analysis

| | Successful Completion | Previous Tx | Previous Inpatient Tx | African American |
|-------------|-----------------------|-------------|-----------------------|------------------|
| Age | -.001 | .058 | .016 | .110 |
| Prev Arrest | -.233** | .004 | -.005 | .236** |
| Prev | -.218** | .021 | .027 | .214** |

| | | | | |
|------------------------|---------|-------|---------|-------|
| Conviction | | | | |
| Prev Violations | -.132 | .056 | -.077 | .082 |
| Prev Incarcerations | -.214** | -.008 | -.038 | .176* |
| Education | .290*** | -.072 | -.181** | .130 |
| Program Length | .318*** | .032 | -.040 | -.075 |

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

Binomial Logistic Regression

Binomial logistic regression was then performed to determine whether prior mental health treatment was a significant predictor of successful program completion while taking into consideration other variables that may account for the relationship. Before performing the regression, preliminary analyses were conducted to ensure that the error terms are independent and the sample size was large enough. The model contained the variables of education and length of program stay. The full model containing all predictors was statistically significant, $\chi^2 (df = 3, N = 251) = 41.89, p = .$, indicating that the model was able to predict successful graduation of the mental health court program. The model as a whole explained 18% (Cox and Snell R square) of the variance in completion and correctly classified 83.9% of cases. As shown in Table 2, length of program stay, whether the client was African American or not, and level of education made a statistically significant contribution to the model at the .05 significance level. This suggests that participants with a higher level of education, longer time in the program, and those that are not African American are significantly more likely to successfully complete, while African

American participants with lower level of education and less time in the program were significantly less likely to successfully complete. In this model, prior mental health treatment was not a significant predictor of graduation at the .05 level. Those with prior inpatient or outpatient mental health treatment were not significantly more likely to successfully graduate than those with no prior mental health treatment. Of the variables significantly predictive of mental health court graduation, the odds ratios indicate that some were more predictive than others. In descending order, the most significant variable was level of education followed by length of program stay and race.

Table 4

Logistic Regression Predicting MHC Graduation (N= 251)

| | Model 1 | |
|---|-------------------|-------|
| | B (SE) | OR |
| Education | .525 (.123)*** | 1.690 |
| Length of Program Stay | .004 (.001)** | 1.004 |
| African American (Referent: All Other Categories) | -1.189 (.392)** | .304 |
| Constant | -7.614 (1.489)*** | .000 |

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

Discussion

This research was conducted in order to determine if prior mental health treatment is related to successful MHC completion. The results of this study do not support the hypothesis that prior mental health treatment is related to successful graduation from a mental health court program, with prior inpatient treatment leading to more successful completion. In fact, the results

of the study support the opposite, that prior inpatient treatment was related to less successful completion.

Although findings are consistent with the findings of Luskin and Ray (2015) that the majority of those who are accepted have a history of mental health treatment, as 95.6% of the participants had previously received mental health treatment, there was no significant difference found in successful completion among those that had a history of mental health treatment in general. However, there was significant difference found among general program outcomes among those with a history of mental health treatment, with incarceration and transference to higher level of care being more common among those with no prior mental health treatment than those with prior mental health treatment. This finding provides some support for the hypothesis. Conversely, considering that only five of the 251 had received no prior mental health treatment at all, findings may not be generalizable to MHCs where larger numbers of “treatment naïve” persons are accepted.

The results of the binomial regression showed that education, length of program stay, and whether or not the participant was African American were significant predictors of mental health court completion. Length of program stay can be explained due to the fact that the program is designed to take an average of 12-18 months to complete. Those that are discharged earlier than the time it takes to complete all requirements are usually unsuccessful in the program. Those that stay in the program long enough to complete all requirements are more likely to successfully complete.

Findings also suggested that participants that were not African American and had more education were more likely to complete the program. It is possible that education level may be acting as a proxy for other variables, such as socioeconomic status, intellectual functioning and

social support, which may facilitate successful program completion. Education was also found to be associated with race and prior criminal justice history. It was found that although the majority of participants were African American, they were less likely to complete the program than other participants, particularly White and Asian participants. When the variable of race was dichotomized as African American or not, race became a significant predictor of successful completion. Race may also be a proxy for socioeconomic status and social support. Number of arrests, convictions, and incarcerations, as well as history of prior inpatient mental health treatment were all related to education and successful completion. Fewer arrests, convictions, and incarcerations, along with no prior inpatient treatment are related to a higher education level and therefore higher rate of successful completion. Number of arrests, convictions, and incarcerations were also related to race, with African American participants having more arrests, convictions, and incarcerations than all other races. Prior inpatient mental health treatment, however, was not related to race.

There are many theories that suggest socioeconomic status is related to criminal involvement as well. Those from higher SES families grow up receiving more support financially and emotionally and receive more supervision than those from lower SES families. They may receive more favorable treatment from police and the criminal justice system when they come into contact with them, leading law enforcement to be more likely to dismiss their behavior than to arrest them (Galloway & Skardhamar, 2010; Robles, 2005). The relationship between number of arrests, convictions, and incarcerations and education is supported by research that suggests education acts as a deterrent from crime or recidivism, leading to lower instances of re-arrest, in turn leading to lower instances of convictions and incarcerations (Matsuyama & Prell, 2010).

The relationship between education and previous inpatient treatment is less explored and more difficult to explain, as there is no research that has looked at this. It is possible that more highly educated individuals are more functional and adaptive in regards to their mental illness than those with lower education levels, as severe mental illness can impede one's ability to achieve higher levels of education. This logic can also be applied to the finding that prior inpatient mental health treatment was related to less successful completion. Participants with more severe mental illness that lead to hospitalization may impede their ability to complete the program, just as it may impede their ability to continue with their education. This would support the finding that participants without a history of inpatient treatment are more likely to successfully complete the program. Another possible explanation for this can be linked to socioeconomic status, with participants of higher SES receiving more familial and financial support to receive constant outpatient mental health care and medication if needed to prevent them from having to be hospitalized. Someone from a low SES may rely on inpatient mental health care more frequently as they may not receive the same constant care and support.

Implications

These findings suggest that those that are considered the more healthy and functional clients are more likely to complete the mental health court program than those with more severe mental illness. This is problematic, because these programs are specifically targeted towards use with severely mentally ill individuals. With evidence to support the idea that participants with less education and prior inpatient mental health treatment fair worse in mental health court programs, these programs could benefit from tailoring their program specifically to individuals with very low education levels as well as those with severe mental illness that have impaired daily functioning. A suggestion would be use materials with elementary reading levels and

implement a psycho-educational element to the program to better address the client's educational deficits that may prevent them from completing the program. In regards to severe mental illness, the program should be re-structured to take this into account and problem solve ways to increase motivation and participation among these severely mentally ill individuals. Possible home interventions such as an Assertive Community Treatment (ACT) team may be beneficial for this population.

Additionally, the completion rate of 23.5% found in this study appears to be troublingly low while other studies that have found completion rates to be approximately 55% (Ray, Hood & Canada, 2015). Taking into consideration the large differences among MHC programs nationwide, Brooklyn LINK may not be representative of MHC programs as a whole due to the variation in selection criteria of participants. However, other factors that may have contributed to the low completion rate include the restriction of the time period of admission to 2015-2016, operationalization of "successful completion, and the location of the program.

Restricting the participants to those admitted in 2015 and 2016 only allotted participants two to three years to complete the program before data was collected. There may be a higher rate of successful completion for those that took even longer to complete, if data was collected from an earlier time point, possibly including participants admitted between 2013 and 2014.

Also, it is unclear how other studies operationalize "successful completion." In this study, those that were hospitalized were excluded, although they could have completed all requirements necessary to be considered a successful completion. Also, we excluded participants that were discharged due to receiving services from multiple agencies regardless of their standing in the program. It is unclear what other studies classified as successful completion, which could have had a large impact on the percentage of successful completions.

Another important consideration is the location of the study and how this could impact successful completion. More than half of those that did not complete were discharged due to whereabouts unknown, which is directly related to a lack of stable housing for clients. In New York City, it is especially difficult to find housing due to the high cost market and large homeless population competing for housing opportunities. If a client is unable to secure housing or loses their housing assignment and is unable to communicate this with the agency, there is no way to contact them and their cases are typically closed after loss of contact for 30 days or more.

Although the results from this study cannot be generalizable to all mental health court programs, the low rate of completion necessitates further exploration, as this may be problematic regarding overall effectiveness of these programs. In this program specifically, it may be beneficial to implement ways to reduce loss of contact with clients, including home check-ins and increased communication with other services the client may be receiving.

Limitations and Further Research

Although this research may be highly impactful for mental health court programs, this study also has some limitations. Due to the naturalistic nature of the study, a causal relationship cannot be inferred between treatment history, education, length of program stay, and MHC graduation. Additionally, because the data was extracted from an archival data set, the data collected was limited to what was originally collected by the court. Without being able to follow up and clarify with the participants, it is difficult to determine whether or not each participant understood what constitutes prior treatment. Some people may have received counseling or treatment during a prior incarceration that they do not classify as treatment, since it was not in the typical clinical setting. Further research is needed to conduct a more controlled experiment in order to determine whether causality can be inferred between treatment history and MHC

graduation. In this experiment, it would be advantageous to explore the concept of prior treatment through follow up questions, in order to clarify the definition of treatment and make sure the definition is clear and constant for all participants. Also, it would be beneficial to use a larger sample in order to gain a larger sample of participants with no prior mental health treatment, as there were only five individuals out of the sample of 251 that reported no prior mental health treatment.

Conclusions

Overall, this study provides a strong framework for future studies to further examine the relationship between prior mental health treatment and MHC graduation as well as other variables such as education and the relationship between mental illness and MHC graduation. The analyses provide sufficient evidence for further exploration into this topic, and possible resolutions should be discussed in order to remedy this issue and further increase MHC graduation rates leading to even lower recidivism rates.

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Appendix A

Questions Reviewed from Charts:

1. Number of Prior Arrests
2. Number of Prior Convictions
3. Number of Prior Incarcerations
4. Admission Date
5. Discharge Date
6. Age at Intake
7. Date of Birth
8. Diagnosis
9. Reason for Discharge
10. Ethnicity
11. Gender
12. Are you currently being treated for a psychiatric condition?
13. Are you currently receiving medication for this condition?
14. Has client ever seen a mental health professional?
15. Have you ever been hospitalized for a psychiatric illness?
16. Highest level of education
17. Is client currently employed?
18. Marital Status