



Published in final edited form as:

*Int J Forensic Ment Health*. 2013 April 1; 12(2): 116–125. doi:10.1080/14999013.2013.791351.

## Predictors of Criminal Justice Outcomes Among Mental Health Courts Participants: The Role of Perceived Coercion and Subjective Mental Health Recovery

Christina Pratt<sup>1</sup>, Philip T. Yanos<sup>2</sup>, Sarah L. Kopelovich<sup>3</sup>, Joshua Koerner<sup>4</sup>, and Mary Jane Alexander<sup>5</sup>

Christina Pratt: cpratt@nki.rfmh.org

<sup>1</sup>Center to Study Recovery in Social Contexts, Nathan Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY 10962

<sup>2</sup>John Jay College of Criminal Justice, City University of New York. 524 West 59<sup>th</sup> Street, New York, NY 10019

<sup>3</sup>John Jay College of Criminal Justice and The Graduate Center, City University of New York, 524 West 59<sup>th</sup> Street, New York, NY 10019

<sup>4</sup>Center to Study Recovery in Social Contexts, Nathan Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY 10962

<sup>5</sup>Center to Study Recovery in Social Contexts, Nathan Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY 10962

### Abstract

Internationally, one effort to reduce the number of people with serious mental illness (SMI) in jails and prisons is the development of Mental Health Courts (MHC). Research on MHCs to date has been disproportionately focused on the study of recidivism and re-incarceration over the potential of these problem-solving courts to facilitate mental health recovery and affect the slope or gradient of opportunity for recovery. Despite the strong conceptual links between the MHC approach and the recovery-orientation in mental health, the capacity for MHCs to facilitate recovery has not been explored. This user-informed mental health and criminal justice (MH/CJ) community based participatory (CBPR) study assesses the extent to which MHC practices align with recovery-oriented principles and may subsequently affect criminal justice outcomes. We report on the experiences and perceptions of 51 MHC participants across four metropolitan Mental Health Courts. Specifically, the current study assesses: 1) how defendants' perceptions of court practices, particularly with regard to procedural justice and coercion, relate to perceptions of mental health recovery and psychiatric symptoms, and, 2) how perceptions of procedural justice and mental health recovery relate to subsequent criminal justice outcomes. The authors hypothesized that perceived coercion and mental health recovery would be inversely related, that perceived coercion would be associated with worse criminal justice outcomes, and perceptions of mental health recovery would be associated with better criminal justice outcomes. Results suggest that perceived coercion in the MHC experience was negatively associated with perceptions of recovery among MHC participants. Perceptions of "negative pressures," a component of coercion, were important predictors of criminal justice involvement in the 12 month period following MHC admission, even when controlling for other factors that were related to criminal justice outcomes, and that an increase in procedural justice was associated with a decrease in symptoms but curiously not to an increase in attitudes toward recovery. Implications and future directions are discussed.

## Keywords

Mental Health Court; procedural justice; recovery; capabilities approach; CBPR

People with co-occurring diagnoses of serious mental illness (SMI) and substance abuse enter the criminal justice system as defendants, serve time in prison and jails, and frequently reenter the system as repeat offenders (King, Freiberg, Batagol, & Hyams, 2009; Steadman et al, 2009). Over 1.1 million people diagnosed with mental illness are arrested in the US each year (Lyons & Walsh, 2010; Steadman, Osher, Robbins, Case & Samuels, 2009). In fact, incarceration of people with diagnoses of SMI is eight times the rate of public psychiatric hospitalization (Akland, 2010; SAMHSA GAINS, 2009) and 15% of men and 31% of women in jails and prisons meet criteria for a serious mental illness (Steadman et al., 2009). One effort to reduce the number of people with SMI in jails and prisons is the development of mental health courts (MHCs) both in the US and internationally (World Health Organization, 2004). Currently, the number of MHCs approaches 320, compared to the original two MHCs in 1997 (Lerner-Wren, 2010; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2010). In their seminal longitudinal, multi-site study, Steadman et al (2010) found that MHCs achieved key criminal justice goals of significantly reduced rates of recidivism, reduced time in incarceration for participants, and improved public safety outcomes. Their study provides support for the notion that MHCs can be an effective tool for reducing criminal justice involvement for people with serious mental illness, yet the mechanisms underlying this observed effect are not yet understood.

Despite compelling evidence that MHCs have positive effects on costs, criminal justice burden, and public safety outcomes, there is durable documentation of variability in the practices of MHCs (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006) and a general lack of consensus on what aspects of MHC practice are more likely to facilitate positive outcomes. Thus, research is needed to deduce which aspects of MHC practice are most effective. An area that is relevant in this regard concerns the concept of *recovery-oriented services*. Recovery-oriented services are distinguished by policies, procedures, interventions, and attitudes that have been identified as supporting mental health recovery (Anthony, 1993; 2000; 2004; Barton, 1998; Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Onken, Craig, Ridgway, Ralph, & Cook, 2007). At the most foundational level, recovery-oriented services have been aligned with basic human rights and social justice (e.g., Jacobson & Greenley, 2001). Recovery has been defined as a “process of changing one’s attitudes, values, feelings, goals, skills and/or roles [in order to live] a satisfying, hopeful, and contributing life even with the limitations caused by the illness” (Anthony, 1993, p. 13). Recovery approaches to complex mental health and substance use disorders promote opportunities for citizens to live lives worth living, to work, and to participate in valued roles and occupations in their communities (e.g., Anthony, 1993; Barber, 2012; Deegan, 1988; Harding, 2005; Hogan, 2003; New Freedom Commission, 2003; Slade, 2009). Recovery-centered practices prescribe collaborative treatments, equal access to effective services, and opportunities for employment, education, and self-advancement.

The extent to which MHC practices align with recovery-oriented principles and facilitate recovery has not been explored; however, there are strong conceptual links between the MHC approach and the mental health recovery-orientation. Fisler (2005) highlights that MHCs, in the ideal, aim to partner with defendants and community agencies to “foster therapeutic alliances...using...technique[s]—[of] empathy, warmth, and allowance of self-expression” (p. 597). Recovery in social contexts—the capacity for a life worth living outside of complex conditions, systems, and forensic supervision—aligns with key components of procedural justice. The capabilities approach to recovery (Hopper, 2007)

offers an analogous conceptual framework to procedural justice. Each approach is punctuated by participation (having a voice)—the opportunity to present one’s own side of the dispute and be heard by a decision maker with authority; dignity—to be treated with respect and personhood; hope, to have one’s rights acknowledged; and trust that members of the community associated with the highest level of authority are concerned with one’s welfare.

Although previous studies suggest that low levels of coercion and high levels of perceived fairness in MHCs are related to reduced recidivism (Christy, Boothroyd, Petrila, & Poythress, 2005), MHC procedures have been critiqued as inherently coercive and likely discordant with principles of recovery (Ryan & Whelan, 2012). To access MHCs as an alternative to incarceration, defendants with psychiatric diagnoses either agree to court ordered conditions of treatment through dual allocutions of persistent illness and law violation or face typical prosecution and probable (re)incarceration. The line between coercion and choice may indeed be narrow. The concept of legal coercion does not necessarily coincide with the psychological perception of coercion (Winick, 2002). Monahan and colleagues’ MacArthur studies (Monahan et al., 1995) examined the causes and correlates of what makes people feel coerced and concluded that, even though individuals were subjected to legal compulsion, they did not feel coerced when treated with dignity and respect by people who they perceived as providing them with a sense of “voice” (the ability to have their say), and with “validation” (the impression that what they said was taken seriously) (Morrissey, Fagan, & Coccozza, 2009). Negative pressures, such as threats and force, tended to make individuals feel coerced, whereas positive pressures, such as persuasion and inducement, did not (Winick, 2002).

The present study explored elements of recovery practice within the contexts of four metropolitan mental health courts through the lens of the Capabilities Framework (CF; Sen, 1999). A capabilities-informed approach to recovery from SMI invites one to consider how social contexts confer opportunities “for lives worth living” by considering the social structural factors that constrain or facilitate functioning (Hopper, 2007). To date, some preliminary efforts have been made to use the capabilities approach to rethink recovery and community inclusion as behavioral health “outcomes” that support self-determination, and make the case for peer participation in research (Hopper, 2007; Hopper & Lincoln, 2009). Such is the origin of the present community based participatory research (CBPR) study. The MHC project arose from a participatory research program dedicated to exploring the meaning and determinants of social recovery for persons diagnosed with severe mental illness. CBPR stakeholders implemented a portfolio of research on social recovery for people with severe psychiatric disability that targeted well being, social participation and self determination as core capabilities of lives worth living. Accordingly, service users, providers and policy makers as well as investigators participated in the development and implementation of research. Of the four MHC project investigators, one researcher had lived experience with psychiatric and criminal justice systems. The peer leader of this study had both the lived experience of long term addiction as well as multiple voluntary and involuntary admissions to locked psychiatric units based upon the diagnosis of a bipolar disorder, in addition to criminal justice involvement. The peer leader joined academic researchers to design a study to query the adaptation of Sen’s CF to recast substantive issues, functional outcomes with the enabling means of community contexts through MHCs. This project represented, activated and supported the CBPR approach with a broad assembly of community and academic partners built in from the start.

As a substantive freedoms approach to human development, CF emphasizes *agency*, and the importance of maximizing a person’s freedom and voice to “choose a life that one has reason to value” (Sen, 1999, p 18). The present study examined the association between

MHC participants' symptoms, subjective recovery experience, perceptions of coercion and procedural fairness, and criminal justice outcomes in the 12-month period following enrollment in four metropolitan MHCs. Consistent with principles of CBPR, the research question was peer (forensic/mental health consumer) driven and the research team incorporated members of the mental health disability community in roles of leadership, training, project implementation and analysis. The MHC CBPR project team examined: 1) how defendant's perceptions of court practices, particularly with regard to procedural justice and coercion, relate to perceptions of mental health recovery and psychiatric symptoms, and, 2) how perceptions of procedural justice and mental health recovery relate to subsequent criminal justice outcomes. It was hypothesized that perceived coercion and mental health recovery would be inversely related, that perceived coercion would be associated with worse criminal justice outcomes, and perceptions of mental health recovery would be associated with better criminal justice outcomes.

## Method

### Participants

Study sites included Westchester County, Brooklyn, Bronx, and Queens, New York MHC programs. Diversion was offered as a voluntary alternative to incarceration for criminal defendants who meet New York state criteria for serious and persistent mental illness (SPMI), including a *DSM-IV-TR* Axis I diagnoses other than substance use/abuse, organic brain syndromes, developmental disabilities or social conditions; functional impairment due to mental illness; SSI or SSDI due to mental illness, and/or reliance on psychiatric treatment, rehabilitation and supports (New York State Office of Mental Health, 2012). The study sample consisted of 51 criminal defendants newly enrolled in 4 MHCs in the New York City-area. We attempted to recruit all new enrollees into the 4 MHCs within a 3-month period. Our recruitment strategy consisted of attempting to recruit all individuals newly enrolled into each of the 4 MHCs within a 3-month period. In order to do so, we arranged to approach new enrollees shortly after they had been accepted by the MHC diversion team. All enrollees that we approached participated in the project, so we encountered no direct "refusals." However, some enrollees may have told the diversion team that they were not interested in speaking with the research team about the project. Unfortunately, we cannot estimate how many such "refusals" occurred.

Due to the comparative nature of the analyses, all courts are hereafter de-identified. Courts were randomly designated A, B, C, or D. Of the 51 total baseline interviews, 47.1% were conducted at Court A, 35.3% were conducted at Court B, 11.8% were conducted at Court C, and 5.9% were conducted at Court D. Due to the small sample attained in courts C and D, these participants were omitted from comparative analyses. Participants in the current study had a mean age of 39.46 (age range: 20 to 62) and were mostly male (64.7%). Racially, the sample was 40.8% African American, 36.7% Latino, 16.3% White, 4.1% Asian, and 2% "other." Most participants (42.0%) had either attained a High School diploma or GED, or no diploma or GED (36.0%), followed by some college (10.0%), an associate's degree (2.0%), a bachelor's degree (2.0%), some graduate school (2.0%), or graduate/professional school (6.0%).

### Measures

**Psychiatric Symptoms and Perceived Recovery**—The Colorado Symptom Index (CSI; Shern et al., 1994) is a 16-item self-report measure of psychiatric symptoms that has been widely used among diverse psychiatric research samples. Boothroyd and Chen (2008) established a cutoff score of 30 to indicate the probable functional impairment and a need for additional psychiatric assessment. Participants in this sample were highly symptomatic at

baseline ( $M = 40.61$ ,  $SD = 14.70$ ,  $SE = 2.08$ , range = 15 to 71). Sixty-six percent of the sample scored at or above the cutoff of 30 recommended by Boothroyd and Chen (2008) as a marker of clinically significant symptoms. Of those, 64% had scored at or above 45, suggesting a highly symptomatic defendant population. The measure's reported specificity (.68) and sensitivity (.76) further suggest that CSI scores above the proposed cut-off are good discriminators of individuals with psychiatric disabilities. Cronbach's alpha of the CSI has been estimated as between .90 to .92 in previous studies (Boothroyd & Chen, 2008; Conrad et al., 2001) which was replicated in the present sample ( $\alpha = .90$ ), indicating a high degree of internal consistency.

*The Recovery Assessment Scale* (RAS; Corrigan, Salzer, Ralph, Sangter, & Keck, 2004) was used to measure participants' subjective sense of recovery. The RAS is a 41-item self-report scale. The RAS is primarily a measure of the subjective dimensions of recovery, as it does not assess functional improvement. It has been found to have five empirically-derived factors: Confidence and Hope (this consists of items regarding self-esteem and hope), Willingness to Ask for Help (which addresses help-seeking), Goal and Success Orientation (which addresses the presence of goals and confidence), Reliance on Others (which addresses reliance on others for support) and Non-Domination by Symptoms (which consists of items concerning the degree to which psychiatric symptoms are the focus of the person's life). In the present study, we found the RAS to have acceptable internal consistency ( $\alpha = .85$ ).

**Procedural Justice and Perceived Coercion**—Consistent with previous empirical literature on application of procedural justice theory to diversion programs (e.g., O'Keefe, 2006; Poythress et al., 2002), two Likert-scale self-report measures were used to assess thematic components of procedural justice: the *Perceptions of Procedural Justice* (PPJ; Cascardi, Poythress, & Hall, 2000; Poythress et al., 2002) and the *Impact of Hearing* (IOH; adapted from Poythress et al., 2002). The *MacArthur Admission Experience Survey: Short Form* (MAES; Gardner et al., 1993) was also administered. On the PPJ, participants are asked to rate on a Likert scale the degree to which (1) they had an opportunity to tell the judge about their personal and legal circumstances, (2) they felt that the judge seemed genuinely interested in them as a person, (3) the judge treated them with respect, (4) the judge treated them fairly, (5) they were satisfied with how the judge treated them and dealt with their case, and (6) they were satisfied with the decisions made regarding their case. Cronbach's coefficient alpha calculated among the current sample suggests an acceptable degree of internal consistency among PPJ scale items ( $\alpha = .71$ ). The possible range of scores on the PPJ is 7 to 42. The observed range in the current sample was 8 to 42.

In contrast with the more traditional aspects of procedural justice that are measured by the PPJ, the 6-item IOH seeks to assess the emotional impact of the court experience on the defendant. On a Likert scale, participants rate whether they felt (1) worse or better, (2) more upset or more calm, (3) less respected or more respected, (4) more confused or more informed, (5) less hopeful or more hopeful, and (6) good or bad in comparison to how they felt prior to court. The IOH aims to target participants' sentiment regarding the totality of the court experience. The IOH demonstrated good internal consistency in the current study ( $\alpha = .84$ ). For the IOH, the possible range is between 7 and 42 and the observed range was 10 to 42.

Perceived coercion was assessed using the MAES (Gardner et al., 1993). The MAES is a 16-item measure comprised of the Perceived Coercion Scale, Negative Pressures Scale, and Voice Scale. All questions require a True/False/Don't Know forced choice response. Responses are then quantified using a scoring schematic provided by the authors. The perceived coercion scale includes positively worded items and relates to perceptions of



choice and voluntariness in joining MHC. The negative pressures scale includes mostly negatively worded items and relates to perceptions of being threatened with commitment and other sanctions in order to coerce participation in MHC. The voice subscale includes items about perceptions of being able to express one's views and desires in the process of admission to MHC. Because the questions in the original version of the scale are directed toward an inpatient population, for the current study questions were rephrased to reflect the experiences of the participants in the context of MHC. A mean imputation approach was used to account for missing values so that mean scores could be computed for each subscale on the MAES. Internal consistency for the subscales was moderate, ranging from .52 to .61. Of 816 total items, there were 32 missing item responses for the MAES or .04% of overall responses for this scale. On the MAES, possible scores range from 0 to 1, and the observed range was from .33 to .83 for Negative Pressures, 0 to 1 for Voice, and 0 to 1 for Perceived Coercion.

**Criminal Justice Involvement**—Data on criminal justice involvement were obtained from the New York State Department of Criminal Justice Services (NYSDCJS). The NYSDCJS records all events of criminal justice involvement occurring in New York state, including arrests, arraignments, jail episodes, and prison sentences. Lifetime data on criminal justice involvement were requested for all participants with an available New York State Identification number (50 of 51 participants). After data were obtained, a manual review was conducted to identify all arrests, jail and prison episodes recorded during the 12-month period following the baseline interview. After NYSDCJS administrative data were added to the file with interview data, the data on arrests, jail and prison episodes were combined into a new dichotomous variable labeled “any criminal justice involvement”, which represented having any recorded criminal justice involvement in the year following the baseline interview.

## Procedure

**Defendant Interviews**—After establishing contact with the MHC diversion teams, research assistants were asked to be contacted whenever new defendants were enrolled in the MHC. Defendants recently enrolled in the MHC within the past four weeks who were no longer incarcerated were considered eligible for the study. An attempt was made to approach all newly enrolled participants at all four MHCs within three weeks of court enrollment. Baseline interviews were orally administered between October 2009 and September 2010. All interviews were conducted by trained Masters-level Research Assistants. After obtaining informed consents, interviewers verbally administered the previously described measures. Participants were compensated with the equivalent of \$20 either in cash or with a gift card, depending on the form of incentive preferred by individual MHC diversion teams for the study participants in their Court.

## Results

Of the 51 participants for whom data were available, 11 participants (21.6%) had some criminal justice involvement in the 12-month period following the baseline interview. Ten participants (19.61%) had a documented arrest. Of these participants, five (50%) had been arrested once, two (20%) had been arrested twice, two (20%) were arrested three times and one participant (10%) had been arrested four times. Three participants (5.9%) had some documented jail days during the 12-month follow-up period, with the number of days ranging from 60 to 184. Finally, only one participant (2.0%) had a documented prison sentence. Since rates for criminal justice involvement were low overall, and all except one participant with criminal justice involvement had a documented arrest, we collapsed data on

criminal justice into a single categorical variable (0 = no criminal justice involvement, 1 = criminal justice involvement).

Table 1 presents demographic characteristics of participants by criminal justice involvement status. As can be seen in Table 1, there were no statistically significant differences between the two groups on age, education, sex and race/ethnicity. However, as there was evidence for a trend for participants with criminal justice involvement to be more likely to be African American, we conducted an additional analysis comparing participants of African American race to all other participants, and found that, when divided in this manner, there was a statistically significant difference between the two groups ( $\chi^2 = 5.76$ ,  $df = 1$ ,  $p = .04$ ), with participants with criminal justice involvement more likely to have been African American. There were no site differences between courts A and B in degree of criminal justice involvement in the 12-month follow-up period studied.

Table 2 presents data on correlations between study scales and demographic variables at baseline. As can be seen in Table 2, subjective mental health recovery as reflected in the RAS was unrelated to demographic variables (with the exception of a trend for female participants to have higher RAS scores) but was negatively related to psychiatric symptoms as measured by the CSI, and, as hypothesized, positively related to perceived procedural justice as measured by the PPJ, and negatively related to perceived coercion as measured by the MAES. The three MAES subscales were not related to psychiatric symptoms as measured by the CSI, but were related to education (participants with more education perceived both more voice and more coercion), and voice was also negatively related to female gender. Two MAES subscales (negative pressures and perceived coercion) were strongly significantly associated with reduced perceived procedural justice. No study scales were significantly associated with race (African-American vs. others). Additional analyses (not in Table 2) explored whether there were any site differences between the two MHCs with sufficient numbers of participants to allow for comparisons (courts A and B). There were no significant differences between the two courts in any of the study scales or demographic variables, although there were non-significant trends for participants in court A to show more perceived coercion in 2 MAES subscale scores: negative pressures ( $M_{\text{Court A}} = .69$ ,  $SD = .17$ ,  $M_{\text{Court B}} = .78$ ,  $SD = .13$ ;  $F = 3.6$ ,  $df = 1, 40$ ,  $p = .06$ ), and voice ( $M_{\text{Court A}} = .19$ ,  $SD = .25$ ,  $M_{\text{Court B}} = .37$ ,  $SD = .42$ ;  $F = 3.1$ ,  $df = 1, 39$ ,  $p = .08$ ).

Table 3 presents data on scales assessing perceived procedural justice, psychiatric symptoms, and perceived recovery by criminal justice involvement in the 12 months following their initial interview. As can be seen in Table 3, two procedural justice measures differed by criminal justice involvement: the PPJ scale and the negative pressures subscale of the MAES. In the case of the PPJ, participants with criminal justice involvement perceived less procedural fairness in their interactions with the mental health court, while in the case of the negative pressures subscale, participants with criminal justice involvement perceived more negative pressure. Supplemental analyses revealed that specific items in the MAES showed marked differences: "People tried to force me to come into the program," and "I was threatened with commitment." With regard to psychiatric symptoms and recovery attitudes, only the "non-domination by symptoms" subscale of the RAS was significant. The finding with regard to this subscale, which includes items related to ability to manage psychiatric symptoms, suggests that participants who had criminal justice involvement during the follow up period felt less able to cope with psychiatric symptoms. This was also supported somewhat by a non-significant trend for participants with criminal justice involvement to have had more psychiatric symptoms as measured by the CSI. As previously stated, scores on the CSI are indicative of clinically significant symptoms for the majority of participants. Participants' pooled scores on the CSI were normally distributed,  $D(50) = 0.105$ ,  $p > .05$ , and were not significantly different between courts A and B,  $t(39) =$

1.09,  $p > .05$ . The mean total score for the RAS indicate that defendants held a somewhat optimistic view of mental illness and their prospects for recovery. Although one could not conclude that such attitudes are an artifact of being diverted, it is interesting to note such relatively high RAS scores at the point of diversion.

Finally, we used logistic regression to determine what constellation of variables were able to most accurately predict which participants would have criminal justice involvement in the 12-month follow up period. We entered all variables that were found to be significantly associated with criminal justice involvement in the bivariate analyses discussed in Table 3 (African-American race versus others, PPJ, MAES-Negative Pressures, and RAS-Non-Domination by Symptoms). Using a stepwise approach, we found that three of the variables, African-American race ( $B = 2.12$ ,  $SE = .92$ ,  $Wald F = 5.33$ ,  $p = .02$ ), MAES-Negative Pressures ( $B = -6.03$ ,  $SE = 2.65$ ,  $Wald F = 5.2$ ,  $p = .02$ ), and RAS- Non-Domination by Symptoms ( $B = -.38$ ,  $SE = .17$ ,  $Wald F = 5.16$ ,  $p = .02$ ), remained in the equation and correctly predicted classification in the criminal justice variable 83.7% of the time. The PPJ variable was removed from the equation because it shared variance with the MAES subscale and was a weaker predictor overall. This indicates that these three variables: MAES-Negative Pressures, RAS-Non-Domination by Symptoms, and race, all made an independent contribution to the prediction of criminal justice involvement in the year following enrollment in the MHC.

## Discussion

Our analyses suggest some interesting findings with regard to associations between perceptions of coercion and recovery and the prediction of criminal justice outcomes in MHC contexts. First, as hypothesized, perceived coercion in the MHC experience was negatively associated with perceptions of recovery among MHC participants. Specific aspects of perceived recovery such as hope and goal-orientation were inversely related to perceptions of coercion in the MHC context. That is, defendants who tended to endorse feelings of being coerced by MHC were less likely to self-report specific positive outlooks on their prospects for recovery. This finding suggests that not only may hope be an important element in the recovery process, it is inversely associated with feeling coerced to take a plea with MHC. Interestingly, aspects of coercion were correlated with gender, wherein female defendants were less likely to feel as though they were permitted to speak on their own behalf, and education, with those who were less educated also reporting less opportunity for voice and higher perceptions of being coerced in to the court. This finding may point to differential treatment in the courts included in the current study on the basis of gender and level of education and warrant further investigation looking specifically at the perceptions of court experiences of minorities, disempowered, and disenfranchised populations.

Regarding the effects of feeling coerced on subsequent criminal justice involvement, perceptions of “negative pressures”—a component of coercion—were found to be predictors of criminal justice involvement in the 12 month period following MHC admission, even when controlling for other factors that were related to criminal justice outcomes (African-American race and perceptions of control over symptoms). This suggests that MHC participants who are less voluntarily “invested” in MHC process, and feel that they have been coerced into the process, are more likely to recidivate and therefore less likely to succeed in attaining the goals of MHC. It was unclear from the study findings to what extent perceptions of coercion were related to actual MHC practices. In previous analyses for the same study (Kopelovich S, Yanos P, Pratt C & Koerner J (2013)), we found that courts A and B differed significantly in the practices of MHC judges, with judges in court A demonstrating less procedural fairness than judges in the other courts studied. As there was a



non-significant trend for participants in court A to have perceived more coercion than participants in court B, it is plausible that some portion of participant perceptions were related to actual court workgroup practice differences between the courts. Alternatively, it is equally possible that this correlation is attributable to defendants at higher risk for re-offense being more likely to report higher levels of perceived coercion and to be less engaged in the process (see Barber-Rioja, Dewey, Kopelovich, & Kucharski, 2012, for examples of risk factors for recidivism among a similar sample of MHC defendants).

The racial differences that were found in the prediction of criminal justice involvement are consistent with previous research reflecting higher arrest and incarceration rates among African Americans. In fact, Roque (2011) asserts that “the finding that African Americans are disproportionately arrested and incarcerated is one of the most persistent, historical ‘facts’ in crime and justice research” (p. 293). Although racial differences in levels of perceived procedural justice were not apparent in our sample, this may be an artifact of MHC settings. Studies have yet to surface regarding whether MHC defendants with lengthier histories of criminal justice involvement are more prone to have higher levels of PJ for their MHC experience than those without such histories, but a previous study conducted by the current authors indicates that research assistants tended to assign lower ratings of procedural justice than the defendants themselves gave (Kopelovich S, Yanos P, Pratt C & Koerner J (2013)). More research is needed to ascertain how MHCs may be of particular benefit to African Americans in interrupting the cycle of criminal justice involvement. The research question, posed by the peer investigator, was the result of an understanding of Sen’s Capability Framework; that persons in the American “caste” system were those with psychiatric and/or dual diagnoses whose disabilities became the cause of their criminal justice involvement. The question was, at its base, whether such persons could be backed out of the criminal justice system with the cooperation of defense and prosecuting attorneys, enlightened judges, as well as a community mental health system which tended to see such people in terms of the danger they presented to the other program participants.

Finally, contrary to the hypothesis that perceived recovery would be correlated with improved criminal justice outcomes, the current study was unable to detect a meaningful relationship between perceived recovery and subsequent criminal justice outcomes, with the exception of a subscale related to beliefs in control over psychiatric symptoms. This suggests that a specific aspect of perceived recovery—namely, the belief that one cannot control one’s symptoms—might impact the likelihood that one will recidivate. Although the specific mechanism by which this might impact criminal justice outcomes is unclear, a plausible explanation might be that individuals who do not feel that they have control over their symptoms may be more likely to experience angry outbursts or use illegal substances in a way that may increase risk for re-arrest. Another interpretation regarding the relationships between participants’ perception of their symptom control and criminal justice involvement might be that those who express little control over symptoms may feel somewhat absolved from responsibility for behavior not under their control or may engage less (or less meaningfully) in diversion services designed to reduce criminal behavior. Future studies should strive to collect information pertaining to psychiatric diagnosis to test whether the sentiment of having a sense of control over one’s symptoms is associated with particular disorders that may themselves increase the risk of criminal justice involvement, such as substance use disorders. Alternatively, the belief that one has no control or agency regarding one’s symptoms may create a sense of helplessness and hopelessness which, in turn, increases the risk of recidivism or disengagement from diversion services. Future studies should explore the degree to which newly enrolled MHC defendants endorse feelings of helplessness and hopelessness and assess for correlative associations.

Several limitations of the present study should be noted. First, we note that our project lacked a comparison group of persons with SMI who were not participants in MHC. This limits the extent to which we can conclude that findings are unique to MHC contexts or would occur with participants in any court setting. Second, our sample size was relatively small, limiting the generalizability of findings and reducing statistical power. Third, we note that the 12-month period in which we examined re-arrest and reincarceration is relatively short, and research examining longer follow-up periods is needed. Finally, the small and unequally distributed sample represents another limitation to the current study. Because the same 3-month window of baseline data collection was maintained for each of the four sites, those Mental Health Courts that enrolled few new defendants during the data collection window did not add substantially to the total sample size. Aggregating data of all four courts obscures the heterogeneity of the defendants and their experiences in each court. This small sample of MHC participants was further reduced by attrition on follow-up, thereby attenuating the study's statistical power.

How MHCs influence defendant agency, opportunity, and choice to engage in community based services and treatment remain unanswered. MHCs presume that participants voluntarily surrender some autonomy in exchange for guidance from MHC teams that aims to reverse problems of lives on the street associated with trouble with the law. Specific mechanisms merit testing and specification with respect to what factors of MHC forensic team work influence (or fail to influence) individual motivation for renewed life trajectories toward recovery. MHCs aim: to equip participants with the tools, resources, and services they need to lead law abiding, community integrated lives of value warrants broader inquiry. Observations made by research team members indicate that the actions of the diversion treatment team are likely to be as important to participants' experience and engagement in MHC process as the activities that occur within the court, especially the actions of the judge (Kopelovich S, Yanos P, Pratt C & Koerner J (2013)). Closer and more extensive observations of the diversion treatment teams are suggested to characterize their interactions with defendants, and to assess the extent to which recovery-oriented practices are associated with defendants' perceptions of procedural justice or coercion, their subjective and objective recovery outcomes and their authentic engagement in court processes.

## Acknowledgments

This project was supported by the Center to Study Recovery in Social Contexts (Mary Jane Alexander, PI, NIMH P20MH078188) Nathan Kline Institute for Psychiatric Research, Orangeburg, New York 10962.

Support for the work presented here was provided by the Center to Study Recovery in Social Contexts, which is funded by grant P20MH078188 from the National Institute of Mental Health (NIMH) and is supported in part by the New York State Office of Mental Health (NYS OMH) at the Nathan S. Kline Institute for Psychiatric Research (NKI). The authors would like to express their gratitude to each of our funding agencies for the support of this research. In addition, the authors thank the stakeholders of Bronx MHC/Bronx TASC, Brooklyn MHC/EAC-LINK, Queens MHC/Queens TASC, and Westchester County MHC for access to courtroom, staff, and participants and for welcoming our research ideas with open arms. Finally, the authors express gratitude to Research Assistants Bonnie Sultan, MA, Stephen Quesada, MA, and Courtney Harding, MA, for their hard work.

## References

- Akland, G. Prisons & Jails are North Carolina's New Mental Hospitals. 2010. Retrieved from [http://www.nami-wake.org/files/Prison\\_Mental\\_Illness\\_NAMIWake\\_Oct10.pdf](http://www.nami-wake.org/files/Prison_Mental_Illness_NAMIWake_Oct10.pdf)
- Anthony WA. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*. 1993; 16:11–24.
- Anthony WA. The principle of personhood: The field's transcendent principle. *Psychiatric Rehabilitation Journal*. 2004; 27:205.10.2975/27.2004.205.205 [PubMed: 14982325]

- Anthony WA. A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal*. 2000; 24:159–168.
- Barber M. Recovery as the New Medical Model for Psychiatry. *Psychiatric Services*. 2012; 63(3):277–279.10.1176/appi.ps.201100248 [PubMed: 22388534]
- Barber-Rioja V, Dewey L, Kopelovich S, Kucharski LT. The utility of the HCR-20 and PCL:SV in the prediction of diversion non-compliance and re-incarceration in diversion programs. *Criminal Justice and Behavior*. 2012; 39(4):475–492.10.1177/0093854811432609
- Barton R. The rehabilitation-recovery paradigm: A statement of philosophy for a public mental health system. *Psychiatric Rehabilitation Skills*. 1998; 2(2):171–187.10.1080/10973435.1998.10387561
- Boothroyd RA, Chen HJ. The psychometric properties of the Colorado Symptom Index. *Administration and Policy in Mental Health*. 2008; 35:370–378.10.1007/s10488-008-0179-6 [PubMed: 18561020]
- Cascardi M, Poythress NG, Hall A. Procedural justice in the context of civil commitment: An analogue study. *Behavioral Sciences and the Law*. 2000; 18:731–740.10.1002/bsl.421 [PubMed: 11180419]
- Christy, Boothroyd R, Petrila J, Poythress. Evaluating the efficiency and community safety goals of the Broward County Mental Health Court. *Behavioral Science & Law*. 2005; 23:227–243.10.1002/bsl.647
- Conrad KJ, Yagelka JR, Matters MD, Rich AR, Williams V, Buchanan M. Reliability and validity of a Modified Colorado Symptom Index in a national homeless sample. *Mental Health Services Research*. 2001; 3:141–153.10.1023/A:1011571531303 [PubMed: 11718206]
- Corrigan PW, Salzer M, Ralph RO, Sangster Y, Keck L. Examining the factor structure of the Recovery Assessment Scale. *Schizophrenia Bulletin*. 2004; 30:1035–1041.10.1093/oxfordjournals.schbul.a007118 [PubMed: 15957202]
- Deegan PE. Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*. 1988; 11(4):11–19.10.3109/09638288.2010.505998
- Fisler C. Building trust and managing risk: A look at felony mental health court. *Psychology, Public Policy and Law*. 2005; 11:587–604.10.1037/1076-8971.11.4.587
- Frazer, MS. The impact of the community court model of defendant perceptions of fairness. The Center for Court Innovation; New York: 2006. Retrieved from [http://www.courtinnovation.org/sites/default/files/Procedural\\_Fairness.pdf](http://www.courtinnovation.org/sites/default/files/Procedural_Fairness.pdf)
- Frese F, Stanley J, Kress K, Vogel-Scibilia S. Evidence-based practices: Integrating evidence-based practices and the recovery model. *Psychiatric Services*. 2001; 52:1462–1468.10.1176/appi.ps.52.11.1462 [PubMed: 11684741]
- Gardner W, Hoge KS, Bennett N, Roth LH, Lidz CW, Monahan J, Mulvey EP. Two scales for measuring patients perception of coercion during mental hospital admission. *Behavioral Sciences & the Law*. 1993; 11:307–321.10.1002/bsl.2370110308 [PubMed: 10150233]
- Hogan MF. New Freedom Commission Report: The President’s New Freedom Commission. Recommendations to transform mental health care in America. *Psychiatric Services*. 2003; 54:1467–1474.10.1176/appi.ps.54.11.1467 [PubMed: 14600303]
- Hopper K. Rethinking social recovery in schizophrenia: What a capabilities approach might offer. *Social Science & Medicine*. 2007; 65:868–879.10.1016/j.socscimed.2007.04.012 [PubMed: 17499900]
- Hopper, K.; Lincoln, A. Participation in public mental health research: A conceptual framework and report from practice. In: Amering; Schrank; Wallcroft, editors. *Handbook of Service User Involvement in Mental Health Research*. Wiley-Blackwell; 2009.
- Human Rights Watch. Ill Equipped: US Prisons and Offenders with Mental Illness. Washington, D.C: 2003. Retrieved from <http://www.hrw.org/reports/2003/10/21/ill-equipped>
- Jacobson N, Greenley D. What is recovery? A conceptual model and explication. *Psychiatric Services*. 2001; 52(4):482–485.10.1176/appi.ps.52.4.482 [PubMed: 11274493]
- King, MS.; Freiberg, A.; Batagol, B.; Hyams, R. *Non-adversarial Justice*. Sydney: The Federation Press; 2009.
- Kopelovich S, Yanos P, Pratt C, Koerner J. Procedural justice in mental health courts: Judicial practices, participant perceptions and outcomes related to mental health recovery. *International Journal of Law and Psychiatry*. 2013.10.1016/j.ijlp.2013.01.004

- Lerner Wren G. Mental Health Courts: Serving Justice and Promoting Recovery. Loyola University Chicago School of Law, Beazley Institute for Health Law and Policy. *Annals of Health Law*. 2010; 19:577. [PubMed: 21456399]
- Lyons, S.; Walsh, N. Money well spent: How positive social investments reduce incarceration rates, improve public safety, and promote the well-being of communities. Washington, D.C: Justice Policy Institute; 2010. Retrieved from [http://www.justicepolicy.org/images/upload/10-09\\_REP\\_MoneyWellSpent\\_PS-DC-AC-JJ.pdf](http://www.justicepolicy.org/images/upload/10-09_REP_MoneyWellSpent_PS-DC-AC-JJ.pdf)
- Monahan J, Hoge SK, Lidz C, Roth LH, Bennett N, Gardner W, Mulvey E. Coercion and commitment: Understanding involuntary mental hospital admission. *International Journal of Law and Psychiatry*. 1995; 18:249–236.10.1016/0160-2527(95)00010-F [PubMed: 7591396]
- Morrissey JP, Fagan JA, Cocozza JJ. New models of collaboration between criminal justice and mental health systems. *American Journal of Psychiatry*. 2009; 166(11):1211–1214.10.1176/appi.ajp.2009.09050670 [PubMed: 19884234]
- New Freedom Commission on Mental Health. Achieving the promise: Transforming mental health care in America. Final Report. DHHS Pub. No. SMA-03-3832. 2003. Retrieved from <http://store.samhsa.gov/shin/content/SMA03-3831/SMA03-3831.pdf>
- New York State Office of Mental Health. (last updated 11/15/2012) retrieved from [http://www.omh.ny.gov/omhweb/guidance/serious\\_persistent\\_mental\\_illness.html](http://www.omh.ny.gov/omhweb/guidance/serious_persistent_mental_illness.html)
- O’Keefe, K. The Brooklyn Mental Health Court evaluation: Planning, Implementation, courtroom dynamics, and participant outcomes. 2006. Retrieved from Center for Court Innovation website: Retrieved from <http://www.courtinnovation.org/research/brooklyn-mental-health-court-evaluation-planning-implementation-courtroom-dynamics-and-part?url=research%2Fbrowse%2Fall&mode=browse&type=all&topic=All&author=969>
- Onken S, Craig C, Ridgway P, Ralph R, Cook J. An Analysis of the Definitions and Elements of Recovery: A Review of the Literature. *Psychiatric Rehabilitation Journal*. 2007; 31(1):9–22.10.2975/31.1.2007.9.22 [PubMed: 17694711]
- Poythress NG, Petrila J, McGaha A, Boothroyd R. Perceived coercion and procedural justice in the Broward Mental Health Court. *International Journal of Law and Psychiatry*. 2002; 25:517–533.10.1016/S0160-2527(01)00110-8 [PubMed: 12371265]
- Redlich AD, Steadman HJ, Monahan J, Robbins PC, Petrila J. Patterns of practice in mental health courts: a national survey. *Law and Human Behavior*. 2006; 30(3):347–362.10.1007/s10979-006-9036-x [PubMed: 16775775]
- Roque M. Racial disparities in the criminal justice system and perceptions of legitimacy: A theoretical linkage. *Race and Justice*. 2011; 1(3):292–315.10.1177/2153368711409758
- Ryan, S.; Whelan, D. Diversion of offenders with mental disorders: Mental Health Courts. *Journal of Current Legal Issues*. 2012. Retrieved from <http://webjcli.ncl.ac.uk/2012/issue1/ryan1.html>
- SAMHSA. Ending an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-Occurring Disorders. 2009. Retrieved from <http://www.gainscenter.samhsa.gov/html/nlf/default.asp>
- Sen, A. *Development as Freedom*. New York: Random House; 1999.
- Slade, M. *Personal recovery and mental illness*. Cambridge, UK: Cambridge University Press; 2009.
- Steadman H, Redlich A, Callahan L, Robbins PC, Vesselinov R. Effect of Mental Health Courts on arrests and jail days: A multisite study. *Archives of General Psychiatry*. 2010; 68:167–172.10.1001/archgenpsychiatry.2010.134 [PubMed: 20921111]
- Steadman HJ, Osher FC, Robbins PC, Case B, Samuels S. Prevalence of serious mental illness among jail inmates. *Psychiatric Services*. 2009; 60(6):761–765.10.1037/t04571-000 [PubMed: 19487344]
- Torrey, EF.; Kennard, A.; Eslinger, D.; Lamb, R.; Pavle, J. More mentally ill persons are in jails and prisons than hospitals: A survey of the states. Treatment Advocacy Center; 2010. Retrieved from [http://www.treatmentadvocacycenter.org/storage/documents/final\\_jails\\_v\\_hospitals\\_study.pdf](http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf)
- Tyler. Restorative Justice and Procedural Justice: Dealing with Rule Breaking. *Journal of Social Issues*. 2006; 62(2):307–326.10.1111/j.1540-4560.2006.00452.x
- Tyler, T.; Huo, YJ. *Trust in the Law: Encouraging Public Cooperation with the Police and Courts*. New York: Russell-Sage; 2002.

- World Health Organization. The World Health Report 2004: Changing History, Annex Table 3. 2004.  
Retrieved from [http://www.who.int/whr/2004/annex/topic/en/annex\\_3\\_en.pdf](http://www.who.int/whr/2004/annex/topic/en/annex_3_en.pdf)
- Wexler, D. Therapeutic jurisprudence and readiness for rehabilitation. *Arizona Legal Studies*. 2007.  
Retrieved from <http://ssrn.com/abstract=929014>
- Winick B. Therapeutic jurisprudence and problem solving courts. *Fordham Urban Law Journal*. 2002;  
30(3):1055–1103.



**Table 1**  
Demographic Characteristics of Participants by Criminal Justice Involvement

Variable	No Criminal Justice Involvement in 12 Months After Baseline (n= 39)		Criminal Justice Involvement in 12 Months After Baseline (n = 11)		Total (n= 50)	
	n	%	n	%	n	%
Gender: Male	27	67.5	6	54.5	33	66
Female	12	30.8	5	45.5	17	34
Ethnicity: White (not Hispanic)	7	17.9	1	9.1	8	16
Black (not Hispanic)	13	33.3	8	72.7	21	42
Hispanic	16	41	2	18.2	18	36
Other	3	7.7	0	0	3	6
Education: Less Than High School	15	38.5	4	36.4	19	38
High School Graduate	16	41	5	45.5	21	42
More Than High School	8	20.5	2	18.2	10	20
	Mean ± SD		Mean ± SD		Mean ± SD	
Age:	39.74±11.63		38.36±12.40		39.44±11.69	

**Table 2**  
 Correlation Between Demographic, Procedural Justice, Symptoms and Perceived Recovery at Baseline (n = 51)

	1	2	3	4	5	6	7	8	9	10
1. Sex (0 = Male, 1 = Female)	---									
2. Race (0 = All Others, 1 = African American)	.383*	---								
3. Education	-.144	-.155	---							
4. Age	-.031	-.056	.081	---						
5. PPI	.099	.030	-.357*	-.105	---					
6. IOH	.036	-.050	-.108	-.063	.525*	---				
7. Colorado Symptom Index	.008	-.059	-.309*	-.192	-.199	-.331*	---			
8. MAES voice (higher = more)	-.280*	-.110	.385*	.268 <sup>†</sup>	-.235	-.441*	-.126	---		
9. MAES negative pressures (lower = more)	-.003	-.013	-.063	-.105	.510*	.482	-.176	-.191	---	
10. MAES Perceived Coercion (higher = more)	-.160	.130	.395*	-.032	-.551*	-.504*	.080	.473*	-.248 <sup>†</sup>	---
11. RAS total	.246 <sup>†</sup>	.027	-.028	.084	.307*	.223	-.393*	-.115	.198	-.306*

\* p < .05

<sup>†</sup> p < .01

<sup>1</sup> Perceptions of Procedural Justice Scale (PPJ)

<sup>2</sup> Impression of Hearing Scale (IOH)

<sup>3</sup> Colorado Symptom Index (CSI)

<sup>4</sup> MacArthur Admissions Experience Scale (MAES)

<sup>5</sup> Recovery Assessment Scale (RAS)

**Table 3**  
Perceived Procedural Justice, Psychiatric Symptoms, and Perceived Recovery by Criminal Justice Involvement

Variable	No Criminal Justice Involvement in 12 Months After Baseline (n= 39)		Criminal Justice Involvement in 12 Months After Baseline (n = 11)		Total (n= 50)		F (df)	p	η <sup>2</sup>
	Mean	SD	Mean	SD	Mean	SD			
*PPJ	32.88	6.58	27.09	10.69	31.60	7.92	4.93 (1,48)	.031	.09
IOH	32.28	8.24	30.18	11.06	31.82	8.85	.478 (1, 48)	.493	.01
CSI	37.94	13.91	44.7	11.67	39.43	13.63	2.16 (1, 48)	.148	.04
MAES-Voice (higher = more)	.23	.32	.27	.36	.24	.33	.126 (1.47)	.724	.00
*MAES Negative Pressures (lower = more)	.76	.13	.64	.19	.73	.15	6.08 (1,48)	.017	.11
MAES Perceived Coercion (higher = more)	.29	.32	.37	.29	.31	.31	.49 (1,48)	.483	.01
RAS Confidence and Hope	35.53	5.81	36.73	4.88	35.8	5.59	.389 (1,47)	.536	.01
RAS Willingness to Ask for Help	12.08	2.27	12.55	1.51	12.18	2.19	.409 (1,47)	.526	.01
RAS Goal and Success Orientation	21.66	2.94	21.27	3.13	21.57	2.96	.142 (1,47)	.708	.00
RAS Reliance on Others	15.55	2.76	17.18	2.18	15.92	2.71	3.22 (1,47)	.079	.06
RAS Non Domination by Symptoms	10.47	2.78	8.36	2.34	9.99	2.81	5.22 (1,47)	.027	.10

<sup>1</sup> Perceptions of Procedural Justice Scale (PPJ)

<sup>2</sup> Impression of Hearing Scale (IOH)

<sup>3</sup> Colorado Symptom Index (CSI)

<sup>4</sup> MacArthur Admissions Experience Scale (MAES)

<sup>5</sup> Recovery Assessment Scale (RAS)