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From Referral to Disposition: Case Processing in Seven Mental Health Courts

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The number of mental health courts in the United States is rapidly increasing, from one in 1997 to nearly 100 in 2004. However, to date there is comparatively little research regarding these specialty courts. The present study reports data on the referral and disposition decision-making processes of seven mental health courts. Information on all referrals to the seven courts over a three-month period was gathered. Results show that, in comparison with individuals involved in the criminal justice system, mental health court clients are more likely to be older, White, and women than individuals in the general criminal justice system. Furthermore, this over-representation occurs at the point of referral, rather than at the point of the court's decision to accept or reject a referral. In addition, the length of time from referral to diversion is much longer in these mental health courts than in other types of diversion programs. Implications of these findings are discussed. Copyright © 2005 John Wiley & Sons, Ltd.

Mental health courts have grown rapidly in the United States, from one in 1997 to approximately 100 today (National GAINS Center, 2004). However, research on these specialty courts has not kept pace with their growth. To date, the multi-site studies that exist are descriptions of the structures and operations of four early courts (Goldkamp & Irons-Guynn, 2000), those courts plus four others (Griffin, Steadman, & Petrila, 2002), and seven newer courts supported by the 2002 Bureau

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of Justice Assistance Mental Health Courts Initiative that Redlich, Steadman, Monahan, Petrila, and Griffin (in press) termed ''second generation'' courts, in contrast to the ''first generation'' examined in the two prior studies.

The most ambitious research projects published have been single-site outcome studies in Broward County, FL and Santa Barbara, CA. The Broward study has produced a series of papers on the operation of the court (Petrila, Poythress, McGaha, & Boothroyd, 2001; Poythress, Petrila, McGaha, & Boothroyd, 2002), and the characteristics and service use of the participants (Boothroyd, Poythress, McGaha, & Petrila, 2003), with analyses on participant outcomes now being conducted. The Santa Barbara study was a randomized control trial comparing an MHC participant sample and a treatment-as-usual (control) sample (Cosden, Ellens, Schnell, Yasmeen, & Wolfe, 2003). Both samples had been referred and found eligible for the MHC, but were randomly assigned into their respective groupings. The authors found that the experimental and control groups had similar rearrest rates and days in jail over the first year, but the MHC subjects were more often rearrested for technical violations of probation while the controls were rearrested for more serious charges.

The dearth of research on the outcomes of mental health courts relative to their proliferation is not surprising. The growth in the number of courts reflects the broader trend in court administration towards problem-solving specialty courts such as drug courts, domestic violence courts, and community courts (Petrila, 2003). In addition, the emergence of mental health courts reflects the frustration of the criminal justice system in processing a higher volume of persons with serious mental illness and seeing some of the same persons with mental illnesses continually recycle through arrest, criminal court adjudication, and release. As a result, the number of mental health courts has expanded rapidly for reasons other than an empirical database demonstrating their efficacy (Steadman, Davidson, & Brown, 2001).

In many ways, the mental health court movement sharply contrasts the drug court movement. For example, drug courts nearly from their inception had a strong, federally supported model from which to draw. In contrast, mental health courts tend to be locally driven, reflecting the styles and values of founding judges. Drug and mental health courts do share rapid and prolific growth. The first drug court was established in Dade County, FL, in 1989. Today there are 1823 drug courts. This widespread enthusiasm reflects a response to the need for a therapeutic alternative to the stringent sentencing schemes for drug crimes enacted in the 1980s. This option, when combined with early federal support for a model for the structure of drug courts that required a standard training procedure for all recipients of federal grants via heavily funded technical assistance centers, fueled adoption in jurisdictions across the country. Moreover, research has suggested positive outcomes for drug court clients (Belenko, 1999), fueling their continued growth.

Mental health courts have developed in a different context. To date, the only federally supported technical assistance for these courts is the center operated by the Council of State Governments, established in 2003 to provide support for the 37 mental health courts funded by the Bureau of Justice Assistance in 2002 and 2003. Other than an initial grantee meeting held in January 2004, there are no formal training requirements for these courts' personnel. Nor has the federal government articulated either a specific or general model for the core characteristics of MHCs. Rather, communities have largely followed their own paths in creating programs that will best serve local needs. Whether the research on mental health courts can

inform program development in the same manner as research has informed the development of drug courts remains to be seen.

Our goal in this paper is to advance the knowledge base that can inform communities searching for alternatives to the unnecessary incarceration of people with serious mental illness. The present study was designed to examine the referral and disposition decision-making processes of mental health courts (MHCs). Given that mental health courts have emerged without reference to a standard model, it is important to begin to understand the characteristics not only of those who enter the court's jurisdiction, but also to understand the characteristics of those *referred* for possible entry to the court and the processes by which communities make such decisions. To our knowledge, there is only one prior study of case processing, which occurred in the Marian County, IN, Psychiatric Assertion Identification and Referral (PAIR) Program (Luskin, 2001). Luskin's case study of this court-based diversion program found that a history of felony convictions, a current charge of a crime against a person, and being male decreased chances for diversion. In contrast, older males and younger females were advantaged for diversion.

We present data from seven MHCs, all of which were partially funded by the Bureau of Justice Assistance. The seven courts (major cities within the jurisdiction are in parentheses) were (1) Santa Clara, County, CA (San Jose); (2) Orange County, NC (Chapel Hill, Hillsborough); (3) Allegheny County, PA (Pittsburgh); (4) Washoe County, NV (Reno, Sparks); (5) Brooklyn, NY (Brooklyn); (6) Bonneville County, ID (Idaho Falls); and (7) Orange County, CA (Anaheim, Santa Ana). The courts varied in caseload size (from approximately 20 in Bonneville County to more than 600 in Santa Clara County), but all followed a therapeutic jurisprudence model (Wexler & Winick, 1992). More specifically, the court proceedings were less formal than most traditional court proceedings, and usually one judge was assigned responsibility for the court's docket. The courts all aimed to increase the willingness of defendants to participate in treatment and to positively affect their mental health. The presiding judges usually attempted to create an alliance with the mental health court client, often doing so through praise for small and large accomplishments. In addition, non-compliance with court mandates did not necessarily result in the use of formal sanctions (e.g. increased supervision, jail), but rather was viewed as a near inevitable part of court participation, relapse, and recovery. More descriptive information about these courts can be found in the article by Redlich et al. (in press).

Our research questions concerned (1) how cases were referred, processed, and disposed of by the courts and (2) whether there were factors that distinguished cases *accepted* by the court from cases *referred* to the court. We were also especially interested in whether mental health courts, like the majority of other jail diversion programs (Naples & Steadman, 2003), would have older, White women disproportionately represented in comparison to their numbers in the criminal justice system as a whole. That is, the number of older, White women involved in the justice system is low, but individuals with these three characteristics—separately and combined—make up significant portions of the persons diverted from the criminal justice system to community-based mental health treatment. The design of the present study allows for determinations of whether this over-representation is a product of the diversion referral or acceptance process. Finally, findings from this study are intended to inform a prospective, multi-site outcome study currently being planned.

METHOD

Data were collected on all ''formal referrals'' to the seven courts during a 3-month time period. A formal referral was identified slightly differently for each court, but generally it was a person who had passed through that court's pre-defined referral process.

Court staff completed a one-page questionnaire for every formal referral between November 1, 2003, and January 31, 2004. The questionnaire had three parts: (1) identification of the referring agent, (2) characteristics of the referred person, and (3) the disposition decision. For the referring agent, a list of potential agents was supplied (e.g. Public Defender's Office, Other Judge/Magistrate), as well as an ''other'' option. Characteristics of the referred person included demographic information (age, gender, race/ethnicity), criminal charge information (most severe current charge, number of misdemeanor and felony charges), and mental health/substance abuse information (diagnosis if available, presence of substance abuse problems). Information on the disposition decision included the date of disposition, whether the referred person had been accepted or rejected for entry into the court, or whether a decision had not been made (either because the defendant opted out of consideration or for another reason). If the referred person had been accepted, information was collected on whether the person actually enrolled. If the person was rejected, reasons for rejection were obtained.

Generally, one person at each court completed the questionnaire. Depending upon the size of the court, the role of the person within the court differed. For example, in some of the larger courts where resources for a ''data'' employee were available, this person completed the forms. In order to allow time for disposition of all referred cases, data collection ran for 5 months.

RESULTS

Over the 3 study months, 285 persons were referred to the seven courts, varying from 15 to 91 referrals per court: Santa Clara County, CA, 36; Orange County, NC, 18; Allegheny County, PA, 91; Washoe County, NV, 73; Brooklyn, NY, 28; Bonneville County, ID, 15; and Orange County, CA, 24.

Referring Agent

As seen in Table 1, five of the seven courts listed the public defender's office as either their primary or secondary referral source. Another common source of referrals was

Table 1. Main referring agents

	Primary referring agent	Secondary referring agent
Santa Clara Co., CA	Other judge/magistrate (58%)	Public defender's office (28%)
Orange Co., NC	Public defender's office (78%)	District attorney's office (17%)
Allegheny Co., PA	Forensic diversion program (33%)	Public defender's office (29%)
Washoe Co., NV	Court officials (34%)	Other judge/magistrate (30%)
Brooklyn, NY	Public defender's office (43%)	Competency examination order (29%)
Bonneville Co., ID	Public defender's office (80%)	Probation (13%)
Orange Co., CA	Mental health court judge (58%)	Other judge/magistrate (42%)
Overall	Public defender's office (29%)	Other judge/magistrate (20%)

another judge or magistrate in the court system. Six of the seven courts processed their MHC cases post-adjudication, thereby allowing other judges to make referrals to the mental health courts. Finally, nearly one-third of referrals to the Brooklyn, NY, MHC originated from competency to stand trial examination orders. All persons referred for competency exams in Brooklyn are required to be referred to this MHC.

Characteristics of Referrals

In comparison to persons in jails and prisons (see Beck, Karburg, & Harrison, 2002), mental health court referrals in our sample were more likely to be older, White, and women. As seen in Table 2, the mean age of referral for five of the seven courts was mid-30s, and percentages of those 35 and older ranged from 20 to 71%. The Bureau of Justice Statistics (Beck et al., 2002) reports that only 39% of all inmates are age 35 and older, whereas in our overall sample 53% were age 35 and older. Four of the seven courts had participant age 35 or older rates that were substantially higher than the national rate, one court had a similar rate, and two courts had rates that were lower.

The percentage of men referred to the mental health courts ranged from 45 to 72% with an overall mean of 60%. In U.S. jails and prisons, men make up 90 to 94% of all inmates (Beck et al., 2002). Thus, proportionally, at least in these courts, women are much more likely to be referred to these seven mental health courts than men. There was wide variability across the seven courts in the ethnicity of

Table 2. Characteristics of referrals

	CA 1	NC	PA	NV	NY	ID	CA 2	Overall
Demographic characteristics								
Mean age in years	36.7	36.2	38.5	36.4	29.3	26.3	34.7	35.8
% 35 years and older	54.5	47.1	71.4	60.3	26.1	20.0	41.7	52.5
% Men	72.2	61.1	67.0	45.2	71.4	53.3	54.2	60.4
% White	55.6	50.0	52.3	75.3	7.7	93.3	70.8	58.4
% African American	19.4	38.9	45.5	11.0	61.5	0	8.3	28.7
Mental health characteristics								
No/unknown mental illness	19.5	11.1	6.6	20.6	17.9	20.0	16.6	14.7
% Schizo spectrum	38.9	27.8	27.5	35.6	17.9	20.0	16.7	28.8
% Bipolar	5.6	11.1	27.5	21.9	17.9	26.7	0	18.9
% Depression/mood	19.4	16.7	28.6	16.4	32.1	6.7	25.0	22.5
% Personality	0	5.6	0	1.4	0	13.3	0	1.4
% Anxiety	2.8	11.1	4.4	4.1	0	13.3	4.2	4.6
% Substance related	11.1	0	1.1	0	3.6	0	37.5	5.3
% Other diagnoses	2.8	16.7	4.4	0	3.6	0	0	3.2
Criminal charge characteristics								
% Felony charges	69.4	16.7	6.6	46.6	89.3	93.3	100	46.1
% Drug related	74.2	5.9	10.2	13.7	23.1	33.3	100	28.5
% Minor offenses	0	29.4	21.6	15.2	3.8	0	0	13.1
% Property	16.1	29.4	22.7	39.7	11.5	33.3	0	24.5
% Crimes against persons	0	11.8	15.9	2.7	7.7	0	0	7.3
% Violent	5.6	17.7	28.4	23.3	50.0	20.0	0	22.9
% Other charges	2.8	5.9	1.1	5.5	3.8	13.4	0	3.6

CA 1 = Santa Clara Co., CA; CA 2 = Orange County, CA.

individuals referred, which may have reflected the geographic diversity of the courts (for example, in Bonneville County, the overwhelming majority population of the county is White). Proportions of Whites referred to the courts ranged from 8 to 93%. Again, when compared to jail and prison populations, which are comprised of 63% minorities, Whites are overrepresented in most of the courts. One exception is Brooklyn, where the majority of persons referred were non-White.

Across the seven courts there was no clear pattern regarding the mental health characteristics of the participants. Generally the three most common diagnoses reported were schizophrenia/schizoaffective disorder, bipolar disorder, and depressive/mood disorders. In the Orange County, CA, MHC, which is a dual-diagnosis court with funding drawn from appropriations for substance abuse treatment, a substantial number of referrals had been diagnosed with substance-related disorders, such as methamphetamine dependence and drug-induced psychosis. Many of the other courts noted that they were unwilling or unable to take on such cases, sometimes due to limitations in the types of case community mental health service providers were allowed to consider. Finally, about 20% of the referrals in five of the seven courts were described as not having a mental disorder after further screening and assessment, or it was unknown whether the person had a mental disorder. In the other two courts, rates were lower at 7% (PA) and 11% (NC).

Most courts maintained a clear misdemeanor/felony distinction. That is, for four courts, the majority of referrals had felony charges, whereas for two courts, most referrals had misdemeanor-only charges. In contrast, in the Washoe County, NV, MHC, the number of referrals with felony charges and with misdemeanor-only charges was approximately the same.

In terms of the types of charge, in the two California MHCs, which were both dual-diagnosis courts and partially funded by California Proposition 36 Funds (i.e. a mechanism allowing for treatment alternatives to incarceration for first-time and second-time nonviolent drug possession offenders), the majority of referrals had drug-related charges as their most serious current charge. In the Orange County, CA, court, 100% of the charges were drug related, which was a requirement of the court. Importantly, given that the ''first generation'' of mental health courts generally avoided assuming jurisdiction over individuals charged with violent offenses, six of these seven courts had referrals with charges that suggested that the offense could have been violent (e.g. aggravated assault, arson, robbery).

Disposition Decisions

The proportion of all referrals ultimately accepted by the courts ranged from 20 to 100% (see Table 3). The Bonneville County, ID, MHC had the lowest rate, of 20%, most likely because this court is linked to an ACT team that has a maximum capacity of 20 participants. Orange County, CA, had a similar acceptance rate. Three courts accepted approximately 50% of referred cases, while the remaining two courts accepted all or nearly all of their referrals. The percentage of defendants opting out of the court before a decision was made or where no decision was made was generally low (5%), with one exception. In slightly less than one-third of their referred cases, Washoe County, NV, did not decide to accept or reject the referral, because the referred person had been let out of jail on ''time served.''

Table 3. Disposition decisions

	CA 1	NC	PA	NV	NY	ID	CA 2	Overall
Disposition decisions								
% Accepted	88.9	100	44.0	49.3	50.0	20.0	20.8	51.9
% Rejected	11.1	0	46.2	19.2	39.3	73.3	62.5	34.0
% Defendant opted out	0	0	7.7	4.1	7.1	6.7	8.3	5.3
% Decision not made	0	0	2.2	27.4	3.6	0	8.3	8.8
Time from referral to disposition								
Mean in days	1.19	10.9	47.3	18.8	25.3	20.6	36.2	27.5
Mode in days	0	0	*	5	14	*	42	0
Acceptance results								
% Defendants enrolled	100	100	82.5	100	100	33.3	100	93.9
Primary rejection reasons								
% Ineligible: mental disorder	100	NA	4.8	14.3	36.4	36.4	86.7	29.9
% Ineligible: crime	0	NA	23.8	21.4	9.1	18.2	13.3	18.6
% DA declined	0	NA	40.5	0	0	0	0	17.5
% Incompetent/unstable	0	NA	0	14.3	45.5	0	0	7.2

CA 1 = Santa Clara Co., CA; CA 2 = Orange County, CA. *Cannot be calculated, multiple modes.

The length of time that elapsed from referral to disposition varied widely, ranging from an average of 1 day to more than 45 days (Table 3). The modal time period across the seven courts was 0 days (occurring 39 times, 14%), i.e. the decision was made on the day of referral. However, the Santa Clara County, CA, and Orange County, NC, MHCs accounted for 33 of these 39 cases. Of the remaining five courts, all but one (Allegheny County, PA) had made at least one disposition decision on the same day the person had been referred. When the 39 cases of same day referral–disposition decision are excluded, the average length of time across courts from referral to the decision to accept or reject the referral was 32 days.

Most of the individuals accepted by the MHC team also agreed to enroll in the court. In five of the seven courts, 100% of those offered acceptance into the mental health courts enrolled. In the Bonneville County, ID, court, the rate of one-third enrollment is somewhat misleading. The Bonneville County MHC accepted three persons, and of these one enrolled. One of the other two individuals was supposed to enroll after getting out of prison (this court is a post-conviction MHC) and the other had been extradited to Wisconsin. In the Allegheny County, PA, MHC, seven persons who had been accepted did not enroll: one person chose not to enroll, one person was considered too unstable to enroll, and the five remaining could not be located. Interestingly, for these seven individuals, the lag time between referral and acceptance was quite long: for the person who declined enrollment, 64 days; for the person who was unstable, 129 days; and for the five who could not be found, 70–80 days.

While people were rejected for a variety of reasons (Table 3), a primary reason accounting for 30% of all rejections (but ranging from 5 to 100% across courts) was that the referred person was ineligible because of mental health status. More specifically, this could mean that the person (1) did not have a mental disorder or (2) did not have a mental disorder consistent with the court's eligibility requirements (e.g. did not have an Axis I diagnosis). Another common basis for rejection was that the person was ineligible for reasons relating to current or past criminal

charges, accounting for approximately one-fifth of the rejections. In one court—the Allegheny County, PA, MHC—a significant portion (41%) of referrals were rejected because the DA declined to permit the case to proceed to MHC. The primary reason (46%) for rejection in the Brooklyn MHC was that the referred person was considered incompetent or too unstable at that time to make the decision to enroll and to participate in the court's proceedings. As noted above, a large portion of Brooklyn's referrals originated from competency examination orders from other criminal courts. Only one other court (Washoe County, NV) cited incompetence to proceed as a reason for rejection. Finally, other less common rejection reasons included that other parties or agencies (i.e. defense attorney, probation, mental health care system) declined (6.2%); that the person was considered unmotivated/too hostile (3.1%); or that the person was deemed more appropriate for another specialty court, such as a drug or pre-booking diversion court (5.2%).

Characteristics of Persons Accepted

In the section above, we discussed the characteristics of persons *referred* to the seven mental health courts. Of major interest is whether persons who are accepted into the courts differ from those referred. Because of small sample sizes, we were precluded from examining the data for each site separately. Thus, for the analyses described below, we first collapsed data across six of the seven courts (data from the Orange County, NC, MHC have been excluded because they did not reject anyone). Second, to examine whether the results we found across the six courts held for two of the courts individually, we re-conducted separate analyses with data from the Allegheny County, PA, and Washoe County, NV, MHCs. These two courts were the only ones to have sufficient numbers of accepted and rejected persons to conduct reliable analyses (see Table 3). Because we were unable to conduct analyses separately for each of the seven courts, these findings should be viewed with caution, while providing preliminary insight into an important, understudied area.

For demographic characteristics, we focused on age and gender. For mental health characteristics, we focused on no or unknown mental illness versus mental illness versus serious mental illness (i.e. schizophrenia, schizoaffective, and bipolar disorders). For criminal characteristics, we focused on percent accepted/rejected with violent charges. We performed logistic regressions predicting characteristics of persons who were accepted into the courts compared with persons who were rejected. Persons who opted out or for whom no disposition decision was made were excluded. Lastly, we examined whether the time lag between referral and disposition was shorter for persons who had been accepted versus rejected.

The logistic regression, which included six of the seven courts and predicted differences between those accepted ($n = 130$) and those rejected ($n = 97$), was significant, $\chi^2(5) = 37.71$, $p < 0.001$, Nagelkerke $R^2 = 0.21$, and 69% of participants were correctly classified. As shown in Table 4, age was not a significant predictor of acceptance decisions. The difference between the mean age of those accepted, $M = 35.12$, and those rejected, $M = 36.49$, was not significant, $F(1, 237) = 0.92$. The rates of acceptance for men and women also did not differ. Overall, of those accepted for enrollment, 42% were women. In addition, being

Table 4. Predictors of acceptance decisions

	All MHCs except NC			PA			NV		
	B	Wald (1)	*p*	B	Wald (1)	*p*	B	Wald (1)	*p*
Age	−0.01	0.25	0.62	0.01	0.05	0.83	−0.07	2.58	0.11
Gender (0 = male, 1 = female)	0.51	2.58	0.11	1.44	6.05	0.01	−0.41	0.21	0.64
White (0 = no, 1 = yes)	−0.18	0.36	0.55	0.24	0.19	0.67	0.75	0.52	0.47
Mental illness (0 = no MI, 1 = MI, 2 = SMI)	1.30	28.37	0.001	1.34	7.93	0.01	1.75	8.38	0.01
Violent charges (0 = no, 1 = yes)	−0.48	1.73	0.19	−0.68	1.38	0.24	-0.28	0.08	0.78

MI = mental illness; SMI = serious mental illness.

White was not predictive of acceptance decisions (overall, 56% of those accepted were White).

In terms of mental health status, a large significant effect emerged (Table 4). Not surprisingly, persons who did not have a mental illness or persons whose mental illness status was unknown were more likely to be rejected than accepted. However, a total of five persons were accepted into an MHC without a known mental disorder. Moreover, persons with schizophrenia, schizoaffective, and bipolar disorders were much more likely to be accepted than rejected. Of those referrals with a serious mental illness, 76% were accepted. Persons with other types of mental disorder (e.g. depression, substance-related disorders) were approximately equally likely to be accepted or rejected (i.e. 44% were accepted). Another area of interest concerned acceptance/rejection rates of those with violent charges. Persons with violent charges were no more or less likely to be accepted than those without similar charges.

Next, we conducted logistic regressions to determine whether the results we found overall (excluding NC) held for the Allegheny County, PA, and Washoe County, NV, courts. Separate regression analyses were conducted and both were significant, $\chi^2(5) \geq 15.39$, $p < 0.01$, Nagelkerke $R^2 = 0.29$ for PA and 0.38 for NV. For the PA and NV MHCs, respectively, 71 and 80% of participants were correctly classified. Results concerning age, being White, and severity of mental illness did not change (see Table 4). Specifically, age and being White did not influence acceptance–rejection decisions, but degree of severity of mental illness positively predicted acceptance decisions. In regard to gender, women were more likely to be accepted (69%) than men (38%) in the PA court, but for the NV court men (74%) and women (70%) were accepted at equivalent rates. In regard to violent charges, results remained non-significant.

Lastly, we conducted an analysis of variance (ANOVA) to determine whether the mean time between referral and disposition differed significantly between those who were accepted and those rejected. When data from all of the MHCs were entered (again, excepting North Carolina), the main effect of time was significant, $F(1, 222) = 4.11$, $p < 0.05$. Decisions for persons who had been accepted, $M = 25.43$ days, were made in shorter periods of time than for those who had been rejected, $M = 32.95$ days. However, when data from Pennsylvania and Nevada only were entered into separate ANOVAs, the time between referral and disposition decision for those accepted and rejected was non-significant, $F(1, 47/80) \leq 1.75$.

DISCUSSION

Prior research has shown that there is no single model for the structure of U.S. mental health courts. Similarly, the case processing data presented here show that there is no standard way in which cases are managed from referral to the decision to accept or reject the person for admission to the MHC. The parties that make initial referrals to the mental health courts are fairly similar. Public defender offices were either the primary or secondary reference in five of seven of the courts studied. At the same time, there are few commonalities concerning the characteristics of those referred. Mean age of referrals varied from 26 to 38 years. The proportion of cases that were male ranged from 45 to 72%. Ethnicity was highly variable from 0% African American to 62% (though as noted earlier this may reflect, at least in part, the ethnic make-up of the communities in question). Similarly, mental health diagnoses varied widely as did criminal charges—felonies ranged from 7 to 100%. The time from referral to court decisions averaged from 1 to 47 days. However, the courts were quite similar in that almost all individuals who were offered mental health court as an alternative to normal criminal processing accepted.

One of our research questions was whether the participants in these mental health courts would reflect the nearly universal pattern of other types of jail diversion program where older, White women are over-represented as compared to their proportions among all arrestees. Should this be the case, because we had referral data, we would be able to determine whether this was the result of screening after referral or the referral pattern itself.

In general, differences between referrals and those accepted by the courts were non-significant for these three demographic factors. However, in the Allegheny County, PA, MHC, gender was influential in acceptance decisions: women were more likely to be accepted than men, accounting for one-third of referrals (which, as noted above, is substantially higher than national rates of 6–10% of women in jail/prison populations), and of the women referrals more than two-thirds were accepted. In the Marion County, IN MHC, Luskin (2001) reported similar results such that younger (but not older) women were advantaged for diversion into treatment.[1] For whatever reasons, we found that individuals in our sample referred to MHC were more likely to be older, White and female than individuals being arrested. The finding that mental health jail diversion programs are disproportionally composed of older, White women is consistent enough to warrant further investigation. Do these three characteristics increase (or are they perceived by decision makers to increase) the probability of favorable outcomes (i.e. less recidivism, increased treatment engagement)? A prospective, multi-site mental health court study, which we are now planning, will help to distinguish whether successful outcomes are largely a product of the type of person in the court or a product of the court mandates themselves.

[1]Although we did not have sufficient numbers in the individual courts to perform comparable analyses to Luskin (2001), we do note that the men and women referred into the seven courts had similar ages, M for men = 35.4, M for women = 36.5, $F(1, 276) = 0.60$. The same non-significant difference for age by gender was found in the Allegheny County, PA, MHC. Thus, it was not the case that women were more likely to be accepted because they were younger. Moreover, we found that age did not influence acceptance decisions.

Our descriptive data on referral patterns and case processing provide insight into how mental health courts operate as new forms of jail diversion for persons with serious mental illness and co-occurring substance use disorders. However, this is only an initial step to approaching the core question: for whom do such courts work and why? Between the previously published research and data reported here, we can see that despite wide variations, mental health courts can be arrayed across some key dimensions. For example, much about how cases are processed and ultimately supervised in the community depends on the ratio of felony to misdemeanor cases handled by the court (see Redlich et al., in press). Both the length of supervision and the available sanctions for non-compliance vary considerably by whether the charges are felonies or misdemeanors. Likewise, whether charges are dropped, continued, or a guilty plea is required can determine whether community supervision with reports back to the court is primarily the responsibility of the criminal justice system via probation departments or the mental health system via case managers (see Griffin et al., 2002).

In order to develop a meaningful sampling strategy for an outcome study, it was essential to provide basic descriptive work on the characteristics of such courts. It is now time for the field to conduct both single- and multi-site studies that follow mental health court participants into the community, measure the services and supervision they receive, and collect outcome data on clinical, satisfaction, quality of life, and social policy indicators, including recidivism, violence, and hospitalization, as well as cost data that can assess the effectiveness and the cost-effectiveness of mental health courts. More specifically, what types of detainees are most likely to profit from which of the various types of mental health court that are proliferating across the U.S., and at what price? Ultimately, the question is a broader one of whether mental health courts are the preferred public policy option for jail diversion and, if so, for whom and why?

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