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Mental Health Courts and Their Selection Processes: Modeling Variation for Consistency

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Abstract

Admission into mental health courts is based on a complicated and often variable decision-making process that involves multiple parties representing different expertise and interests. To the extent that eligibility criteria of mental health courts are more suggestive than deterministic, selection bias can be expected. Very little research has focused on the selection processes underpinning problem-solving courts even though such processes may dominate the performance of these interventions. This article describes a qualitative study designed to deconstruct the selection and admission processes of mental health courts. In this article, we describe a multi-stage, complex process for screening and admitting clients into mental health courts. The selection filtering model that is described has three eligibility screening stages: initial, assessment, and evaluation. The results of this study suggest that clients selected by mental health courts are shaped by the formal and informal selection criteria, as well as by the local treatment system.

Keywords

Mental health courts; Admission processes; Selection bias

Over the last 30 years, problem-solving courts have shifted the criminal court's focus from criminal processing to therapeutic healing (Casey & Rottman, 2003). Mental health courts, one type of problem-solving courts, are diversion interventions designed to engage defendants with mental illnesses in treatment in lieu of incarceration (Wolff, 2003). These courts have grown in popularity in recent years, with over 170 currently being in operation throughout the United States. For perspective, there are nearly 2500 drug courts in operation in the United States (<http://www.ndci.org>). The political appeal as well as diffusion of these courts is being fueled in part by favorable, albeit speculative, performance evidence. The "evidence" inclusive of numerous descriptive accounts, anecdotal assessments, and quasi-experimental studies describes modest but uneven positive outcomes associated with participation in mental health courts (Almquist & Dodd, 2009; Center for Behavioral Health Services and Criminal Justice Research, 2009). Interpreting this evidence is challenging because it is unclear with regard to the extent to which the improved outcomes can be

attributed to the mental health court intervention itself, its process for selecting clients, or some combination of these and other unmeasured factors.

Admission into mental health courts is based on a complicated and often variable decision-making process that involves multiple parties representing different expertise and interests (e.g., judges, prosecutors, defense attorneys, victims, clients, clinicians. etc.) (Wolff, 2002; Wolff & Pogorzelski, 2005). The mere reason that a defendant has a combined criminal charge and mental illness falling within the court's eligibility criteria is not sufficient to determine admission into the court. Likewise, the fact that a criminal charge and/or mental illness (of a defendant) fall outside the court's eligibility criteria is not sufficient to preclude admission. To the extent that the eligibility criteria of mental health courts are more suggestive than deterministic, selection bias can be expected. Also if practiced routinely, selection bias in case selection may, in part or in full, drive performance outcomes more than the interventions themselves (Luskin, 2001). For example, the program may admit persons who are particularly low- or high-risk, or who are inappropriate for the services offered by the intervention.

Not knowing the source of the improved outcomes attributed to mental health courts compromises the transportability of the intervention and its effectiveness to other settings. If performance outcomes are driven by (idiosyncratic) case selection processes, then the mental health court intervention can only be expected to work for a specific class of defendants with mental illnesses, not the general class of defendants with mental illnesses. This is especially problematic when the special class of defendants is small relative to the general class (suggesting weak penetration into the target population), or the decision rule process generating the special class of defendants cannot be readily replicated because it relies on hard-to-measure factors (e.g., "treatability").

Very little research has focused on the selection processes underpinning problem-solving courts even though such processes may dominate the performance of these interventions. For this reason, this article describes a qualitative study designed to deconstruct the selection and admission processes of mental health courts, including key decision points and decision makers, and then model them in ways that can capture and document consistency and variability in selection. Without an understanding of the court's targeting, recruitment, and selection process, the results from formative evaluations and early efficacy and effectiveness studies can lead to misleading conclusions, inappropriate expansion or dissemination of interventions, poor replication of the program model, and the distortion of the evidence base.

Mental Health Courts and Client Selection

Mental health courts have several defining characteristics including: (1) a specialized docket of cases, in which defendants have a mental illness; (2) a collaborative and non-adversarial team comprised of a judge, prosecuting and defense attorneys, and a mental health representative; (3) a link to a local mental health system; and (4) some form of compliance monitoring, with sanctions for non-compliance (Wolff, 2002). Some arrested individuals with mental illnesses are offered the option of participating in a mental health court in lieu of traditional court processing (i.e., they do not go to court, plead guilt or innocence, and receive a sentence if found guilty). Clients of mental health courts may forgo criminal processing (i.e., they are not prosecuted) altogether, undergo criminal processing (i.e., they are prosecuted on criminal charges) but forgo sentencing, or receive an alternative favorable sentence for participating and completing the mental health court program (Goldkamp & Irons-Guynn, 2000; Steadman, Davidson, & Brown, 2001; Watson, Hanrahan, Luchins, & Lurigio, 2001).

The eligibility criteria for mental health courts typically require that defendants have a mental illness, which may or may not be defined as serious, chronic, or persistent, and criminal charges that are non-violent in nature and most often classified as a misdemeanor (Wolff, 2002; Wolff & Pogorzelski, 2005), although some mental health courts accept violent charges and felonies (Goldkamp & Irons-Guynn, 2000; Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). How these cases are identified, screened, and recruited is less clear. Potential clients could be referred to the mental health court by a prosecutor, defense attorney, family member, treatment provider, judge, jail personnel, police officer, and so forth. They may be screened formally by the court team or a case coordinator with mental health training, with or without the assistance of mental health staff. The information used to determine eligibility may be formalized in a screening protocol, or it may be more informal and specific to a team or individual. Even when found eligible for the court, issues of treatability, motivation, convictability, and support from victims and the defense attorney may independently impact selection and recruitment of clients.

The confluence of all these factors on selection easily predicts variation in client pools among and between mental health courts. Variation in the client pools may occur because of eligibility requirements mandated by criminal justice personnel or the court itself, poor or inconsistent program identification or recruitment practices, mixed or variable support among team members, improper matching of services to the target population, or other forms of structural rigidities or flexibilities that restrict or expand the identification, recruitment, or selection of ostensibly eligible clients. In addition, courts may use different incentives and disincentives to encourage participation in the court and, as such, introduce selection bias (Redlich, Hoover, Summers, & Steadman, 2010). These motivational inducements may foster or hinder the interests of potential clients and the support from defense attorneys.

Selection bias limits the “penetration” of diversion interventions into the target population. For example, in drug court and treatment diversion programs, it is typical for only about one-third of eligible offenders to be admitted to the programs, with one-third being rejected at some point in the recruitment process and one-third refusing to participate (Belenko, 2002; Lang & Belenko, 2000). Random assignment does not guarantee representativeness (Wolff, 2000). Candidates for inclusion ultimately self-select to participate in many randomized clinical trials, and as such they may not be representative of the general target population, resulting in poor external validity and low generalizability (Brown et al., 2009; Grimshaw & Eccles, 2004; Tucker & Roth, 2006). In part, this may explain why it can be difficult to replicate significant effects when interventions are brought to scale or implemented in different sites under less rigorous experimental controls.

None of the above issues has been rigorously studied, and issues of selection bias are routinely ignored in the clinical trials and the effectiveness literature (Farrington, 2003; Oxman, 1994; Schulz et al. 1995). For intervention research to accurately and reliably inform research, practice, and policy, it is important to understand how best to create a recruitment process that allows more equal access to programs, minimizes selection bias, identifies the potential sources of such bias, and estimates of penetration into the target population. This article is the first to examine and model this selection and admission process for mental health courts.

Methods

The unit of analysis is an intervention. Qualitative methods and document review were used to deconstruct six mental health courts into their structural and procedural parts, with emphasis on the parts that relate to the court’s design, targeting, and recruitment processes.

The deconstruction of the courts focused primarily on how potential clients were identified, screened, and recruited for participation in the courts and on the decision rules used to exclude and include defendants with mental health problems.

Site Selection

Six courts from different regions in the United States were selected according to four criteria: they had an adult caseload; had been in operation for at least 3 years; had one prior external performance evaluation; and they had program size (defined as capacity or typical caseload). A sampling frame of mental health courts was compiled using information from the Council of Governments Justice Center Local Programs Database, the National Center for State Courts, court administration or mental health systems in various states, and by contacting program managers or judges for specific mental health courts (Council of Governments Justice Center Local Programs Database; National Center for State Courts). The initial frame included 173 adult mental health courts. Criteria-specific information was obtained for 56 mental health courts.

For the remaining courts, a staff person could not be reached or was unable to respond to several queries about this information.

Of the courts for which information was available, 24 (43%) mental health courts met the first three eligibility criteria. For the fourth criteria, these 24 were ranked by caseload size, ranging from 25 to over 500 participants. We divided the range into quartiles, and selected courts in the second and third quartiles (43–145). To ensure regional representativeness, one of the mental health courts selected had a program size outside the second and third quartiles, but was located in a targeted region of the United States. All the six courts selected agreed to participate in the study. The participating mental health courts served 60–182 clients per year in geographic areas with populations ranging from 100,000 to over one million people in the following regions of the country: Northeast, South, Midwest, West, or Pacific Northwest.

Interviewee Selection

The interviewee population consisted of key informants affiliated with each court, such as judges, prosecutors, defense attorneys, probation, and program staff, in addition to staff from organizations that provide services to clients of these courts. A snowball sampling method was used to identify interviewees. Initially, key informants for each court were identified through discussions with a liaison for each court and a review of relevant court materials. From these interviews, other key informants were identified. A total of 87 people were invited to participate in an interview, of which two declined, yielding a final sample of 85 (98% response rate). Written consent was obtained from each interviewee. The interviewee sample included 9 judges, 8 prosecutors, 10 defense attorneys, 13 court managers, coordinators, or supervisors, 13 behavioral health court staff, 23 service providers, 4 probation/supervision or law enforcement agents, and 7 other informants (e.g., NAMI representatives, paralegals, research staff, jail administrators).

Data Collection and Analysis

The authors spent 1 week at each court site conducting interviews and observing court sessions and court-related meetings. A semi-structured interview protocol was used to interview key informants. Interviews and site visits were conducted by two doctoral- and one masters-level researchers. Site visits occurred between April 2009 and July 2009. With the exception of three interviews conducted by telephone, interviews were conducted on site, in person, and were audio-recorded. Court sessions and staff meetings were not recorded, although copious notes were taken. Recordings of interviews were transcribed and

entered into *Atlas.ti* software. A preliminary codebook was created on key aspects of the study and on themes that emerged during the interview process. Two researchers independently coded all of the transcripts. After the coding was completed, the reviewers discussed and came to an agreement on all coded passages, and re-defined, deleted, added, and merged codes until a final codebook was generated. One researcher then conducted a second- and third-stage analysis of the portions of the data that directly pertained to client identification, selection, and recruitment process. In addition to the field data, written background material was obtained from each court and used in the analysis. This information included initial court prospectus/application, historical documents describing aspects of the court and its modification, all quarterly and annual reports and court evaluations (process and impact), and documents related to informed consent, waivers, and eligibility determination. In addition, to provide local contextual information, basic background information on the local criminal justice population was obtained from local government agencies.

Results

The selection of clients for mental health courts was characterized by three stages: initial screening; assessment screening, and evaluation screening. The terminology here reflects the screening language of the American Psychiatric Association's framework for *Psychiatric Services in Jails and Prisons* (2000). Initial screening originates with one of the two filtering agents: the district attorney or the mental health court coordinator/supervisor/director. The outcome of this process is the sample of clients enrolled in a mental health court. For ease of exposition, we will refer to candidates for mental health court as "clients."

"Selection" Filtering Models of Mental Health Courts

Three stages of client screening were identified for mental health courts. Each stage will be described in turn.

Stage 1: Initial Screening—Stage 1, referred to as initial eligibility screening, captures the process by which defendants with mental illnesses are identified as potential clients for the court. This centralizing stage was found to have one of the two "filtering" agents. They are the district attorney and the mental health court team coordinator/director/supervisor. Referrals for initial screening come from a variety of sources including the mental health court team itself, prosecutors, district attorneys, arraignment courts, police officers, defense attorneys, probation officers, jail staff, family members, and advocacy groups such as NAMI.

The initial filtering agents have two primary functions. First, they serve a clearinghouse function whereby all potential clients for the mental health court are centrally referred for initial consideration. Second, they perform an initial eligibility screening function that considers whether referred potential clients are sufficiently appropriate for the court. In general, initial screening compares the potential client's charges and criminal history, as well as evidence of mental illness to the mental health court's formal eligibility criteria. At this stage of review, prosecutors as filtering agents typically consult with victims, as well as defense attorneys, on their willingness to have the case referred to a mental health court. Mental health court coordinators/directors/supervisors as filtering agents may also consult with prosecutors and defense attorneys on these issues. This varies, however, by court. In our sample, Court Four had a clinical supervisor who unilaterally decided initial eligibility for the court. This person collected clinical and criminal history evidence and rendered a decision without consulting the prosecutor or the mental health team. By contrast, the initial

mental health court coordinators for the other courts variably consulted with prosecutors and the judge during Stage 1 screening.

In Stage 1, selection variation effects are introduced at several points. Participation among the referral sources is central. Some mental health courts may not be well known or respected by referral sources, reducing the number and type of clients referred to Stage 1 filtering agents. Courts with more system-wide support, that are integrated more formally or informally with referral sources, such as the jails and defense attorneys, and with more favorable reputations are likely to have more sources of referrals and greater flows of potential clients, yielding greater penetration into the target population of defendants with mental illnesses. All the courts in our sample were well known and respected; however, the support from prosecutors and defense attorneys varied among courts. More specifically, for all but two mental health courts in our sample, defense attorneys were identified as the largest referral source. These courts also reported strong support from the defense and prosecuting attorneys. The two mental health courts with the least support from defense and prosecuting attorneys relied either on the mental health court clinical staff to identify cases or a wide variety of referral sources. Client identification for these two courts depended solidly on active recruitment by the mental health court coordinators or case managers.

The criteria used by Stage 1 filtering agents to screen potential clients for referral to the mental health court introduce another potential source of selection variation. Formal criteria for eligibility vary among mental health courts by the types of charges and criminal histories (see Table 1, Stage 1 in Appendix). Speaking in general, mental health courts only allow cases with non-violent, misdemeanor charges (Wolff, 2002; Wolff & Pogorzelski, 2005). Half of the mental health courts in our sample considered cases with felony convictions. However, filtering agents in our sample were found to vary in their willingness to bend the interpretation of the charges to fit the case for the mental health court: if, for example, the district attorney had a weak case against the defendant, then mental illness played a central role in the violent criminal behavior, or the victim was a family member. In addition, while many filtering agents required the victim's assent before referring cases to the mental health court, there was considerable variation in the extent to which filtering agents worked with the victims to gain their buy-in. Some other informal and idiosyncratic filtering screens used by these agents included the potential client's prior experience with the mental health court, support from other referral sources, and the nature and history of the client's problems in the community and service use history. A summary of selection variation among the six mental health courts by stage can be found in the Appendix (Table 1).

Stage 2: Assessment Eligibility Screening—Potential clients who meet the requirements of Stage 1 initial eligibility are then referred for a more in-depth review and screening to Stage 2 in the screening process, conducted by the mental health court team. Stage 2 assessment eligibility screening focuses principally on determination and assessment of behavioral health problems and related criminal history issues. Court Six is an exception. This court conducts assessment eligibility screening in Stage 1, focusing only on criminal history issues in Stage 2.

All mental health courts have eligibility criteria related to mental disorder. Some courts in our sample defined their clinical criteria broadly—any Axis I disorder as well as dementia, organic brain damage or developmental disabilities, and chronic alcoholism with psychosis, while others used narrow criteria inclusive only of schizophrenia, schizoaffective disorder, or bipolar disorder with an additional requirement of being “disengaged from community services” (see Table 1, Stage 2 in Appendix). Documentation of mental disorder also varied among courts in our sample; some courts required a psychiatric evaluation or mental health assessment, whereas others accepted a diagnosis obtained from case record review.

Even when potential clients met the formal diagnostic criteria, other clinical factors were considered. Clinical screening staff reported considering other types of co-occurring behavioral health problems, such as personality disorders or drug or alcohol problems. These problems may disqualify a potential client if they are deemed primary to the criminal behavior. All of the courts in our sample would consider cases with co-occurring substance abuse or personality disorders if they were not the primary diagnoses, and two would occasionally consider certain Axis II diagnoses, particularly borderline personality disorder, as primary diagnoses.

Other informal eligibility criteria reported by clinical staff related to treatment engagement. For example, some clinical staff reported that eligible clients usually must have a history of treatment but not a history of leaving treatment programs and qualify for intensive case management services. “Treat-ability” was a major criterion mentioned by most clinical staff and it was determined in part by treatment history and client compliance with treatment. Compliance with treatment was based in part on a review of treatment history and in part by the clinician’s subjective assessment of the client’s willingness and ability to comply with treatment conditions that would be mandated by the court. Other eligibility criteria reported by clinicians of the courts in our sample included their assessment of the strength of connection between the client’s mental illness and criminal behavior; violence risk; and the client’s “suitability” for the court.

Another key eligibility criterion involves criminal justice status, including the current charges and criminal history. While the clinical team works up the clinical assessment in Stage 2, other team members may be gathering criminal history data and consulting with the defense and prosecuting attorneys. However, this depends on who conducts the Stage 1 filtering. When the district attorney is the Stage 1 filtering agent, legal determination is in place before Stage 2 is initiated and, as such, mental health court team members do not conduct criminal history reviews. Criminal history review may play a more primary role in Stage 2 screening if the mental health team conducts a rigorous mental health screening during Stage 1 (e.g., Court Six).

Once the case review is complete, the case is considered by the mental health court team for admission to the mental health court; this is the final step of Stage 2. Even here, the process used by the team to make selection decisions varies. Courts in our sample were mixed in how they reviewed cases; two courts used an “assembly line” process, three courts used a “team” approach, and another used a proxy decision maker. The assembly-line process involves a series of “sign offs” by various mental health court team members: clinical staff, prosecutor, defense attorney, and judge. According to one study informant, at any point in the process various team members could question or appeal a rejection that was made by the district attorney or mental health screeners, but this rarely happened, and for the most part, team members trusted each screener’s decisions. Courts using a team approach often convene review meetings but always discuss the merits of the case among team members, although not always in a meeting setting. The proxy decision maker, typically the clinical coordinator, supervisor, or director, has the delegated authority to make unilateral selection decisions on behalf of the mental health court team.

All of these case review approaches include clinical staff making a recommendation for or against admission. Cases that satisfy initial eligibility criteria can be rejected in Stage 2 on (1) *diagnostic grounds*—not having the required Axis I diagnosis or having a primary diagnosis of substance abuse or personality disorder; or having the required Axis I disorder but not needing intensive case management; (2) *service availability grounds*—treatment services required are not available or client does not meet diagnostic eligibility required by the treatment provider; and (3) *mitigating factor grounds*—weak connection between mental

illness and criminal behavior; assessed not treatable, too prone to violence, or “not suitable” for the court, meaning the client’s demeanor or issues do not “fit the culture” of the mental health court. The recommendation proffered by the clinical staff may be rejected by the defense attorney, prosecutor, or the judge. In some cases, the legal and clinical staff may recommend admission to the mental health court, only to have the recommendation rejected by the judge. In our sample of courts, judges associated with four of the six courts usually deferred to and accepted the recommendations of the clinical staff. The other two courts were strongly judge driven, having judges who were integrally involved in the selection process and who would use their judgment to override recommendations offered by the clinical staff.

Overall, in Stage 2, the selection process was highly variable. Some mental health court teams have highly evolved collaborative selection processes in which communication flows smoothly among the various team members and respect for professional expertise characterizes the culture of engagement. These teams generally reached consensus easily and followed the recommendations of the clinical team members. Other courts relied less on team models of selection and more on the preferences of the clinical supervisor, judge, or prosecutor, which were informed by the recommendations of the clinical staff.

Moreover, selection variation during Stage 2 is endogenous to the formal and informal diagnostic criteria for eligibility, the clinical data used to determine clinical eligibility, the subjective and objective judgments used to determine “treatability” and “suitability,” and the social process by which clinical and criminal information and recommendations are communicated and processed within the mental health court team.

Stage 3: Evaluation Eligibility Screening—Stage 3 is the final step in the selection process and pertains to the decisions of the mental health court judge and the client before final approval for admission. Some judges within our sample required a first meeting with approved clients before admitting them to the court and these judges reserved the right to veto their participation in the court, regardless of staff decisions made in Stages 1 or 2 (see Table 1, Evaluation Eligibility Screening in Appendix). Clients approved for the court also have the right to refuse participation. Approved clients may refuse to participate in the court after learning about the conditions of the court relative to traditional criminal processing and based on advice of counsel. All things considered, they may decide or be advised by their attorney that it is not in their best interest to participate in the court even though they have been approved for admission.

Motivation also may be externally induced by the court through the use of incentives that encourage participation. Incentives used by our sample of mental health courts included dismissing criminal charges upon successful completion, waiving jail time, or reducing the charges from a felony to a misdemeanor or the sentencing conditions. Induced motivation may encourage the participation of clients who are less intrinsically motivated to treatment and more extrinsically averse to criminalization. A number of studies of substance abuse treatment have pointed to the important and sometimes complex roles of both internal and external motivation in initial treatment engagement as well as long-term retention (Joe, Simpson, & Broome, 1998; Wild, Roberts, & Cooper, 2002; Young & Belenko, 2002). Our findings suggest that the selection process for mental health courts incorporates elements of both internal and external motivation.

Discussion

It has been argued that mental health courts as a model of intervention are idiosyncratic in their design and implementation (Goldkamp & Irons-Guynn, 2000; Wolff & Pogorzelski,

2005). Relatedly, issues of selection bias by mental health courts, as well as other problem-solving courts such as drug courts, have been raised by critics as a possible explanation for their putative treatment and criminal justice outcomes (Belenko, 2002; Belenko, Wolff, & Holland, 2009; Wolff, 2003). For these reasons, our study was designed as an in-depth analysis of the selection procedures and processes of a sample of mental health courts, with the goal of developing a generalized understanding of the selection process used by mental health courts to identify, screen, and recruit clients.

Our data indicate that there is general consistency among mental health courts in the stages used to identify, screen, and select clients for mental health courts. We found three general stages, which we labeled as initial, assessment, and evaluation eligibility screening stages; two centralizing “filtering” agents—district attorney and mental health court team coordinator/director/supervisor; and multiple referral sources—mental health teams, courts, police officers, defense attorneys, probation officers, jail staff, family and other agents for persons with mental illness. The order of the screening stages was consistent across the six sample mental health courts, although the content of the screening varied depending on the type of filtering agent; prosecutor filtering agents focused narrowly on criminal screening in Stage 1 initial eligibility screening, while mental health court filtering agents may focus on clinical screening. There were also some generalized tendencies, with mental health courts with more support from the legal community to rely more on referrals from defense attorneys, whereas courts with less support relied more on the pro-activity of the mental health court team to identify cases from a wider group of referral sources.

While the sampled mental health courts filtered cases through three eligibility stages, there was considerable variation within these three stages, making each court somewhat unique in the profile of clients selected for participation. Variation was introduced in Stage 1 primarily through the criminal justice requirement that filtered out certain types of current criminal charges (e.g., all felonies, particular types of felonies, or misdemeanors with sentences of less than 60 days), certain types or number of current or prior convictions (e.g., sex offenses, extreme violence, or more than three felonies in the previous 10 years), or cases in which the defendant was not in custody. Also, some courts filtered out cases in which the victim did not consent to mental health court diversion, mental illness was not strongly linked to criminal behavior, or the victim was not a family member. The criminal cases left after the Stage 1 filter varied from infractions to misdemeanors with sentences of more than or less than 60 days to violent felonies in which the crime may or may not have been directly linked to client’s mental illness.

In most courts sampled, Stage 2 focused primarily on the behavioral health assessment evidence. The diagnostic filter used in Stage 2 among the sampled courts ranged from any Axis I disorder to only severe and persistent mental disorders in which the person had a need for intensive case management, and sometimes included Axis II disorders (e.g., borderline personality disorder) or developmental disabilities if treatment resources were available. The service filter, if applied, eliminated cases in which the client’s diagnosis did not meet the diagnostic criteria of the treatment provider or where services needed by the client were not locally available. The service filters used by the courts sampled were endogenous; it was related less to the court itself and more to the local treatment service system connected to the court, adding an environmental dimension to client selection (Wolff & Pogorzelski, 2005). Finally, a more refined clinical filter was applied to the remaining cases. This filter screened on “treatability,” “suitability,” and “risk of violence.” This filter focused on clinical impressions of the client’s ability to engage in treatment or comply with court expectations. Overall, the recommendations of the mental health court clinical staff informed and, in many of the sampled courts, determined the final Stage 2 selection of cases for the mental health court. There were, however, different decision-making approaches used by the sampled

courts (proxy decision maker, assembly line process, team approach, etc.) to reach case selection decisions.

Preferences of the selected client and judge served as the final filter in Stage 3. In some courts, judges wanted a “meet and greet” with the prospective client before signing off on a client’s admission to the court, while other judges did not require such meetings. All courts, however, required that prospective clients give consent to participate in the court, where consenting included a requirement of treatment compliance. Consent to participate was encouraged in different ways by different courts: most relied on differing degrees on legal motivations regarding the charges upon completion of the program; some agreed to dismiss or reduce charges; while others eliminated jail time.

By choosing (self-selecting) to participate in the mental health court, clients may be signaling that they have treatment preferences that align with those of the court. In terms of selection bias, motivation to the treatment goals of the court may result in a self-selected group of clients who accepts their mental disorder and are amenable to mental health treatment. This type of preference matching is most likely for misdemeanor clients who, by participating in the court, might be under court supervision longer than if they plead guilty in criminal court but will be guaranteed access to treatment while under the court’s supervision. Clients with felony convictions have more legal motivation to participate in mental health courts, which may override their reluctance to engage in treatment (Redlich et al., 2010). Motivation to treatment is important because it predicts treatment engagement (Kreyenbuhl, Nossel, & Dixon, 2009; DiClemente, Nidecker, & Bellack, 2008) and may, in effect, predispose mental health courts to successful treatment and perhaps criminal justice outcomes.

Overall, we found both consistency and diversity within the process of selecting clients for the sampled mental health courts. Whether we accurately captured the full range of selection consistency and diversity among mental health courts is an empirical question for the next stage of research. Nonetheless, a limitation of our study is that it is based on only six mental health courts. These courts were sampled to broadly represent the size, maturity, and geographic location of mental health courts and for the purpose of understanding their selection processes and to identify patterns of selection behavior. Our goal was not to quantify the representativeness of each type of selection process but to describe general and deviating patterns observed in the selection process. As such, we deconstructed the selection processes of these courts and developed a general model of selection. The three stages readily emerged from our data, as did the domains of variation. The range of variation found in these six courts broadly fits the descriptive characterization of mental health courts (Goldkamp & Irons-Guynn, 2000; Redlich et al., 2006).

This article has identified a multi-stage, complex process for screening and admitting clients into mental health courts that involve a number of key decision points and filter agents. As such, it is not surprising that mental health and other problem-solving courts admit only a relatively small proportion of potentially eligible persons. Our findings suggest that there is enough likely variation in the selection processes of mental health courts to recommend the development of methods to measure and document the selection processes of mental health courts. This information is required to control for the effects of selection on outcomes within and across mental health court evaluations. Indeed, sample selection variation on the order described herein could be used to explain the mixed and variable findings for mental health courts; they are driven by the variation in client samples, not the court itself. This hypothesis cannot be tested without a more standardized method for measuring who is selected and deselected from the court, nor will we be able to test for the “penetration” potential of mental health courts as a diversion strategy.

Our general model suggests that the clients selected ultimately by the court will be shaped by the formal and informal selection criteria of the courts, as well as by the local treatment system. The challenge is to develop a selection tool that can capture the variation in meaningful ways that are measureable. It will be relatively straightforward to measure the screening filters based on hard evidence, such as criminal charges and diagnostic criteria, but will be harder to measure the soft evidence filters that rely on judgments and preferences, which are known for their subjectivity. These measurement challenges, however, pale in comparison to the challenges of making any sense out of the existing mental health court evidence base without a way to control for selection effects.

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Appendix

See Table 1.

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Table 1

Summary of selection variation among the six mental health courts by stage

Mental health court	Type of filter agent	Stage 1: initial eligibility screening	Stage 2: assessment eligibility screening	Stage 3: evaluation eligibility screening
Court 1	District attorney	<p><i>PF Screener:</i> District attorney</p> <p><i>Criminal History Screen:</i> Felonies and misdemeanors are considered, including violent charges</p> <p><i>Mental Health Screen:</i> None</p> <p><i>Screen Out Factors:</i> Cases with extreme violence, e.g., murder, very serious sex offenses, violence where serious injuries resulted, violence where a gun was used. Otherwise, the court will look at most charges on a case-by-case basis</p> <p><i>Consent Factors:</i> With rare exception, victim's consent is required. Also, the assigned prosecutor on the case must agree to the MHC.</p>	<p><i>Evidence Collected:</i> DA passes eligible cases to the MHC director. Clients are independently assessed by a psychiatrist, master's-level clinical social worker, and a case manager; MHC team makes a consensus assessment about MH eligibility</p> <p><i>Screener:</i> MHC team</p> <p><i>MH Screen:</i> Severe and persistent mental illness, defined as bipolar, schizophrenia, schizoaffective disorder, and major depression. Some exceptions made for people with severe anxiety or PTSD. Co-occurring substance abuse or Axis II allowed but not if primary diagnosis. Exceptions made for young people (~ages 16–20) who are not seriously mentally ill but who have mild mental illness, e.g., non-major depression</p> <p><i>Other Eligibility Factors:</i> Strength of connection between mental illness and criminal behavior; treatment compliance while in jail (i.e., must take meds because shows "motivation."); past treatment compliance; and suitability for the court (i.e., "fits with the culture of the court")</p>	<p><i>Judicial Discretion:</i> MHC court judge meets with each client and can veto participation</p> <p><i>Client Discretion:</i> Client must consent to participate</p> <p><i>Participation Incentives:</i> Client is presented with a legal offer ranging from case dismissal to charge reduction</p> <p><i>Participation Requirements:</i> Client must plead guilty to the charges, and agree to abide by treatment recommendations</p>
Court 2	District attorney	<p><i>PF Screener:</i> District attorney</p> <p><i>Criminal History Screen:</i> Misdemeanors and infractions are considered. DA reviews current charges and criminal history</p> <p><i>Mental Health Screen:</i> None</p> <p><i>Screen Out Factors:</i> Defendants who have had more than 3 felony convictions in the past 10 years, any prior murder, or sex offense convictions are not eligible. No traffic offenses (like DUI) allowed</p> <p><i>Consent Factors:</i> None reported</p>	<p><i>Evidence Collected:</i> Clients are screened by a master's-level MHC monitor, who determines initial diagnostic eligibility</p> <p><i>Screener:</i> MHC monitor</p> <p><i>Mental Health Screen:</i> Schizophrenia, schizoaffective disorder, bipolar disorder or major depression.</p> <p>Co-occurring substance abuse or Axis II allowed but not if primary diagnosis. Sometimes allow a primary diagnosis of mental retardation or borderline personality disorder</p> <p><i>Other Eligibility Factors:</i> Client must meet diagnostic eligibility required by the local treatment provider</p>	<p><i>Judicial Discretion:</i> None reported</p> <p><i>Client Discretion:</i> Client must consent to participate</p> <p><i>Participation Incentives:</i> Charges will be dismissed upon graduation</p> <p><i>Participation Requirements:</i> No plea is required. Client must agree to adhere to treatment conditions</p>
Court 3	Mental health court	<p><i>PF Screener:</i> MHC coordinators with master's or doctoral-level clinical training</p> <p><i>Criminal History Screen:</i> All misdemeanors; Felonies if reduced to misdemeanors</p> <p><i>Mental Health Screen:</i> Axis I mental illness, dementia, organic brain disorder, developmental disabilities or chronic alcoholism with psychosis. Co-occurring substance abuse or Axis II allowed but not if primary diagnosis</p> <p><i>Screen Out Factors:</i> Violent criminal history;</p>	<p><i>Evidence Collected:</i> Client is observed for a period of time under preliminary supervision by the MHC. For those in active treatment, treatment information is collected from provider; For those without treatment history, a full diagnostic evaluation is conducted. During this time, the prosecution and defense attorneys discuss possible case outcomes</p> <p><i>Screener:</i> Entire MHC team</p> <p><i>Eligibility Criteria:</i> Eligible diagnosis and demonstrated compliance with initial treatment</p>	<p><i>Judicial Discretion:</i> MHC court judge must agree to allow the client to participate</p> <p><i>Client Discretion:</i> Client must consent to participate</p> <p><i>Participation Incentives:</i> Client is presented with a legal offer that ranges from case dismissal to reduction of charge to avoidance of jail time</p> <p><i>Participation Requirements:</i> Client must plead guilty before formally entering the program. The client is also presented with a</p>

Mental health court	Type of filter agent	Stage 1: initial eligibility screening	Stage 2: assessment eligibility screening	Stage 3: evaluation eligibility screening
Court 4	Mental health court	<p>felony case not reduced to misdemeanor; prior multiple failures with MHC; out-of-county residency</p> <p><i>Consent Factors:</i> If the case is a felony, the victim's consent is sought, but not absolute requirement</p> <p><i>PF Screener:</i> Clinical supervisor of MHC</p> <p><i>Criminal History Screen:</i> Misdemeanors with sentence of 60 days or more of jail time</p> <p><i>Mental Health Screen:</i> Diagnosis of bipolar, schizo-affective, or schizophrenia, and generally disengaged from community-based treatment. Co-occurring substance abuse or Axis II allowed but not if primary diagnosis</p> <p><i>Screen Out Factors:</i> No prior sex offense convictions</p> <p><i>Consent Factors:</i> None reported</p>	<p>plan</p> <p><i>Screen Out Factors:</i> Treatment services are not available; lack of treatment compliance; new serious charges while being considered for MHC</p> <p><i>Evidence Collected:</i> MHC clinical supervisor or jail MH clinician conducts a mental health evaluation. MHC supervisor conducts criminal background as well</p> <p><i>Screener:</i> MHC clinical supervisor</p> <p><i>Eligibility Criteria:</i> Eligible diagnosis and would "benefit" from services (target those who are disengaged from treatment services)</p> <p><i>Screen Out Factors:</i> Criminal history primarily drug-driven; already receiving more treatment services than MHC can provide; do not want treatment; too resource intensive (e.g., might be determined for someone with a co-occurring Axis II disorder, for example)</p>	<p>treatment plan that he or she will have to follow if he or she enters mental health court</p> <p><i>Judicial Discretion:</i> Judge meets each client before they officially participate, but the judge almost always goes with clinical recommendation</p> <p><i>Client Discretion:</i> Client must consent to participate</p> <p><i>Participation Incentives:</i> Charges will be dismissed if client successfully completes program</p> <p><i>Participation Requirements:</i> Client must plead guilty to the charges and comply with treatment recommendations</p>
Court 5	Mental health court	<p><i>PF Screener:</i> MHC director</p> <p><i>Criminal History Screen:</i> Misdemeanors or low-level, non-violent felonies. Violent felonies are accepted on case-by-case basis and accepted only if crime was strongly or directly linked to mental illness or victim was a family member</p> <p><i>Mental Health Screen:</i> Schizophrenia, schizoaffective disorder, bipolar and major depression</p> <p><i>Screen Out Factors:</i> Extensive history of violence</p> <p>Violent felonies except in special cases noted above</p> <p><i>Consent Factors:</i> None reported</p>	<p><i>Evidence Collected:</i> MHC director collects prior treatment and diagnostic information from local agencies; also gets information from the jail about psychotropic medications and prescribing physician</p> <p><i>Screener:</i> MHC director and prosecutor for misdemeanor cases; defense, prosecutor, judge, and MHC director for felony cases</p> <p><i>Mental Health Screen:</i> Eligible diagnosis</p> <p><i>Other Eligibility Factors:</i> For felony court, a long history of hospitalizations because it demonstrates person has been sick for awhile. Must have a service plan that includes a place to live, treatment, etc</p> <p><i>Screen Out Factors:</i> No service plan</p>	<p><i>Judicial Discretion:</i> For cases involving felonies, MHC judge meets each client before allowing him or her to participate</p> <p><i>Client Discretion:</i> Client must consent to participate</p> <p><i>Participation Incentives:</i> A wide variety of case outcomes exist for both the misdemeanor and felony tracks</p> <p><i>Participation Requirements:</i> Some clients must plead guilty to the charges before participating, while others are not required to plea before participation. All clients must comply with the treatment plan given to them by their providers</p>
Court 6	Mental health court	<p><i>PF Screener:</i> Master's level clinician at the jail</p> <p><i>Criminal History Screen:</i> Accept violent and nonviolent felonies and misdemeanors but only if person is in-custody</p> <p><i>Mental Health Screen:</i> Axis I diagnosis or a diagnosis of borderline personality disorder (if BPD is assessed to drive criminal behavior) or mental retardation (if service plan can be made with local regional center), with long history of using EIR services, and needs intensive case management. Exceptions are made for clients who don't have an in-county mental health service history, or clients who don't have a mental health history because they have had their first break</p> <p><i>Evidence Collected:</i> MH evaluation conducted at jail. Jail-based clinician accesses person's in-</p>	<p><i>Evidence Collected:</i> Criminal history</p> <p><i>Mental Health Screen:</i> Conducted in Stage 1</p> <p><i>Legal Screen:</i> MHC District attorney looks at the person's current charge and criminal history. Prosecutor will consult with the district attorney on the case but retains final discretion. Violent crimes are considered if connection between the crime and mental illness is strong. Victims are consulted but their consent is not required. Merits of the case are considered</p> <p><i>Screen Out Factors:</i> Any case where the prosecutor's office wouldn't have otherwise settled for anything less than state prison. The prosecution must be willing to settle the case for probation. No murders or sex offenses. A criminal history that includes a prior sex offense conviction is considered on a case-by-case basis</p>	<p><i>Judicial Discretion:</i> The judge may veto participation</p> <p><i>Client Discretion:</i> Client must consent to participate</p> <p><i>Participation Incentives:</i> Case outcomes vary from case dismissal to reduction of charges to other options</p> <p><i>Participation Requirements:</i> Sometimes the person must plead guilty before participating, sometimes not. Client must agree to the treatment plan</p>

Mental health court	Type of filter agent	Stage 1: initial eligibility screening	Stage 2: assessment eligibility screening	Stage 3: evaluation eligibility screening
		county service use history, which may be augmented with MH records and social history provided by defense attorney <i>Screen Out Factors:</i> No clear connection between the crime and mental illness; no murder or sex offenses; do not need ICM services; or have history of leaving treatment programs <i>Consent Factors:</i> None reported		