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The Broward Mental Health Court: process, outcomes, and service utilization

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1. Introduction

Mental health courts are one of a variety of special jurisdiction courts that have been created in a number of countries, including the United States (Petrla, 2003). While there is no prototypical mental health court (Steadman, Davidson, & Brown, 2001; Watson, Luchins, & Hanrahan, 2001), most of those in existence today share several common characteristics. These include (a) the creation of a special docket (usually, but not always, nonviolent misdemeanants with mental illness) that is (b) handled by a particular judge, with (c) a primary goal of diverting defendants from the criminal justice system and into treatment (Goldkamp & Irons-Guynn, 2000).

In addition, the principle of therapeutic jurisprudence has been influential as a philosophic basis for the creation of some if not all mental health courts. “Therapeutic jurisprudence” has been offered as a way for courts and attorneys to examine “the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences” (Wexler & Winick, 1991). Both mental health court (Wren, 1998) and drug court judges (Hora, Schma, & Rosenthal, 1999) have been explicit in their reliance on therapeutic jurisprudence as the underpinning of their courts.

We are currently evaluating the Broward County Florida Mental Health Court (MHC), one of the first mental health courts in the United States.¹ Full details of this evaluation are

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¹ The Broward Court, created in 1997, appears to have been the first mental health court created in the 1990s, subsequent to the widespread development of drug courts. However, a court in Marion County, IN, created in 1980, may have the distinction of being the first mental health court created in the United States (Steadman et al., 2001).

described elsewhere (McGaha, Boothroyd, Poythress, Petril, & Ort, 2002; Petril, Poythress, McGaha, & Boothroyd, 2001). In one part of the evaluation, we have examined the MHC process itself, including the volume and nature of courtroom communications and formal outcomes. We have also gathered data on the utilization of treatment services by individuals in the MHC as well as by individuals in a traditional misdemeanor court chosen as a comparison site (Hillsborough County). In this article, we report findings from these two aspects of the evaluation, referring to them as Study 1 (the court process) and Study 2 (the utilization data).

2. Study 1: description of mental health court process and outcomes

The Broward Court, like many drug and mental health courts, describes itself explicitly as a treatment court. In treatment courts, the roles of the judge and counsel are often characterized as less adversarial than in traditional court, with an emphasis on enabling the defendant to gain access to treatment and other supports.

Informal observations of the Broward Court indicated a substantial role for the defendant, presumably because of the court's desire to create an alliance with the defendant. Our descriptive study of the court process focused on the extent to which various participants were involved in the proceeding and the topics that were discussed. In contrast to traditional misdemeanor court, where informal observation revealed that the primary focus of the proceedings was to move the case to a legal disposition,² we anticipated that discussion of formal legal issues would be minimal in light of the greater focus on mental health and treatment related topics. At the same time, however, the defendant's entry into the mental health court must be voluntary³ and, as in any criminal proceeding, defendants must be considered competent to proceed.⁴ Thus, we examined the extent to which these issues were addressed in the transcripts.

Finally, our informal observations of the Broward Court suggested that, despite its emphasis on linking defendants to treatment, neither the treatment linkages nor the formal legal outcomes were identical across all cases. A mental health court such as the Broward Court has a variety of ways in which it might resolve a case. The court may close a case at first hearing, or it may keep the case open (in order to maintain jurisdiction) and monitor the defendant's progress in treatment through subsequent "status" hearings. It is important to understand how these paths were articulated and how many defendants were placed on each path. Similarly, there may be variations in the court's stated expectations regarding treatment. As our evaluation progressed, it became evident that some individuals did not enter mental health treatment from the mental health court. That could have reflected a lack of follow-up by the court or treatment providers, or it could have reflected a decision by the court to simply

² In Study 2 below, we describe a sample of cases from a traditional misdemeanor court.

³ Defendants have the right to decline participation in the mental health court and have their cases heard in a regular misdemeanor court. As the discussion below suggests, not all defendants report that they are aware of this right.

⁴ There is a legal presumption of competence that can be challenged by either party or by the court; in the absence of such a challenge, cases are allowed to proceed.

close a case. In order to attempt to understand this issue more clearly, we thought it important to ascertain how the court framed its expectations regarding the question of subsequent treatment for the defendant.

2.1. Method

2.1.1. Coding of court transcripts

Our prospective study of the MHC included 121 defendants whose cases were accepted into the court between December 1, 1999 and April 30, 2001 (see Study 2 below for a description of the sample). To evaluate the court process and outcomes for these cases, we obtained and coded official court transcripts for these cases.⁵

A comprehensive form was created for coding the content of the transcripts. Content categories related to legal issues (e.g., mention of the voluntary nature of the court, mention of the defendant's competence, mention of current or prior offenses), mental health issues (mention of current or past illness, treatment, use of psychotropic medications, etc.), and disposition (legal findings, directives into treatment). A dozen cases were initially coded by the third author and a graduate student, resulting in high levels of agreement across all categories. Subsequently, the graduate student coded the remaining cases.

2.2. Results

2.2.1. Who talks at mental health court?

From a simple count of the number of times a participant was listed as a speaker in each transcript, the mean numbers of utterances for each participant was calculated. On average, about 54 utterances were made at initial hearings in mental health court. The judge, defendant, mental health staff, public defender, and state attorney were usually the only people who spoke. The process was substantially a dialogue between the judge—who typically was responsible for nearly half (47%) of the communications at the hearing ($M=25.72$, $S.D.=19.21$) and the defendant—whose comments accounted for 33% of the utterances on the record ($M=17.39$, $S.D.=15.75$). The remaining comments came from the mental health staff (7%) and attorneys (12%). The mental health staff did not testify as sworn witnesses, nor did they (or any other witnesses) take the witness stand. Rather, they merely responded from the floor, usually in response to queries from the judge. Very infrequently, and usually very briefly, a friend or family member of a defendant also spoke at the hearing.

2.2.2. What is discussed at mental health court?

Both legal and clinical issues appeared in the MHC transcripts. Two important legal issues relevant to MHC participation include (a) the defendants' understanding that the primary focus of the court is on treatment involvement rather than adjudication of the legal case and

⁵ We are grateful to the MacArthur Foundation Research Initiative on Mandated Community Treatment for funds used to purchase the mental health court transcripts. Copies of transcripts could not be obtained from the legal transcription service for 17 of the mental health court cases; therefore these analyses are based on 104 cases.

(b) the defendants' understanding that participation in the court is voluntary—defendants choose to have their case adjudicated in a regular misdemeanor court rather than in MHC. Our coding of the transcripts revealed that the primary purpose and focus of the MHC was explicitly announced in 28.4% of cases.⁶ In 15.7% of cases, the transcript included explicit statements by the judge regarding voluntary participation and/or the defendant's prerogative to have his or her case transferred to regular misdemeanor court.⁷

The transcripts contained some mention of a defendant's competence-to-proceed in 29.4% of cases. When this issue did arise, the court declared the defendant to be competent 73.3% of the time and incompetent in only 3.3% of cases. Mental health evaluations were ordered in 13.3% of these cases; in 10% of the cases in which the issue was mentioned, the action taken (if any) was not clear from the record.

Consistent with the court's identification as a "treatment court," the presentation of material related to the pending criminal charges was cursory. Although the name or nature of the defendant's charge was mentioned in 70.6% of cases, this most commonly occurred in a single utterance when the judge called the case from the docket, as in "The next case is Mr. ___, who is here on a charge of trespassing." In only 2.9% of cases did any other information about the charge appear on the record and witnesses to the offense were never called for questioning. Observation of the court by the authors suggests that the court avoided extended discussion of the pending charges to avoid compromising the defendant's right to avoid self-incrimination. A defendant's prior record was alluded to in 58.8% of the cases, usually when the court was considering public safety issues in contemplation of disposition. No detail on prior offenses was found in any transcript.

Mental health issues were discussed in most cases and these discussions were typically more extensive than were those of legal issues. Transcripts revealed that defendants' current or prior symptoms and diagnoses (42.2%), use of psychotropic medications (24.5%), and treatment/placement issues (83.6%) were the most commonly explored mental health issues. Other issues related to mental health and social adjustment that arose with some frequency included housing (34.0%) and employment (10.2%).

2.2.3. *Case outcomes*

At the conclusion of the initial hearings in MHC, the defendant's legal case remained open in about one-third (36%) of cases. These cases were usually scheduled for a "status hearing"

⁶ It is highly likely, however, that more than 28.4% of the defendants in our sample were aware of the primary purpose and focus of the mental health court and more than 15.7% were aware of the voluntary nature of the court. In our frequent observations of the court, the judge sometimes, prior to calling cases, offered a blanket statement to all present in the court, including the array of defendants waiting to have their individuals' cases called. This blanket statement sometimes included statements about the treatment approach of the court, the voluntary nature of the court, or both.

⁷ A slight majority (53.7%) of the clients indicated being told about the voluntary nature of the court when asked in their enrollment interviews. However, over half (54.7%) of those who indicated such knowledge said they were told about the voluntary nature of the court *after* their initial hearing. Clients self-reported that they were told about the voluntary nature of the court by the public defender (31.8%), judge (28.8%), and mental health professionals (25.8%).

several weeks later at which the court would receive information about the defendant's participation and progress in treatment and reconsider legal disposition of the case.

In most other instances,⁸ the court made a legal disposition of the case. In 26% of cases, the defendant was found “guilty” and credited with time served (21%) and/or assigned a brief period of probation (5%). Charges were formally dismissed in 2% of cases and, in the remainder (39%) of cases, the disposition was “adjudication withheld,” usually (33% of all cases) without probation.⁹

2.2.4. *Treatment linkages*

Our informal observations of court hearings revealed a variety of ways through which the MHC attempts to link defendants to mental health services. Often the defendant was someone already known to the local treatment community and had been involved in treatment prior to his or her arrest on the index offense; the court in such cases typically sought to identify the existing treatment provider and to encourage the defendant to continue with a previously established treatment plan. Some defendants had been referred to a crisis stabilization unit either from the jail, or after appearing before the MHC at a first appearance in such an acute state that they appeared unable to consent competently to participation in the court. Such defendants often returned to the court within a week or two after stabilization and with a treatment plan that had been developed during this initial intervention; linkage in this case was commonly to encourage the defendant to pursue this newly established plan.

A second type of linkage was derived from the recommendations of the mental health staff that evaluated defendants as they came into court. These brief assessments sometimes resulted in recommendations to the judge for referrals to specific community agencies known to provide services appropriate to the assessed needs. In these cases, the client was referred to the specific agency (sometimes with assistance from court personnel in making the initial appointment) and/or provided funding for initial transportation to the service agency.

Finally, it was observed in some cases that the court-based either on recommendations of court mental health staff or self-reported needs of the defendant—would merely provide general information (e.g., an agency name and address, an agency brochure describing services) about where services might be sought. These defendants were encouraged and exhorted to follow-up on their own, and the court did not explicitly commit court resources (personnel or transportation funds) to assist in making the linkage.

Each of these linkage methods was reflected in the transcripts of our sample of MHC defendants. The primary linkage strategies utilized by the court involved either referral to an agency with which the defendant had a previous or recently established treatment plan (35.3%), or referral to a specific agency deemed to provide services appropriate with assessed needs (35.3%). A small group of defendants (11.1%) was encouraged to initiate treatment

⁸ In about 3% of the transcripts, legal disposition of the case was not explicit.

⁹ Florida courts have the authority to withhold an adjudication of guilt and may also place the defendant on probation. Fla. R. Crim. P. 3.670 (2002). According to the Honorable Ginger Lerner Wren, who presides over the Broward County MHC, “adjudication withheld” is used as an outcome at the end of a case; she views this as a verdict “softer” than a verdict of guilty (personal communication between Judge Lerner Wren and John Petrla, July 9, 2002).

contacts largely through their own efforts and, for about 18% of defendants, the court transcript did not include explicit linkage information.¹⁰

2.2.5. *Equity in the mental health court process*

In a final set of analyses, we examined whether various aspects of the MHC process and outcomes, as described above, were administered equitably across race and gender.

We found no evidence of differential treatment by race (Caucasian, $n=64$ vs. African–American, $n=23$) in terms of the extensiveness of the hearings.¹¹ Transcripts revealed a mean of 63.00 utterances (S.D.=48.1) in 21 cases involving African–American defendants compared to 52.35 (S.D.=36.8) utterances in 62 cases involving Caucasian defendants [$t(81)=1.26$, $P=.213$]. Similarly, the mean number of utterances in hearings involving 28 female defendants—59.96 (S.D.=44.09) did not differ significantly from the mean in the hearings of 65 male defendants—52.71 (S.D.=41.20) [$t(91)=-0.77$, $P=.44$].

A pair of 2×2 contingency tables was constructed to compare legal disposition (adjudicated guilty vs. adjudication withheld) separately by race (Caucasian vs. African American) and by gender. These analyses revealed no significant difference in the proportion adjudicated guilty either by race ($\chi^2=0.34$, $P=.56$) or by gender ($\chi^2=3.08$, $P=.08$).

Contingency tables were constructed to compare the distribution of three treatment linkage strategies (described above) separately across groups by race (African–American vs. Caucasian) and gender. These analyses revealed no significant difference in the utilization of treatment linkage strategies either by race ($\chi^2=0.14$, $P=.93$) or by gender ($\chi^2=0.63$, $P=.73$).

3. Study 2: pathways into treatment and mental health service utilization

In Study 2, we explored the use of mental health services by defendants in the Broward MHC, including a comparison with mental health service utilization by a group of mentally ill misdemeanants tried in a traditional misdemeanor court. Three specific questions were addressed:

- Does involvement with the MHC affect the likelihood that a misdemeanant with mental health problems will subsequently receive treatment?
- Among defendants who access behavioral health services, does the MHC impact the volume of services a defendant received?
- Among defendants whose cases are heard in the MHC, what is the relationship between the use of mental health services and type of service linkage strategy noted in the court transcript?

¹⁰ Because of the (sometimes extensive) off-the-record conversations between the court mental health staff and defendants, it is possible that explicit treatment linkage strategies were communicated to some of these defendants.

¹¹ Analyses by race were limited to African–American and Caucasian defendants, as these were the only categories with sizeable numbers for comparisons.

3.1. Method

3.1.1. Participants

The Broward MHC sample ($n = 121$) consisted of English-speaking defendants of either gender, between the ages of 18 and 64, whose cases were accepted by the MHC between December 1, 1999 and April 30, 2001. MHC jurisdiction depends on judicial findings that the individual (a) is charged with a nonviolent misdemeanor, ordinance violation, or criminal traffic offense;¹² (b) currently has, or previously has had, mental health problems;¹³ (c) is able and willing to make a voluntary choice to have the case disposed in the MHC; and (d) would not pose significant public safety concerns. Individuals not meeting all of these criteria are returned to a regular misdemeanor court for disposition of their cases.

Our comparison group included 101 defendants from another county in Florida that does not have a MHC but who met the criteria (a) and (b) above for MHC jurisdiction in Broward County. Each currently had, or reported a history of, mental health problems.¹⁴ To minimize the chance that clinical and demographic variables would be confounded with site differences in this study, our design called for the MHC and comparison samples to be matched on certain demographic variables (age, gender, race) and on current mental status. Thus, the recruitment in the comparison county lagged recruitment in the Broward MHC by a couple of months in order to permit selection of comparison clients whose demographic and clinical features matched those of the Broward sample.

The characteristics of the subjects from the Broward County Mental Health Court and the comparison court in Hillsborough County are summarized in [Table 1](#).¹⁵ Data are only reported on 116 mental health court clients and 97 comparison court clients as several participants in each group had requested to be disenrolled from the study and as such their data have been excluded from these analyses. As can be seen, the procedure for matching samples was successful; no significant differences were found between the two groups of defendants in terms of gender, race/ethnicity, age, or overall level of psychopathology

¹² Individuals charged with misdemeanor battery offenses may be accepted into MHC if the victim in the case agrees to this route of disposition. The Broward MHC does not accept persons charged with domestic violence or driving while intoxicated charges.

¹³ Mental health screening is conducted in court or just prior to court by mental health professionals who work with the court or graduate students in clinical psychology from Nova Southeastern University working under supervision ([Rabaska, 2000](#)). However, the court may accept jurisdiction in the absence of formal diagnostic findings.

¹⁴ In the comparison county, defendants with mental health issues were not automatically identified by the fact of their referral to/acceptance by a MHC. Thus, at the control site, research assistants identified individuals at the daily first appearance court with charges of a nature that would allow them into the mental health court. Those of this subset, who were housed on mental health units in the jail, were referred for psychiatric care/assessment in the jail, or who based on observation were possible candidates were considered for interviews. When the presence of current symptoms and/or a history of mental illness was questionable prior to the consent process the research assistant conducted a brief screen to probe on issues such as current symptoms and history (see [McGaha et al., 2002](#) for more details).

¹⁵ Due to a small number of cases with missing data, the n 's reported here differ slightly from those reported in [Poythress et al. \(2002\)](#).

Table 1
 Characteristics of study participants

Characteristic	Mental health court (<i>n</i> = 116)	Comparison court (<i>n</i> = 97)	<i>P</i>
Gender:			NS
Male	68.1%	58.8%	
Female	31.9%	41.2%	
Race/ethnicity:			NS
White	61.3%	55.7%	
Black	23.5%	21.6%	
Hispanic	9.2%	9.3%	
Other	5.9%	13.4%	
Age:			NS
Mean	38.4	38.0	
S.D.	10.53	9.61	
Range	18–63	20–57	
BPRS score:			NS
Mean	34.143	34.11	
S.D.	9.83	7.79	
Range	18–65	18–55	

(measured using the Brief Psychiatric Rating Scale—Anchored Version: [Woerner, Mannuzza, & Kane, 1988](#)).

3.1.2. Measures and procedure

3.1.2.1. Self-reported mental health service use. As part of a larger interview-based research protocol ([Petrila et al., 2001](#)) and using procedures described elsewhere in greater detail ([Poythress, Petrila, McGaha, & Boothroyd, 2002](#)), self-report data on the use of mental health, medical, and substance abuse services were obtained from subjects in the MHC and comparison samples. Briefly, participants were recruited using procedures approved by the University of South Florida Institutional Review Board. Informed consent was obtained at enrollment, and trained research assistants contacted participants 1, 4, and 8 months after enrollment for subsequent administrations of the protocol.¹⁶ Each participant was paid US\$20 upon completion of each protocol administration.

3.1.2.2. Administrative data sources. Additional data were obtained from administrative data sets available to our research team. We retrieved records of all mental health and substance abuse services paid for by either Medicaid or State general revenue dollars for all

¹⁶ The 8-month timeframe for follow-up with the comparison group was driven by another aspect of the research that involved analyses related to criminal recidivism. For the MHC group, additional waves of interviews at 12 and 16 months provided further service use data (not reported here).

213 participants for the 8-month period preceding enrollment in the study and for the 8-month period postenrollment (the same time period covered by the self-report data).

3.1.3. Analyses

A two-group repeated measures analysis of variance (ANOVA) was conducted using the administrative data to assess for group differences in the service penetration rates and the volume of services defendants received in the 8 months before and after their initial court appearance. *Penetration* was defined as having received any treatment at all (regardless of the number or type of services received) during the time frame of analysis, while *volume* was a gross measure of treatment involvement computed by totaling the number of discrete service units received.

Independent *t*-tests were conducted on the self-report data to compare the service penetration rates and volume of service between the two groups during the 8 months following their court appearance. Finally, for those defendants whose cases were heard in the mental health court, the relationship between the use of services and type of service linkage strategy noted in the court transcript (see Study 1) was examined using chi-square analyses.

3.2. Results

The findings are summarized by the major research questions.

3.2.1. Does involvement with the MHC affect the likelihood a misdemeanant with mental health problems will subsequently receive treatment?

Analyses of administrative and self-report service use data were conducted to compare the penetration rates for defendants served by the mental health and comparison court. Given that 22 of the defendants returning to the MHC came directly from a hospital or crisis stabilization unit and therefore were more likely to have an existing treatment plan and the fact that similar defendants in the comparison court could not be identified and enrolled in the study, these 22 defendants were omitted from the analysis to permit a fairer and more conservative comparison of the impact of the MHC in engaging individuals in treatment. The results of this analysis are summarized in Fig. 1.

As is shown in this figure, no significant difference was found in the behavioral health service penetration rates between sites prior to enrollment into the study [$t(197) = -1.06$, $P < .29$], although misdemeanants in the Broward County MHC were slightly more likely to have received behavioral-health services in the 8 months prior to enrollment in the study (36%) compared to individuals residing in Hillsborough County (29%). However, even when controlling for these small initial differences in service utilization, a significant county-by-time interaction was found [$F(1,197) = 6.21$, $P = .05$]. The use of behavioral health services by defendants whose cases were heard in the MHC increased significantly during the 8 months following enrollment in the study (from 36% to 53%), while the likelihood of using services among defendants in the comparison court remained virtually unchanged

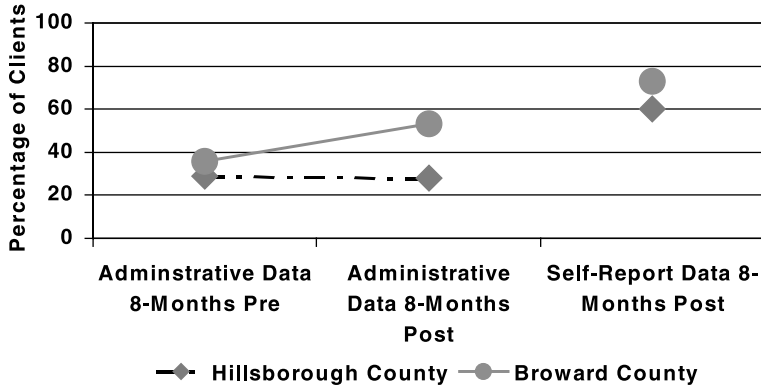


Fig. 1. Pre- and post-service penetration rates (administrative and self-report data).

(from 29% to 28%). The effect size of this difference in administrative data penetration rate during 8 months following the initial court appearance is 0.52, a moderate effect according to Cohen (1977).

Administrative service utilization data were available on 21 different behavioral health services. Higher rates of service use were reported by defendants served by the mental health court in 14 of the 21 service categories. A sign test performed on these findings suggest the probability of this occurrence is $P=.09$, assuming a random effect (50–50). Interestingly, the service categories in which defendants from the comparison court had higher levels of utilization were emergency services and more intensive levels of residential treatment.

A related analysis investigated whether the defendants using services after their initial court appearance were the same individuals who were using services prior to their court appearance. These findings are summarized in Table 2. A chi-square analysis was performed to determine if the pre- to postservice utilization patterns differed between courts and a significant difference was found [$\chi^2(3, n = 192) = 13.76, P=.003$]. As is shown in this table, defendants in the comparison court were more likely to *not* be using services both before and after their court appearance relative to those who appeared in the mental health court. Additionally, comparison court defendants were less than half as likely to begin treatment after their court appearance and nearly 50% more likely to stop receiving treatment after their court appearance relative to mental health court defendants.

Table 2

Service use patterns pre- and post-court appearance (administrative data)

	Mental health court ($n = 95$)	Comparison court ($n = 97$)	$P <$
Service use pattern:			.003
No services used pre or post	36.8%	58.8%	
Services used both pre and post	28.4%	17.5%	
Services used post but not pre	26.3%	11.3%	
Services used pre but not post	8.4%	12.4%	

Service penetration rates for the 8 months following court appearance were also examined using defendants' self-report data. Due to the inability to conduct follow-up interviews after the initial court appearance, 10 MHC defendants (10.3%) and 9 comparison court defendants (8.9%) were lost to attrition. The number of interviews among those who were interviewed differed significantly between the two sites [$t(177)=2.26, P<.05$]. Self-report service utilization was based on an average of 2.08 interviews (out of 3) among mental health court defendants and 2.35 interviews among those in the comparison court. The smaller number of interviews among MHC recipients decreases the opportunity for them to report service use, also making this a conservative analysis. Despite this fact, MHC participants were more likely to have reported receiving behavioral-health services during the 8-month follow-up period (73%) than were participants from the comparison court (60%); however, this difference is not significant statistically [$t(188.97)=-1.89, P=.61$]¹⁷ (also see Fig. 1). Despite failing to reach a classical level of significance, the effect size associated with this difference in self-reported penetration rate during 8 months postcourt appearance is 0.27, a small effect.

During each interview, respondents were asked about their use of 27 different types of mental health and substance abuse services. Higher rates of service use were reported by MHC defendants in 20 of the 27 service categories. A sign test performed on these results indicate the probability of this occurrence is $P<.05$, again assuming a random effect (50–50). Similar to the findings based on the administrative data, many of the service categories in which defendants served by the comparison court reported higher levels of service utilization involved emergency services and detoxification.

3.2.2. *Among individuals who accessed behavioral health services, did the MHC impact the volume of services a defendant received?*

Between defendants in the two courts who reported receiving any service at all, the mean number of service units received was compared to assess whether there was a difference in the volume of behavioral health services received by MHC and comparison court defendants. A two-group repeated measure ANOVA was performed on the administrative data to assess for group differences in the volume of services received in the 8 months before and after court appearance. These results are summarized in Fig. 2.

A significant group-by-time interaction [$F(1,196)=6.27, P=.013$] was obtained. The mean number of units of behavioral health services defendants in the mental health court received increased by 61.6% (from 18.23 units in the 8 months before to 29.47 units in the 8 months after), while the number of units of service for defendants served by the traditional misdemeanor court decreased by 18.3% (from 19.25 to 15.72 units). The effect size of this difference in service volume during 8 months postcourt appearance is 0.44, bordering on a moderate effect.

A similar analysis was conducted based on defendants' self-report service use data. Significant differences were found in the volume of behavioral health services favoring

¹⁷ Degrees of freedom have been adjusted for unequal group variances.

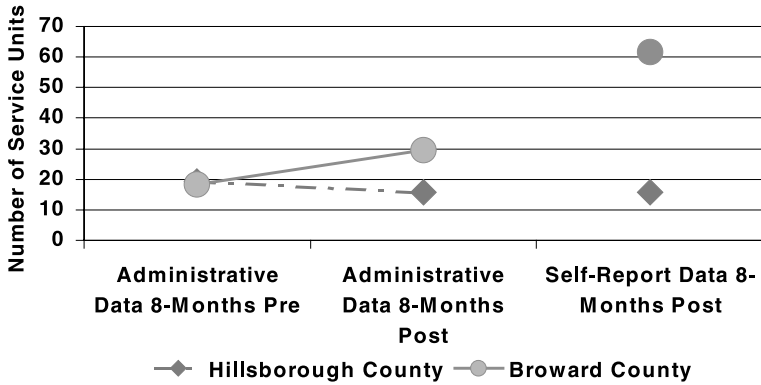


Fig. 2. Pre- and post-service volume (administrative and self-report data).

mental health court defendants [$t(89.05) = -5.43, P < .001$]. MHC service users reported an average of 61.57 units of service in the 8 months following their court appearance, while those in the traditional court reported an average of 15.84 units of service during the same time period. This difference represents a large effect (1.91).

3.2.3. *What is the relationship between their use of mental health services and the type of service linkage strategy noted in the mental health court transcript?*

Chi-square analyses were conducted to examine the relationship between court expectation and anticipated treatment linkages noted in the court transcripts and the likelihood of defendants’ subsequent service use (see Table 3). No significant relationship was found between the type of treatment expectation noted in the court transcript and the likelihood that defendants would use behavioral health services in the 8 months following their hearing. This was true for both the self-report [$\chi^2(3, n = 74) = 4.33, P = NS$] and administrative service data [$\chi^2(3, n = 76) = 2.75, P = NS$]. There was no explicit mention of treatment in the court transcripts of 15.0% of the defendants reporting no service use in the 8 months following their initial court appearance; there was also no explicit mention of treatment in the court transcripts of 16.7% of the defendants who reported service use during this period. Examination of the administrative data, however, reveals a somewhat different finding. Only

Table 3
Receipt of behavioral health services by level of treatment expectation and service data source

Treatment expectation noted in transcript	Self-report		Administrative	
	Used	Did not use	Used	Did not use
No mention of treatment ($n = 15$)	73.3%	26.7%	53.3%	46.7%
Provided general referral information ($n = 10$)	40.0%	60.0%	70.0%	30.0%
Continue with existing treatment plan ($n = 35$)	80.0%	20.0%	48.6%	51.4%
Provide with a explicit referral ($n = 34$)	76.5%	23.5%	64.7%	35.3%

12.5% of the defendants who used services in the 8 months after their court appearance had no mention of treatment in their court transcripts compared to 22.2% defendants who did not use services. Although not statistically significant, this represents a large effect (effect size = 0.89).

4. Discussion

The findings from these studies provide some interesting insights into the Broward MHC process as well as preliminary data regarding service utilization of defendants in the MHC and in a traditional misdemeanor court. The court transcript analyses in Study 1 provide a quantitative and systematic accounting of the court process that distinguishes the MHC from traditional misdemeanor courts. First, the judge appears to have chosen a strategy of deliberately engaging the defendant in a conversation regarding the defendant's perceived treatment needs; there is little that reflects traditional "lawyering" as the attorneys are relegated to relatively minor roles in the hearings. The transcripts also show a focus on treatment issues that is consistent with the court's self-characterization as a "treatment court." The offense itself is rarely discussed. As noted above, our live observations of the court suggest that the court deliberately stays away from discussion of specific details regarding the offense in large part because of a desire to avoid self-incrimination issues in the event the case has to be handled in an ordinary misdemeanor court. Regardless, discussion between the judge and defendant of treatment-related issues comprises the bulk of conversations in the court.

The transcripts also reveal that not all cases before the MHC take the same path. As noted above, the court closed 63% of the cases in our sample at the initial hearing, with a small percentage of these defendants placed on probation. In only about one-fourth of cases was the defendant adjudicated guilty; more often the disposition is "adjudication withheld" and no conviction appears on the defendant's criminal record. This is in stark contrast to the results reported from other studies of other, more traditional misdemeanor courts. For example, [Poythress, Bonnie, Hoge, Monahan, and Oberlander \(1994\)](#) reported that upwards of 90% of misdemeanor cases in Hillsborough County (the comparison site in Study 2) resulted in pleas of either guilty or no contest. In about one-third of cases, the judge in the Broward MHC continues the case, apparently as a mechanism for maintaining jurisdiction so that cases can be monitored, through "status hearings," for oversight of the person's mental status and use of mental health services. This is important in considering how judicial and other resources are allocated in special jurisdiction courts. The Broward Court, at least, does not use a "one-size fits all" approach to all cases.

Findings from both studies are interesting in light of the potential presumption among policy makers and others that all defendants who come before the MHC are linked to treatment. Although it is the court's aspiration that defendants do engage in and comply with mental health services, the court transcripts revealed explicit treatment-linkage strategies in only 82% of cases ([Table 2](#)). In Study 2, only 73% of mental health court clients self-reported involvement in treatment during the 8-month period following their court appearance, and an

even smaller portion (57%) were documented as having received Medicaid or state-funded mental health services.¹⁸

Given that many of its clients are individuals with chronic illnesses who may long have been difficult to engage in treatment, and given the court's limited staff resources to monitor its treatment directives, the fact that not every defendant appearing before the court receives treatment is not surprising. This outcome is also consistent with the court's aspiration to be a noncoercive influence in the lives of its clients. As noted by [Goldkamp and Irons-Guynn \(2000\)](#) and supported by our transcript data, the Broward Court rarely if ever uses punishment (e.g., probation or jail time served) and in many cases is not particularly specific or directive in articulating its expectations regarding treatment.

At the same time, the findings from Study 2 suggest that involvement with the Broward MHC increases the likelihood that defendants will become engaged in the mental health treatment system. There is also evidence based on the cumulative number of service units received that suggests that individuals who do receive treatment receive a higher or more intense dosage of treatment than defendants in the study who appeared before the traditional misdemeanor court. Although the impact of these services on the longer-term outcomes of the defendants is at this time unknown, it is well documented that the "...evidence for treatment being more effective than placebo is overwhelming" ([Department of Health and Human Services, 1999, p. 65](#)).

It also is worth noting that the categories in which comparison court defendants appeared (based on self-reports or administrative data) to have higher levels of service utilization were typically crisis or emergency services or more intensive levels of residential treatment. While our cost analysis study of the Broward MHC and comparison court is on-going, the services used more frequently by defendants in the comparison court are generally associated with higher cost service categories.

These results in the aggregate appear to provide clear evidence that the Broward MHC meets its goal of facilitating access to treatment, albeit imperfectly. The findings from Study 2 do suggest that a greater proportion of defendants in the MHC do subsequently utilize mental health services than defendants in the traditional misdemeanor court. It also appears that this occurs in a manner that enhances procedural fairness while minimizing perceived coercion ([Poythress et al., 2002](#)).

One curious finding from Study 2 was that the MHC clients' subsequent use of mental health services is independent of the court's expressed expectations about treatment, as reflected in the treatment-linkage strategies coded in Study 1. As [Table 3](#) revealed, defendants whose transcripts contained no explicit discussion of treatment-linkage were not statistically less likely than others to access some type of mental health service during follow-up. A

¹⁸ Such differences between self-report and administrative data are not uncommon (see [Stiles, Boothroyd, Snyder, & Zong, 2002](#) for discussion). While there are many reasons why self-report penetration rates and service volume are consistently higher than those obtained from administrative data sources, prominent among these are that administrative data are restricted by pay or source (in these analyses Medicaid and state general revenue) while self-report data are independent of this limitation and can include informal service sources such as self-help groups (e.g., AA).

precise explanation for this unexpected finding cannot be determined from our data, although a number of factors may come into play here. First, transcripts simply may not tell the whole story regarding the Broward MHC process. While the court stenographer's version of the hearing is probably the best record available, it is clear from observing the court that not everything gets captured in the transcript. The relaxed procedure in the mental health court (e.g., witnesses are neither called nor sworn; speaking order is not controlled) sometimes result in several individuals talking at once or several conversations going on simultaneously, and the court reporter cannot monitor all of them simultaneously. Further, there are often private conversations between the defendant and other court participants, including the public defender or mental health consultants, in which treatment-related information (or exhortation) may be communicated.

Second, some of the participants in our study may have previously been to the court, with their mental health histories already known to the judge or other participants at the hearing for which we obtained a transcript. It is possible that in some instances implicit expectations about treatment rather than explicit ones were communicated to the defendant, or that communication occurred in conversations (e.g., with defense counsel or treatment staff) outside of the court hearing as reflected in the transcript. Third, although the court has limited staff resources for the active monitoring of clients' involvement in treatment, some defendants whose transcripts were bereft of treatment-linkage information may have been aided in accessing treatment by the efforts of support staff. Fourth, these findings may reflect a judgment by the court that certain clients had the ability and the means to autonomously pursue treatment.

If there is one potentially troubling finding from the study of MHC transcripts, it is that there is probably considerably less explicit discussion and resolution of the "voluntary participation" issue than legal purists would find desirable. In only 15.7% of transcripts was this issue explicitly discussed, though a little more than half (53.7%) of the clients self-reported during the enrollment interview that they knew that participation in the court was voluntary. This awareness may have come from attending to the judge's general statements about the nature of the court⁸; in addition, some may have been apprised of their legal choices in conversations with their public defender. Nevertheless, this is an issue of some importance that can, and arguably should, be handled on the record in each case individually.

It is also reasonable to ask whether other strategies *not* used by the Broward Court would affect entry into and retention in treatment. For example, what would be the impact of the use of punishment for noncompliance with treatment? What if the court retained jurisdiction in a higher percentage of cases, or required subsequent status hearings as a matter of course? Should a MHC retain staff that assure that treatment orders are followed up, or should that responsibility be vested elsewhere, for example, in the treatment provider or in probation staff? Does the choice of strategy matter in terms of treatment? In addition, while the court has available client specific information regarding mental health needs and treatment options, neither the transcripts nor our observations suggest that such material is made available to the court in systematic fashion. Would more formal presentation of such information have an impact on judicial decision making, or does the informal nature of the court facilitate its work? These questions, while important, also assume of course that treatment is available.

Our findings suggest that the Broward Mental Health Court operates in a manner consistent with its stated mission as a treatment court. They also suggest that at least in comparison to a traditional misdemeanor court, the Broward County MHC enhances treatment access and involvement for a substantial number of defendants appearing before it. While the jury is still out regarding the impact of this treatment on defendants' mental health status, or whether it reduces the likelihood of re-arrest and return to jail, most will likely agree that gaining access to treatment is a necessary if not sufficient condition for attaining these ultimate goals.

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References

- Cohen, J. (1977). *Statistical power analysis for the behavioral sciences*. (Revised ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Department of Health and Human Services (1999). *Mental health: a report of the surgeon general*. Rockville, MD: Author.
- Goldkamp, J. S., & Irons-Guynn, C. (2000). Emerging judicial strategies for the mentally ill in the criminal caseload. *Mental health courts in Fort Lauderdale, Seattle, San Bernadino, and Anchorage*. Philadelphia, PA: Crime and Justice Research Institute (<http://www.ncjrs.org/html/bja/mentalhealth/contents.html>).
- Hora, P. F., Schma, W. G., & Rosenthal, J. T. (1999). Therapeutic jurisprudence and the drug treatment court movement: revolutionizing the criminal justice system's response to drug abuse and crime in America. *Notre Dame Law Review*, 74, 439–537.
- McGaha, A., Boothroyd, R. A., Poythress, N. G., Petrila, J., & Ort, R. G. (2002). Lessons from the Broward County mental health court evaluation. *Program Planning and Evaluation*, 25, 125–135.
- Petrila, J. (2003). An introduction to special jurisdiction courts. *International Journal of Law and Psychiatry* (this issue).
- Petrila, J., Poythress, N., McGaha, A., & Boothroyd, R. (2001, Winter). Preliminary observations from an evaluation of the Broward County Florida Mental Health Court. *Court Review*, 14–22.
- Poythress, N., Bonnie, R. J., Hoge, S. K., Monahan, J., & Oberlander, L. B. (1994). Client abilities to assist counsel and make decisions in criminal cases: findings from three studies. *Law and Human Behavior*, 18, 435–450.
- Poythress, N. G., Petrila, J., McGaha, A., & Boothroyd, R. (2002). Perceived coercion and procedural justice in the Broward County Mental Health Court. *International Journal of Law and Psychiatry*, 25, 517–533.
- Rabaska, L. (2000). A court that sentences psychological care rather than jail time. *Monitor on Psychology*, 31(7), 58–60.
- Steadman, H. J., Davidson, S., & Brown, C. (2001). Mental health courts: their promise and unanswered questions. *Psychiatric Services*, 52, 457–458.
- Stiles, P., Boothroyd, R. A., Snyder, K., & Zong, X. (2002). Service penetration by persons with severe mental illness: how should it be measured? *Journal of Behavioral Health Services*, 29, 198–207.
- Watson, A., Luchins, D., & Hanrahan, P. (2001). Mental health court: promises and limitations. *Journal of the American Academy of Psychiatry and Law*, 28, 476–482.

- Wexler, D. B., & Winick, B. J. (1991). *Essays in therapeutic jurisprudence*. Durham, NC: Carolina Academic Press.
- Woerner, M. G., Mannuzza, S., & Kane, J. M. (1988). Anchoring the BPRS: an aid to improved reliability. *Psychopharmacology Bulletin*, 24, 112–118.
- Wren, G. L. (1998). *Progress Report: July 1997–June 1998, The Nation's First Mental Health Court*. Fort Lauderdale, FL.