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Assessing the Effectiveness of Mental Health Courts in Reducing Recidivism: A Systematic Review with Meta-analysis

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ABSTRACT

Mental Health Courts (MHCs) are a type of treatment court created to divert offenders with mental illness away from incarceration and into community-based treatment. While research on the impact of MHCs on recidivism has produced mixed results, there is a need to determine whether MHCs are effective. In light of this need, and of public support for the balanced justice approach toward mentally ill offenders, this study aims to assess the impact of MHC participation on recidivism. As such, the current study is a systematic review and a meta-analysis which replicates a study conducted by Lowder and colleagues while incorporating modifications to the methodology to reflect the new Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines to determine the effect of MHC participation on recidivism. Results from the 15 included studies show a significant reduction (42.46%) in recidivism for individuals who participated in MHC treatment program. Policy implications, in light of the MHC model's reduction in recidivism and alignment with the ideals of balanced justice, are discussed.

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KEYWORDS

Balanced justice; mental health courts; meta-analysis; recidivism; treatment courts

Mental health courts (MHCs) are a type of treatment court based on the successful drug treatment court (DTC) model (Almquist & Dodd, 2009). The primary aim of MHC is to divert justice-involved individuals suffering from a mental illness away from incarceration and toward community-based rehabilitation. While MHCs vary by jurisdiction, the diversion of the court participant away from incarceration rests on the agreement the individual will abide by all court orders, including, but not limited to, attending court-monitored mental health treatment (Honegger, 2015). While slight variation exists between jurisdictions given their need to adapt to the unique needs of their communities, all treatment court ideology rests firmly on the use of therapeutic jurisprudence (TJ) and effective intervention (EI) (Lucas et al., 2023; Marlowe et al., 2016; Winick, 1997).

TJ, which is the use of the law and courts as a therapeutic agent, combined with EI, which calls for the use of evidence-based interventions to promote the best possible outcomes, ultimately informs the operation of MHCs through their adherence to the 10 Essential Elements of MHCs¹ (Shaffer, 2010; Wexler, 2000). In combination, these elements of the MHC model assist with the primary goal of reducing both the recidivism and incarceration of persons with mental illness through the improvement of mental health functioning for the participants within the court (Honegger, 2015). Additionally, MHCs aim to achieve the goal of reduced recidivism and the incarceration of persons with mental illness through the use of a specialized court docket which focuses primarily on justice-involved individuals diagnosed with a mental illness, voluntary agreement to participate within the court, required mental health treatment alongside any other court-ordered programming requirements, a graduated use of sanctions and incentives to incentivize compliance and punish non-compliance, and on-going judicial interactions through frequent status hearings (Almquist & Dodd, 2009; Canada et al., 2019; Steadman et al., 2001; Thompson et al., 2007).

The creation of MHCs was and is necessitated by the number of individuals incarcerated within the United States who have also been diagnosed with a mental illness. While it is difficult to determine the exact number of adults who are incarcerated and also have a mental health disorder, recent estimates are that 43% of state and 23% of federal prisoners within the United States (US) have a history of a mental health problem with 14% of state and 8% of federal prisoners meeting the threshold for past 30-day serious psychological distress (Maruschak et al., 2021). These estimates highlight the fact that adults with serious psychiatric needs are overrepresented in the prison population compared to the general population. It should come as no surprise, then, that there are currently more than 490 MHCs operating within 39 states/territories (Devall et al., 2022). As such, MHCs have been of interest to scholars researching their effectiveness to ensure that the intended outcomes of reduced incarceration and recidivism for court participants are being realized. As a result, a growing body of literature has emerged to determine if MHCs are successful in reducing recidivism (see Anestis & Carbonnell, 2014; Burns et al., 2013; Costopoulos & Wellman, 2017; Dirks-Linhorst & Linhorst, 2012; Hiday et al., 2013; Lowder et al., 2018; McNeil & Binder, 2007; Moore & Hiday, 2006; Steadman et al., 2001). Additionally, ensuring the success of the MHC model is imperative given its compatibility with, and the general public's acceptance of, balanced justice.

Literature Review

Research has shown that mentally ill inmates serve longer sentences compared to other inmates (Bonfine et al., 2020). Despite the large number of individuals with mental illness in jails and prisons, many facilities are not equipped to provide mental health services and medication to this population (Schaefer & Stefancic, 2003; Wallace & Wang, 2020). This is mostly due to jail and prison overcrowding coupled with a lack

¹The Ten Essential Elements are as follows: 1) planning and administration; 2) target population; 3) timely participant identification and linkage to services; 4) terms of participation; 5) informed choice; 6) treatment supports and services; 7) confidentiality; 8) court team; 9) monitoring adherence to court requirements; and 10) sustainability.

of financial resources and trained personnel (Morris et al., 1997; Schaefer & Stefancic, 2003; Wallace & Wang, 2020). Thus, with a lack of treatment and services during their stay in jail or prison and the lack of services after leaving the correctional system, offenders with mental illnesses find themselves in a system of revolving doors where they are arrested, jailed, and eventually released back into the community to begin this cycle again due to the lack of resources needed to address their needs (Broner et al., 2004; Steadman et al., 1999; Trejo, 2018). Therefore, in an effort to slow or end the cycle of reoffending and decrease the number of adults with mental illnesses entering correctional institutions, MHCs have spread across the United States. Additionally, the proliferation of MHCs coincides with the rising public support for the use of balanced justice when considering the punishment of offenders.

Mental Health Court and Balanced Justice

MHCs were created in order to reduce recidivism among mentally ill offenders by addressing the underlying criminogenic factors contributing to the individual's involvement with the criminal justice system. These goals are accomplished through the use of TJ and EI, which call for combining pro-social rehabilitative treatment with frequent judicial interaction. Additionally, MHCs also aim to reduce the number of incoming court cases, which contribute to decreases in jail and prison overcrowding (Goldkamp & Irons-Guynn, 2000; Petrilà et al., 2000). Furthermore, the MHC model falls within the realm of balanced justice, which aims to strike the balance between punishment and rehabilitation. Previous research has shown the public largely supports the balanced justice model for various types of offenses, including for those who suffer from a severe mental illness (SMI) (Applegate et al., 1997; Atkin-Plunk, 2020; Atkin-Plunk & Sloas, 2019; Cullen et al., 2000; Nagin et al., 2006; Sloas & Atkin-Plunk, 2019; Thielo et al., 2015, 2019; Weaver et al., 2018). Specifically, when examining factors relating to the public's support for balanced justice for mentally ill offenders, Atkin-Plunk (2020), building upon previous literature (see Mears et al., 2015), discovered support for the model, a promising sign for jurisdictions using or considering the MHC model.

In light of the public support for the balanced justice approach toward mentally ill offenders, coupled with the fact that three-quarters of Americans believe that mental health services should be provided to incarcerated individuals and that one in five believe that adequate care is not being provided within correctional settings, the necessity to examine the effectiveness of the MHC model has become paramount (American Psychiatric Association, 2022). Such an examination may provide information about a potential solution to this problem. However, while research assessing the success of MHCs in achieving the above goals has largely shown positive results for reducing arrests (Christy et al., 2005; Herinckx et al., 2005; Hiday & Ray, 2010; Hiday et al., 2013; Moore & Hiday, 2006; Trood et al., 2021), reducing the number of new charges (McNiel & Binder, 2007), charge outcomes (Lowder et al., 2018) and reducing time spent in jail (Christy et al., 2005; Lowder et al., 2016, 2018; Steadman et al., 2011), testing the overall effectiveness of the MHC approach, as opposed to individual courts, has proven more difficult to do.

The Ten Essential Elements of MHCs (see above) were tailored from the successful drug treatment court (DTC) model defined in the Department of Justice Publication *Defining Drug Courts: The Key Components* (United States Department of Justice, 1997). The 10 key components are: 1) substance abuse treatment; 2) a non-adversarial approach; 3) early screening and detection of drug court participants; 4) more access to community treatment options; 5) frequent monitoring and drug testing; 6) coordinated strategies to be implemented involving participant compliance; 7) ongoing judicial interaction with each participant; 8) evaluation of program goals and effectiveness; 9) continuing interdisciplinary education to promote effective drug court planning, implementation, and operation; and 10) forging partnerships with community providers and public agencies to generate local support. While all treatment courts are advised, through the use of best practices, to follow these key components, albeit with slight modifications for differing courts, the potential for substantial variation exists within each court's adherence to, and application of, these components (see Kaiser, 2020; Kaiser & Rhodes, 2019). Operating procedures, then, can vary between jurisdictions and are impacted by differing state laws (eg certain offenses in certain states cannot be considered for inclusion within certain treatment courts) and federal guidelines (eg, federal funding cannot be sought for DTCs if they include participants with violent charges). These variations between differing courts can make cross-comparison a difficult task. Thus, while individual courts can, and have been, empirically examined, claiming that the success of the MHC model as a whole must be done with careful consideration given to the variations in MHC operations and how and why each court selects its target population. While the adherence to the essential elements of MHCs is not the intent of the current examination and is beyond the scope of aims of this study, it must be presented to the reader in order to frame the importance of the current study; through highlighting the variation which exists between individual MHC adherence to these principles, using individual studies to illustrate the success of these types of treatment courts would be inadequate and justifies the current meta-analytical approach undertaken by the authors. Furthermore, despite previous research highlighting the effectiveness of the MHC model in reducing recidivism (Han & Redlich, 2016, 2018; Lowder et al., 2016), little attention has been paid to how this promotes the increasingly popular balanced justice approach to individuals suffering from SMI entering our criminal justice system. Answering the call from researchers such as Sloas and Larrea (2023), this article directly combines the examination of the effectiveness of the MHC model in reducing recidivism considering increasing public support for balanced justice, which is at the heart of the MHC approach. A common approach to remedying the difficulties of cross-comparing treatment courts has been to conduct meta-analyses using independent studies concerning a single theme, such as the type of court and outcome variables. As such, Lowder et al. (2018) conducted a systematic search of three databases and found 17 studies published between 2004 and 2015. Results from their study showed a small effect of MHC participation on recidivism compared to traditional criminal court processing.

As is with any criminal justice intervention, ongoing and rigorous assessment of their impact and effectiveness is needed and should be informed by the best available research evidence. Systematic reviews and meta-analyses aim to identify, summarize

and evaluate findings of evidence-based research. Thus, given the support for the balanced justice model, which is in line with the Ten Essential Elements of MHCs as described above, the current study is a meta-analysis of independent research examining MHC program effectiveness in terms of reductions in participant recidivism. Our study replicates the study conducted by Lowder et al. (2018) with several modifications. First, the current study uses the new 2020 Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). The title and abstract follow new PRISMA recommendations to include important information about the study. The methodology section below also highlights the noteworthy inclusions of new PRISMA guidelines into the research process. For instance, following the new PRISMA guidelines the methodology includes information about the full search strategy for all databases the authors had access to (as opposed to at least one database as the PRISMA 2009 guidelines recommended), an emphasis on the inclusion and exclusion criteria, key-words used in the search and reporting of how many reviewers screened each record retrieved, whether authors worked independently and details about tools used in the process (eg, the use of *abstrackr*). The methodology also includes statements about study characteristics and bias among studies contributing to the results and additional sensitivity analysis (Page et al., 2021). In addition to using the new PRISMA guidelines, the current study differs from Lowder et al.'s (2018) in that it was conducted in February 2023, providing the opportunity for newer research to be included in the analysis. Through our analysis, we hope to contribute to the growing body of knowledge surrounding MHCs and highlight their interconnectedness with balanced justice ideals.

Methodology

Criteria for Inclusion and Exclusion of Studies in the Review

To be eligible for inclusion in this systematic review, studies had to meet several criteria. First, we required an experimental or quasi-experimental design with a comparison group for evaluating the effects of MHCs. Following Mitchell et al.'s (2012) meta-analysis of drug courts and the recommended best practices by the National Drug Court Institute, we excluded evaluations that used program dropouts as the comparison group, as program dropouts are likely to have different baseline characteristics related to study outcomes than individuals who do not drop out (Heck, 2006; Mateyoke-Scrivner et al., 2004). In addition, MHCs were required to be on a docket separate from non-MHC cases and participation had to be voluntary. The MHCs were required to be focused on adults with at least one evaluation outcome being recidivism. Finally, to be included in the meta-analysis, studies needed to have reported sufficient information to compute an effect size.

The number of our selected studies is lower than Lowder et al (2018) and Fox et al. (2021) for several reasons. First, Fox et al. (2021) included MHC evaluations for both adults and juveniles which expanded their results. Moreover, Cross (2011) and Sarteschi et al. (2011) selected studies that included participants who were 17 and older (as opposed to the legal definition of the age at which a person gains the legal status of an adult, ie, 18 years of age in most states according to the Cornell Law

School's, n.d.), which could have inflated the number of selected studies. We elected to focus on adults only which reduced the number of eligible studies.

Lowder et al. (2018) had three primary inclusion criteria: MHC for adults, recidivism being a dependent variable and a comparison group. Our inclusion criteria were more restrictive which led to more studies being excluded. Fox et al. (2021) also had three primary inclusion criteria: a quantitative evaluation of the effects of MHC on recidivism, the presence of effect sizes and published between 1997 and 2020 in a peer-reviewed outlet. Our inclusion and exclusion criteria included studies with an experimental or quasi-experimental design with a comparison group, we excluded program dropouts, selected studies which had a docket separate from non-MHC cases, where participation was voluntary, focused on adults, had one evaluation outcome being recidivism and reported sufficient information to compute effect sizes. Another difference worth noting, the current study used *abstrackr* to screen abstracts of selected studies. Using a machine learning tool to expedite the systematic review process and predict relevant articles could have led to articles being missed. As a result, our selected articles differed from articles selected by previous meta-analyses and Fox and colleagues' (2021) more recent meta-analysis. Nonetheless, while our list of articles may differ from previous meta-analyses, the number and quality of the selected articles allowed us to conduct analyses yielding significant results.

Search Strategy

Following the PRISMA guidelines for reporting inclusion criteria, publication bias assessment, and reporting results (Page et al., 2021), the first step for the search strategy included a computerized keyword search of bibliographic databases. Specifically, Criminal Justice Abstract, Cumulative Index of Nursing and Allied Health (CINAHL) with Full Text, PsycINFO, National Criminal Justice Reference Service (NCJRS), ProQuest Sociological Abstracts, Social Science Citation Index, Science Citation Index, Arts and Humanities Citation Index, PubMed, Nexis Uni, OpenDissertations, and ProQuest Dissertation and Theses databases were included. The keywords used were as follows: ("mental health court*" OR "diversion program*" OR "problem solving court*") AND (recidivism OR evaluation OR "re-arrest" OR "re-conviction"). The last search was conducted in February 2023.

Eligible evaluations were also retrieved by carefully reviewing the reference sections of existing reviews of MHC evaluations as recommended by Lowder et al. (2018). All studies that appeared to be eligible for this study on a preliminary review of the title were retrieved and uploaded into the open-source web-based semi-automated abstract screening software *abstrackr* (2019). Since the evaluations of *abstrackr* as a citation screening program came back positive (Gates et al., 2018; Wallace et al., 2012), we decided to use this free, open-source program to predict the likelihood of citations being relevant. Abstracts were then examined by two of the authors to determine potential eligibility. This step was facilitated by a structured screening guide. Both authors conducted a pilot test of 50 abstracts and achieved 92% agreement on the screening decisions. The authors then discussed discrepancies and potential issues before moving on to review the remaining studies. The screeners agreed on 97% of

the 356 decisions made during this stage, and all disagreements were centered on whether the sample was eligible for review and were resolved successfully.

Criteria for Determination of Independent Studies

Eligible studies used a two-group design with a post-release outcome measure of recidivism. The two groups were a treatment group and a treatment as usual (TAU) comparison group participants who had their cases adjudicated through traditional courts and did not receive referrals to mental health services through the court. Matching variables used in the selected studies included age, race, gender/sex, prior arrest/prior criminal history, mental health diagnosis/symptom severity, and criminal charge.

Unambiguous eligibility criteria were selected as a prerequisite for this meta-analysis. These criteria were selected because of their sufficiently broad quality to include a diversity of studies but also narrow enough to ensure meaningful results when looking at the pool of selected studies as a whole. Since the outcome of interest is recidivism, when selecting studies, particular attention was paid to how the studies measured recidivism. As a result, several different types of statistical dependencies were observed in the selected evaluations of MHCs. For instance, multiple measures of the outcome measure of interest (ie, recidivism) were used within the studies. For instance, some studies used number of re-arrests as their recidivism measure while others used re-conviction. Additionally, to assess recidivism, studies used multiple follow-up periods ranging from 6 months to 36 months (see [Table 1](#)). Such variation between studies was deemed acceptable, as they allowed for results to show meaningful and diverse results from studies. The study conducted by [Shaw \(2019\)](#) reported three groups. A MHC group, a TAU group, and a UNIT group (participants in UNIT) are similar to MHC participants except that they receive more intensive case management services. After consulting with the MHC staff, the judge-assigned participants either to the MHC group or a UNIT group. Because no other study included a separate group whose participants would receive additional case management, we excluded the UNIT group from the meta-analysis.

Procedure

We fitted a random-effects model to the data. In our model, the average effect size was a log odds ratio, and this was then transformed to an average odds ratio (OR) and calculated a prediction interval for the average odds ratio. The amount of heterogeneity (ie, τ^2), was estimated using the restricted maximum-likelihood estimator ([Viechtbauer, 2005](#)). In addition to the estimate of τ^2 , the Q-test for heterogeneity ([Cochran, 1954](#)) and the I^2 statistic ([Higgins & Thompson, 2002](#)) were produced and reported. In case any amount of heterogeneity is detected (ie, $\tau^2 > 0$, regardless of the results of the Q-test), a prediction interval for the true outcomes was also provided ([Riley et al., 2011](#)).

We examined the Studentized residuals and Cook's distances to determine whether any studies may be outliers and whether they were influential in the context of the

Table 1. Summary of study characteristics.

Study	n	Follow-up length (months)	Recidivism measures	Used court refusers within comparison group	Variables used to match treatment and control groups
Aldigé Hiday et al. (2016)	2,190	24	Re-arrest	No	Charge (non-violent misdemeanors) and severity of mental illness
Anestis and Carbonell (2014)	792	12	Re-arrest	No	Age, gender, race, diagnosis, offense type, offense severity
Bagwell (2013)	1,727	12	Re-arrest resulting in incarceration	Yes	Gender, ethnicity, and age
Christy et al. (2005)	434	12	Re-arrest	No	Race, gender, age, and symptom severity
Cosden et al. (2005)	392	6	Re-arrest	No	Gender, race, mental health diagnosis
Dirks-Linhorst and Linhorst, 2012	2,308	12	Re-arrest	Yes	N/A
Ferguson et al. (2008)	872	12	Re-arrest	No	Gender, race, and age
Gallagher et al. (2018)	714	12	Re-arrest	No	Gender, race, substance use, mental health diagnosis, charge type, charge severity
Han and Redlich (2016)	1,482	6	Re-arrest	No	N/A
Hiday et al. (2013)	1,503	12	Re-arrest	No	Age, gender, race, illegal drug use, and number of prior arrests
Kubiatk et al. (2015)	300	12	Re-arrest	Yes	Charge type (felony or non-violent)
Moore and Hiday (2006)	530	12	Re-arrest	No	Mental health diagnosis, charge, age race, gender, criminal history, prior incarceration, charge severity
Rossman et al. (2012, Site 1)	2,424	24	Re-arrest and conviction	No	Age, race, gender, prior criminal history, offense characteristics, and drug use
Rossman et al. (2012, Site 2)	935	24	Re-arrest and conviction	No	Age, race, gender, prior criminal history, offense characteristics, and drug use
Shaw (2019)	445	120	Re-arrest	Yes	Gender, age, race, initial offense level, prior criminal history, felony prior, violation on initial charge initial charge
Vangemeem (2015)	379	36	Re-arrest	Yes	Gender, race, age, and mental health diagnosis

model (Viechtbauer & Cheung, 2010). We considered studies with a studentized residual larger than the $100 \times (1 - 0.05/(2 \times k))$ th percentile of a standard normal distribution to be potential outliers (ie, using a Bonferroni correction with two-sided $\alpha = 0.05$ for k studies included in the meta-analysis). We followed Viechtbauer's (2005) standard of the distance larger than the median plus six times the interquartile range of the Cook's distances to be influential. Next, we checked for symmetry using two tests—the rank correlation test (Begg & Mazumdar, 1994) and the regression test (Sterne & Egger, 2005). In our examination, we used the standard error of the observed outcomes as a predictor, it is used to check for funnel plot asymmetry. All of the analyses were carried out using R (version 4.3.1) (R Core Team, 2020) and the **metafor** package (version 4.4.0) (Viechtbauer, 2010).

Results

Description of Eligible Studies

Our search identified 1,588 total studies for review. Figure 1 represents a flow chart of the eligibility and study selection process.

After removing duplicates, 1,026 studies remained. After title screening, we found 421 potentially eligible studies. Studies were excluded because they evaluated MHCs for youths (as opposed to adults) or they evaluated a traditional court or treatment court that was not a mental health court (most of the studies excluded at this stage evaluated drug courts). Of the remaining 421 studies, the abstract screening excluded 378 studies because they did not meet the inclusion criteria. Studies either did not report MHC as an intervention, were not empirical, or did not report a MHC level participant outcome (ie, recidivism). Therefore, we retrieved 43 studies for full-text evaluation and examined their reference sections for potentially relevant studies. This strategy yielded an additional six studies. We conducted full-text screening on these 49 reports. Seven were not empirical studies about recidivism in MHCs. Three studies did not examine MHC. Seven studies did not measure recidivism. Six studies did not possess comparison groups and eleven studies were incomplete as they were missing crucial information to assess recidivism (ie, missing numbers on the number of people in either the treatment group or control group who had recidivated or not recidivated). The authors contacted authors of studies with missing data without success. Thus, the total number of studies for this meta-analysis was 15. These studies reported on 16 different MHC models (Rossman et al., 2012), reported on two MHC models.

Overall Mean Effects

A total of $k = 15$ studies were included in the analysis. The observed outcomes ranged from -1.4543 to 0.8673 , with the majority of estimates being negative (80%). The estimated average e based on the random-effects model was $\hat{\mu} = -0.5527$ (95% CI: -0.8749 to -0.2304 , $z = -3.3608$, $p = .0008$). This result indicates that the effect of mental health courts reduces recidivism. This was transformed to an odds ratio (OR = 0.5754; prediction interval = 0.1773 to 1.8676) indicating mental health courts resulted in a 42.46% decrease in recidivism. The prediction interval for the average odds ratio

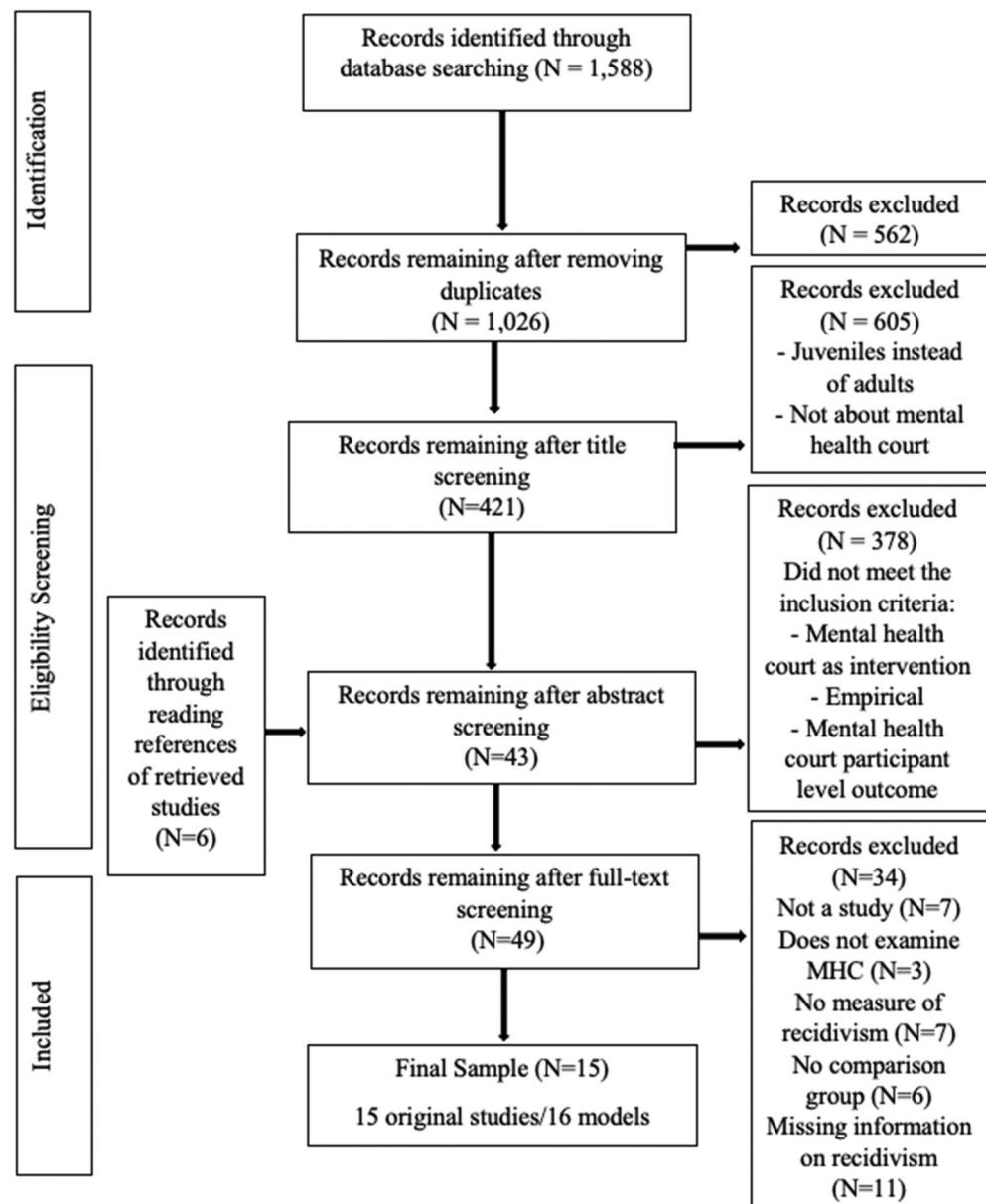


Figure 1. Flow chart of eligibility and study selection.

indicates studies showed as much as an 82.27% decrease in recidivism to an 86.76% increase in recidivism. A forest plot showing the observed outcomes and the estimate based on the random-effects model is shown in Figure 2.

According to the Q-test, the true effect on recidivism appeared to be heterogeneous ($Q(14) = 133.5626, p < .0001, \hat{\tau}^2 = 0.3338, I^2 = 88.1392\%$). A 95% prediction interval for the true effect on recidivism was given by -1.7300 to 0.6247 . Hence,

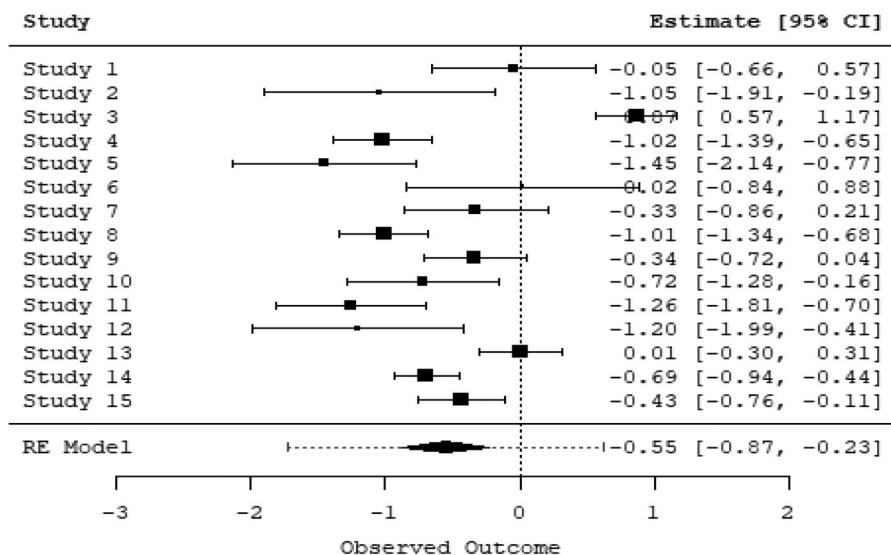


Figure 2. Forest plot showing the observed outcomes and the estimate of the random-effects model.

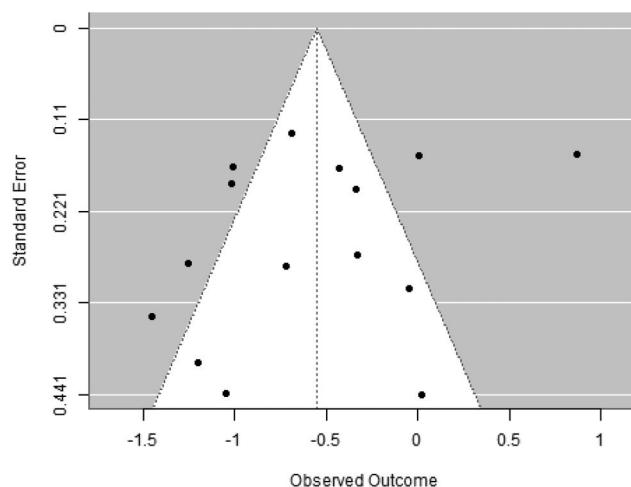


Figure 3. Funnel plot.

although the average effect on recidivism was estimated to be negative, in some studies, the true effect on recidivism may in fact be positive.

An examination of the studentized residuals revealed that one study (3) had a value larger than ± 2.9352 , and in these data and this model, we considered this to be a potential outlier. According to the Cook's distances, we believed this study (#3) could be overly influential.

Figure 3 showed the funnel plot for our study. Neither the rank correlation nor the regression test indicated any funnel plot asymmetry ($p = .9226$ and $p = .2335$, respectively).

Robustness of Findings to Methodological Weakness

Evaluations selected for this study were considered rigorous quasi-experiments because they used a subject-level key variable. Eight studies matched the comparison group with the treatment group on age, race/ethnicity, and sex/gender. One study only included gender and race but omitted age. Six studies matched using prior arrest/prior criminal history and/or current charge. Six studies included matching based on mental health diagnoses or symptom severity and two included drug use and/or substance use diagnoses.

While all studies used re-arrest as their recidivism outcome measure, some varied in that they also included violation resulting in incarceration and conviction as a measure of recidivism. We did not have enough studies to test this variation in measurement as a moderator. Additionally, studies varied in their follow-up length. [Table 1](#) shows that two studies used a follow-up time of 6 months. Seven studies (50% of our sample) used 12 months as their follow-up time. One study used a combination of re-arrest and violation resulting in incarceration, as their recidivism outcome measure with a 12-month follow-up time. One study used 24 months. And one study used 36 months.

Several differences on important key features were noticed. Twelve studies had a measure of co-occurring disorders that would help explain offenders "criminality and recidivism." One study alluded to it but did not directly mention co-occurring disorders (Han & Redlich, [2016](#)). Information about offense type was sparse across the studies. For three studies, the offense type could only be a misdemeanor (Aldigé Hiday et al., [2016](#); Christy et al., [2005](#); Hiday et al., [2013](#)) while Ferguson et al. ([2008](#)), Gallagher et al. ([2018](#)), and Moore and Hiday ([2006](#)) reported that the MHCs allowed misdemeanors and violent offenses, but the degree and circumstances of the violence would be the determining factor of exclusion. Kubiak et al. ([2015](#)) reported non-violent felonies as their offense type while Anestis and Carbonell ([2014](#)) explained that the determination is done on a case-by-case basis.

Studies also varied on the length of treatment provided in MHCs. While all the evaluations included in this study provide evidence of the effectiveness of MHCS in reducing recidivism post-graduation, 10 studies did not specify how long treatment was. For Aldigé Hiday et al. ([2016](#)), treatment ranged from 4 to 6 months. Hiday et al. ([2013](#)) reported treatment length between 4 and 6 months, but the length of treatment could be extended to 7 or 8 months "if participants are making progress." Moore and Hiday ([2006](#)) reported treatment length from 6 to 12 months with a minimum of 6 months of treatment. Rossman et al. ([2012](#)) reported treatment lengths between 6 and 24 months for the MHC in the Bronx and 12 to 24 months for the MHC in Brooklyn.

Additional Sensitivity Analyses

Publication bias is one potential threat to the validity of our conclusions. Even though the evaluations included in this review were found in published, peer-reviewed journals and in unpublished outlets (eg, unpublished dissertations and government reports), we conducted several tests to help assess the possibility and extent of publication bias in our database of studies. We report several tests as a triangulation

strategy in part because there are no very good tests of publication bias (see, for example, Vevea et al., 2019) and because the number of reports available to us (16) is on the low side of the minimum recommended for most publication bias assessments. The three publication tests are trim and fill (Duval & Tweedie, 2000), the rank test (Begg & Mazumdar, 1994), and the regression test (Egger et al., 1997).

The funnel plot from the trim and fill procedure suggested that there was one study “missing” to the right of the mean effect size (ie, in the direction in which we would expect publication bias to operate given that the mean effect size is negative; see Figure 3). The trim and fill procedure inputs these missing effect sizes and adjusts the meta-analytic effect size and statistical significance test to incorporate the missing study effect sizes. We elected to keep the study because even though the existence of some publication bias is possible, it is not severe enough to undermine our overall conclusions about the magnitude and statistical significance of the MHC effect on recidivism.

Discussion

The purpose of this article was to determine if MHCs resulted in a reduction in recidivism. To examine this issue, our search, originally, yielded 421 studies, but based on exclusion criteria the number of studies was reduced to 15 studies that contained the proper information for our analysis.

The main result of this study confirms that MHCs do result in a reduction in recidivism. MHCs constitute a 42% reduction in recidivism. This is consistent with previous meta-analyses (Cross, 2011; Fox et al., 2021; Lowder et al, 2018; Sarteschi et al., 2011) further suggesting the robust nature of the results in the present study. As pointed out in the front-end of this manuscript, while previous research suggests that there exists homogeneity among key program-level characteristics regardless of type of treatment court (eg, drug treatment courts or mental health courts), future research must concern itself with within-group variation (see Kaiser, 2020; Kaiser & Rhodes, 2019). While the authors initially sought to address the issue of heterogeneity within the studies included within this meta-analysis, it simply was not possible to do so. While the initial analyses included a moderator analysis to determine what impact heterogeneity had on certain outcomes, given the limited sample size, the power was much too low. Given the low power, no meaningful interpretation of those results was possible (briefly discussed below and suggested for future researchers to pay attention to once the body of literature examining MHCs grows). Additionally, and considering our findings, practitioners and policymakers alike should take care to pay attention and implement the successful MHC model’s connection with balanced justice and both its growing empirical and public support. Public and political support typically go hand-in-hand with criminal justice interventions. Therefore, by utilizing the public’s support for balanced justice while promoting the MHC model through its empirically tested effectiveness may prove beneficial in aiding with both their creation within new jurisdictions as well as the sustainment of already established MHCs throughout the country. This point agrees with previous research (see Kaiser & Rhodes, 2019), which suggests that policymakers, researchers, and legal practitioners should emphasize the quality and consistency of treatment services and options delivered to certain

types of treatment court participants. Given our justice system's struggle with the number of justice-involved individuals suffering with a SMI, and in conjunction with public support for the balanced justice model, the current study further enforces the need for MHCs and calls for policymakers to utilize these courts to alleviate the current overincarceration of individuals suffering from SMI.

While these results are important and advance MHC research, they must be consumed within the context of their limits. The first limitation is we made the decision to retain a study that may be an outlier. The outlier may be influencing the overall effect size and direction. Analyses, however, with and without the outlier were similar suggesting the outlier is not influencing the overall effect size and direction. The second limitation is the potential heterogeneity of the studies. This may be because some studies included refusers as the comparison group and some studies did not, which is an important distinction that future research should assess. The third limitation is the number of studies in our analysis. The number of studies in the analysis did not allow for a moderator type of analysis to determine the effect of studies containing refusers. In addition, the inability to perform a moderator type of analysis adds another limitation to our results. Our 42% reduction in recidivism may be time-dependent. We included studies with follow-up periods ranging from 6 months to 3 years. The studies we included with longer periods of recidivism may provide a greater opportunity for recidivism. The lack of uniformity in follow-up periods may influence the overall recidivism rate.² Future research should address the moderator issues by using a larger pool of studies with our inclusion and exclusion criteria to examine a moderator effect.

Conclusion

Over the past 30 years, the increasing number of different types of PSCs has led to an increased empirical examination of their effectiveness. While future meta-analyses with more studies not containing a potential outlier study and containing more heterogeneous studies and a product of different inclusion and exclusion criteria that examine a moderator effect are relevant, the results of the current study are substantive. In short, based on the inclusion and exclusion criteria of the present study, MHCs are effective. To clarify, MHCs produced more than a 40% reduction in recidivism. This result suggests the robust nature of MHCs and should become a potential judicial tool for working with individuals with mental illness and be endorsed both by their reductions in recidivism and alignment with the ideals of balanced justice.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

²We thank the anonymous reviewer who suggested the time variability issue in our results. In addition, we are appreciative of this reviewer's notion the outlier study may have a longer follow-up period influencing the recidivism rate. We did attempt to perform the moderator analysis, but we did not feel these results wouldn't be anything by tentative at best due to so few studies in our pool. They are available from the third author on request. In actuality, the outlier study has a follow-up period consistent with the majority of the other studies included in this study.

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