The Winnipeg Mental Health Court: Preliminary Findings on Program Implementation and Criminal Justice Outcomes

Joshua Watts and Michael Weinrath
University of Winnipeg

ABSTRACT

Mental health courts (MHC) are still relatively new in Canada and there is a dearth of research available regarding program structure and outcomes. This article presents preliminary evaluation findings on the operation of the new Winnipeg MHC program, launched in 2012. In addition to profiling the demographic, legal, and mental health backgrounds of program participants, we use a pretest- post-test design to compare rates of criminal justice involvement ($N = 35$). Participation in the MHC appeared to reduce justice system contact, supporting at least initial optimism about program efficacy. Greater inclusion of minorities was an area targeted for improvement. Study findings provide partial support for further development and implementation of mental health courts in Canada.

Key words: mental health court, problem-solving courts, days in custody.

RÉSUMÉ

Les tribunaux pour les personnes ayant des troubles mentaux sont assez récents au Canada, et peu de recherches ont été menées sur leur structure aussi bien que sur les résultats qu'ils permettent d'obtenir. Dans cet article, les auteurs présentent les résultats préliminaires de l'évaluation du fonctionnement du nouveau tribunal pour les personnes ayant des troubles mentaux créé en 2012 à Winnipeg. En plus de décrire les personnes qui y ont recours sur le plan démographique et juridique et en matière de santé mentale, les auteurs utilisent un modèle pré-test-post-test pour comparer les taux de recours de ces personnes au

Joshua Watts, Department of Criminal Justice, Justice Research Institute, University of Winnipeg, Winnipeg, Manitoba; Michael Weinrath, Justice Research Institute, Department of Criminal Justice, University of Winnipeg, Winnipeg, Manitoba.

An earlier version of this paper was presented at the 2015 annual meetings of the Western Society of Criminology in Phoenix, Arizona. Funding for this study was provided by Manitoba Justice and the Winnipeg Regional Health Authority. It was funded as an independent evaluation, i.e., the funders had input but no final say in study design, data collection, reported findings and their interpretation. They have no authority over publication of findings. This article represents the views of the authors and in no way is intended to reflect the position of Manitoba Justice or the Winnipeg Regional Health Authority.

Correspondence concerning this article should be addressed to Michael Weinrath, Justice Research Institute, University of Winnipeg, 515 Portage Avenue, Winnipeg, MB R3B 2E9. Email: m.weinrath@uwinnipeg.ca

doi:10.7870/cjcmh-2017-005
Published by Canadian Periodical for Community Studies Inc.

système de justice pénale (N=35). Les résultats montrent que les tribunaux pour les personnes ayant des troubles mentaux semblent réduire le recours au système judiciaire, ce qui, à tout le moins, confirmerait leur efficacité souhaitée. Une plus grande inclusion des minorités serait toutefois un point à améliorer. Ces résultats offrent des éléments intéressants pour la mise en place de futurs tribunaux pour les personnes ayant des troubles mentaux au Canada.

Mots clés : tribunal pour les personnes ayant des troubles mentaux, tribunaux ayant pour mission de résoudre des problèmes précis, nombre de jours de détention.

Rather than processing individuals dealing with mental health conditions through an often punitive justice system, mental health courts have been introduced in jurisdictions around the world to give an alternative to custody and provide necessary treatment regimes. Canada has added mental health courts in larger urban centres in the provinces of Quebec, Ontario, New Brunswick, Nova Scotia, Newfoundland, and in 2012, in Winnipeg, Manitoba. Despite some of the courts being around since the early 2000s, published research is limited (Slinger & Roesch, 2010), but some recent studies of note have been undertaken in the provinces of Quebec (MacDonald & Dumais, 2015), Ontario (Bain, 2013; Davis, Peterson-Badali, Weagant, & Skilling, 2015; Verhaaf & Scott, 2015), Saskatchewan (Barron, Moore, Luther, & Wormith, 2015), New Brunswick (Campbell, Canales, Wei, Moser, & Joshi, 2011; Campbell et al., 2015) and Nova Scotia (Ennis, McLeod, Watt, Campbell, & Adams-Quackenbush, 2016; Nova Scotia, 2014). This article aims to fill some of the gaps in knowledge about Canadian mental health courts by providing selected quantitative results from an implementation evaluation conducted in 2014.

LITERATURE REVIEW

Program Overview—Winnipeg Mental Health Court

The Winnipeg mental health court (MHC) was established in 2012 and operates as a post-plea, second generation court, meaning that offenders must voluntarily plead guilty to obtain services. Supervision of offenders is a collective effort by mental health and criminal justice system actors (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). Like other MHCs, potential candidates for the Winnipeg program can be referred from both defence counsel and crown, corrections staff and police, as well as healthcare facilities (Almquist & Dodd, 2009). The program excludes offenders facing sex offences, serious assaults, home invasions, gang membership, and criminal organization (gang or organized crime) offences; past charges of a similar nature may also restrict entry. Referrals must have a serious DSM-IV-TR Axis I condition such as schizophrenia. A committee of crown prosecutors vet the initial application and, if approved, it is referred to the FACT (Forensic Assertive Community Treatment) team to verify an Axis I diagnosis and assess risk.

The Winnipeg MHC team consists of a judge, crown, defence counsel, and members of the FACT team. The psychiatrist plays a lead role in helping to determine appropriate dosage, in consultation with the participant and other members of the FACT team. Incentives included praise from the judge, lowered reporting requirements, reduced curfew restrictions, and/or elimination of urinalysis tests. Some of the sanctions applied for misconduct were censure from the judge at a weekly hearing, an increase in court appearances,

community work service, or a more onerous curfew. Clients are expected to spend 18–24 months in the program, whereupon compliance leads to graduation.

The Winnipeg mental health court operates quite consistently with other Canadian MHCs, except that pre-plea arrangements are more common in other jurisdictions: guilty pleas are not required and charges are often withdrawn upon successful completion of the MHC regime (Ennis et al., 2016; Campbell et al., 2011; MacDonald, Bellot, Sylvestre, Dumais-Michard, & Pelletier, 2014).

Issues in the Mental Health Courts

The first mental health court was established in Broward County, Florida (Boothroyd, Pythress, McGaha, & Pertila, 2003). After assessment of mental health difficulties, MHCs provide outreach services, mobile crisis teams, home visit groups, and assertive community treatment (ACT) teams. Mental health courts have generally been found to at least moderately reduce recidivism and days in custody post-admission, two critical criminal justice outcomes. There is also evidence that MHCs can have a positive impact on clinical outcomes, such as treatment access, General Assessment of Functioning scores (GAF) and inpatient treatment days (Burns, Hiday, & Ray, 2013; Dirks-Linhorst & Linhorst 2012; Hiday, Ray, & Wales, 2014; Ray, 2014; Sarteschi, Vaughn, & Kim, 2011; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011).

The impact of mental health courts on reoffence, jail days, and graduation outcomes can be influenced by background demographic, legal, and risk characteristics (Burns et al., 2013; Reich, Picard-Fritsche, Cerniglia, & Hahn, 2013, Dirks-Linhorst & Linhorst, 2012). Not surprisingly then, appropriate referral of offenders to mental health courts and selection bias have been raised as concerns (Luskin & Ray, 2015). Some research suggests that offenders with mild symptoms and minor offences are being admitted to mental health courts, utilizing costly resources, inflating success rates, and doing little to reduce the use of custody. Gender and race are also problematic, with women over-represented and minorities under-represented in MHCs. While overall findings are equivocal, at least some research suggests that the following factors decrease the chances of a successful MHC referral: being male, an illicit drug user, having a charge for violence, more serious criminal history, and less serious mental health symptoms (Frailing, 2011; Luskin & Ray, 2015; Steadman, Redlich, Griffin, Petrila, & Monahan, 2005).

Canadian studies of mental health courts have reported favourable findings, however at least some have advanced significant criticisms. Qualitative studies conducted on the Montreal and Toronto courts are less sanguine about mental health court efficacy. MacDonald and Dumais (2015) argued that MHCs can work as exclusionary devices along juridical, therapeutic, and "individualization and governance" axes. Legal formalities and controlling perspectives from police, crown, and judiciary may override concerns for mental health, while emphases on structured treatment resulted in the marginalization or "othering" of MHC clients. Likewise, Bain's ethnographic study of the Toronto "102 court" MHC found an over-emphasis on medication and coercive methods by justice and health practitioners to achieve participant compliance. In contrast, interviews with clients in Saskatchewan and New Brunswick report generally favourable attitudes towards the mental health court and its court and treatment teams (Barron et al., 2015; Lane & Campbell, 2009).

METHODS

Research Questions

In this article we will address three research questions pertaining to an implementation evaluation of the Winnipeg mental health court gleaned from the literature. First, who are the clients who are referred to Winnipeg's program? What key demographic, health, and legal/risk data best describes participants? Do they match the likely target group, i.e., offenders with serious mental health conditions and criminal charges likely to result in custodial sanctions? Second, what are the preliminary outcomes for the Winnipeg program? Are there initial signs of positive criminal justice impacts on days in custody? To contextualize our findings, we discuss our descriptive results relative to other Canadian and select US programs. Third, we seek signs of the selection bias problem outlined in the literature, i.e., are there disproportionate race, gender, and lower risk referrals?

Data Sources

Official records in the criminal justice system were made available to us through Manitoba Justice's Computerized Offender Management System (COMS) and the Criminal Court Automated Information Network (CCAIN). Health system data were collected through the Winnipeg Regional Health Authority's (WRHA) paper health record files and the online WRHA Momenta database.

Measures

To assess the relative mental health of admissions we obtained WRHA agency data on DSM diagnoses, such as bipolar disorder, schizophrenia, and substance abuse and reported General Assessment of Functioning (GAF) scores (Aas, 2010.)

We used two instruments to assess risk of clients entering into the MHC program:

(a) The Manitoba Corrections three category offence severity scale, where "most serious" crime examples are murder, aggravated assault, robbery with violence, sexual assault; "medium" includes assault, break and enter, and "least serious" comprises crimes such as theft over and under $5,000, drug possession, driving impaired, breach of court order.

(b) The 8 item provincial institutional risk tool for remand and sentenced prisoners, the Institutional Security Assessment (ISA), which uses static items not amenable to change, such as current age, offence severity, past offences, institutional misconduct, jail release history, and sentence length. Scores are added to classify offenders as high, medium, and low security.

The ISA has been validated as a reliable predictor of institutional misconduct and recidivism (Weinrath & Coles, 2003). The Manitoba offence severity scale has not been validated and reflects the consensus of senior bureaucrats on assigned severity of crimes.

Referral times and formal admission was estimated through WRHA databases. Charges were gleaned from CCAIN and indicate police arrest for alleged crimes. Convictions from CCAIN indicated that a program

participant plead guilty, or was found guilty, of an offence. Days in custody were counted from COMS and reflected time imprisoned in a remand or sentenced Manitoba correctional facility as a result of charges or convictions.

Sampling and Ethics

The study sample included all 35 cases accepted to the Winnipeg MHC from its inception in 2012 to mid-2014. We obtained agreement from 26 of 35 clients to access mental health records data; they were initially contacted through mental health court staff and provided informed consent upon further review when we met with them. All instruments, consent forms, and procedures were first vetted by the University of Winnipeg Ethics Committee and the Winnipeg Regional Health Authority Research Committee.

Participant Demographics

The Winnipeg MHC participant demographics are displayed in Table 1. The program served many different age groups ($N = 35$), with a range of 19–63 years and an average of 39. The group was primarily male (74.0%), single (85.7%), White (Caucasian = 63.0%; Aboriginal = 29.0%) and more than two-thirds reported themselves as unemployed upon program entry.

Analytic Strategy

A profile of key health and justice system risk and health factors for program participants was generated by synthesizing information from the health and justice fields. An overview of admissions, discharges, and time in program provide a glimpse of the early operation of Winnipeg's MHC. To contextualize our findings, we later make comparisons to North American studies in Canada and the US. In a preliminary effort to evaluate program impact we generate comparative data (before/after) on client criminal justice outcomes for charges and days in custody. Our before period stretches to two years pre-program, and our post-admission period covers variable periods because clients had started the program at different times since MHCs began in 2012. We estimated a per month rate (e.g., months-before-program divided by charges, months-post-admission divided by charges) to fairly compare the two periods, and conducted paired *t* tests to assess reliability of the findings.

FINDINGS

Client Health Information

Analysis of the available Axis 1 diagnoses under the DSM-IV-TR revealed that nearly half of Winnipeg MHC participants (46.1%) were referred for schizophrenia, just under a quarter (23.1%) for depression, and the remaining 30.8% for bipolar disorder (Table 1). To their credit, available data confirmed the claim of Winnipeg MHC staff that they only take referrals with Axis I diagnoses.

Participants ($n = 23$) had GAF scores ranging from 25–70 with a mean of 49. The majority of MHC cases (35%) fell into the more serious range of 31–40, while the second most common interval was scores of 61–70 (26%), indicating mild symptoms. The dispersion of scores indicated an incredible diversity of

Table 1

Client health, program, and demographic information

Variable	N	%	Variable	N	%
DSM-IV-TR Axis I			Age		
Bi-Polar Disorder	8	30.8 %	Mean	38. 7	
Depression	6	23.1 %	Standard Deviation	12.3	
Schizophrenia	12	46.1 %	Range	19-63	
Total	26	100.0 %	19-30	10	28.6 %
GAF Scores			31-42	11	31.4%
Mean	49.0		43-54	12	34.3 %
Standard Deviation	13.22		55-66	2	5.7 %
Range	25-70		Total	35	100.0%
21-30	1	4.3 %	Gender		
31-40	8	34.8 %	Male	26	74.3 %
41-50	3	13.0 %	Female	9	25.7 %
51-60	5	21.7 %	Ethnicity		
61-70	6	26.1 %	Caucasian	22	62.9 %
Total	23	99.9 %*	First Nations	8	22.9 %
Missing	3		Metis	2	5.7 %
DSM – Substance Abuse			Black	3	8.6 %
Yes	14	58.3 %	Total	35	100.1%*
No	10	41.7 %			
Total	24	100.0 %	Employment Status		
Missing	2		Employed	6	17.1 %
			Student	2	5.7 %
			Retired/Disability	3	8.6 %
			Unemployed	24	68.6 %
			Total	35	100.0 %
			Marital Status		
			Single	30	85.7 %
			Married	1	2.9 %
			Common-Law	2	5.7 %
			Divorced	2	5.7%
			Total	35	100.0 %

*Values may not add up to 100% due to rounding.

client needs within the program, which presented a range of challenges to the court and FACT teams. Most notably, it was a delicate exercise to ensure that the number of services, treatment, and the relationship between staff and clients were perceived to be equitable and just by other clients. According to DSM-IV-TR criteria, 58.3% of Winnipeg MHC participants had co-occurring substance abuse problems, in addition to an Axis 1 diagnosis.

Justice Data and Risk Level

Over 80% of the Winnipeg MHC sample had a prior criminal history and 37% of these individuals had been convicted of a violent offence at some point (Table 2). Most offenders were referred for violent crimes—80% had committed a crime against the person. We scaled the most recent program referral crimes from low to high, using the severity scale administered by Manitoba Corrections. Approximately half of participants had committed medium severity offences, with 29% categorized as high severity (Table 2). This means that participant violence was often very serious (e.g., aggravated assault, robbery).

If they were in prison, one would hope MHC cases would be classified as *low risk* or as *minimum security* inmates, which indicates that such offenders are not a threat to the public if they escaped. The Institutional Security Assessment (ISA) is administered by Manitoba Corrections on all inmates admitted to provincial custody and is based mostly on past criminal activity and institutional history. Analysis of ISA data ($n = 35$) reveals that 94% of the MHC clientele would be rated as low risk within a correctional centre. While low risk in a prison setting, MHC cases likely would be higher risk in the community, particularly with respect to needs such as addictions or accommodation, which the ISA does not measure. Thus, as MHC clients are ranked low risk in a prison setting, they have good potential to be managed in the community (so long as their needs are addressed) without a risk to the public.

Client Program Information

On average, participants had spent 282 days in the program at the time we conducted our study. With a range of 59–569 days, there were significant differences in client time in the program. For example, just over a third of participants had been in the program for between 1 to 200 days, while only one-fifth of participants had been in the program for more than 400 days. While still early, the Winnipeg program boasted an impressive client retention rate of 89%; out of the 35 admissions only four had been unsuccessfully discharged from the program at the time of our research.

Participant Criminal Justice System Involvement Pre- and Post-Admission

For preliminary outcomes, during data collection we focused on charges, convictions, and days in custody two years prior to program admission and had planned to track participants for two years after the program (Table 2). Unfortunately, at the time of our study two years had not yet passed for clients' program involvement. To control for this, we pro-rated the time spent in the program. Two years prior to program admission the number of charges per client ranged from 0–30, and the average was 8 charges per year per client. There were large differences regarding the frequency of past criminal involvement. More than a third (37%) had 4 or fewer charges, while 29% had between 10–25 charges in the 2 years prior to program

Table 2

Client prior risk and pre-post program criminal involvement

Variable	N	%	Variable	N	%
Criminal History			Manitoba Offence Severity Scale		
Yes	30	85.7	Low	8	22.9
No	5	14.3	Medium	17	48.6
Total	35	100.0	High	10	28.6
			Total	35	100.1*
Offence Types					
Violent	28	80.0	Institutional Security Assessment Rank		
Property	3	8.6	Low	31	93.9
Administrative Offence	4	11.4	Medium	2	6.1
Total	35	100.0	Total	33	100.0
			Missing	2	
Record for Violence					
Yes	13	37.1			
No	22	62.9			
	35	100.0			
Charges 2 Years Pre			Total New Charges Post[1] (variable at risk periods)		
Mean	8.0	Per year	Mean	1.9	
Standard Deviation	7.2		Standard Deviation	6.1	
Range	0-30		Range	0-34	
0-4	13	37.1	0	26	74.3
5-9	12	34.3	1-2	3	8.8
10-14	5	14.3	3-4	2	5.7
15-19	1	2.9	5-6	1	2.9
20-25	4	11.4	7-34	3	8.8
Total	32	100.0	Total	35	100.5*
Convictions 2 Years Pre			Total New Convictions[2] (variable at risk periods)		
Mean	1.0		Mean	0.1	
Standard Deviation	2.0		Standard Deviation	0.5	
Range	0-8		Range	0-3	
			0	33	94.3 %
			1-3	2	5.7 %
			Total	35	100.0 %

Table 2, continued

Variable	N	%	Variable	N	%
Days Custody 2 Years Pre-Admission			New Days in Custody Post[3] (variable at risk periods)		
Mean	145.2		Mean	12.8	
Standard Deviation	120.7		Standard Deviation	31.2	
Range	0-386		Range	0-121	
			0	23	65.4 %
			1 -122	12	34.6%
			Total	35	100.0%

Note *Values may not add up to 100% due to rounding.
[1, 2, 3] The average post program time at risk time is 282 days, so is *not comparable* to the two years pre-program data, which runs for 730 days. Pro-rated comparable figures are provided for custody in Figure 1.

admission. As for convictions, the range of 0–8 convictions was much smaller than charges but still broad. On average, clients each had at least one conviction in the two years prior to program admission.

On average, clients from MHC spent 145.2 days in custody in the two years prior to admission, however there was a large amount of variation: incarceration ranged from 0–386 days (*SD* = 120.7). Prior days in custody is important to assess. According to Burns et al. (2013) the existence of a large number of prior days in custody is a significant factor in predicting the occurrence of recidivism. For example, they argue that those with more than 30 jail days prior to program admission have a 78% lower chance of graduation compared to admissions with 30 or fewer days in custody (Burns et al., 2013).

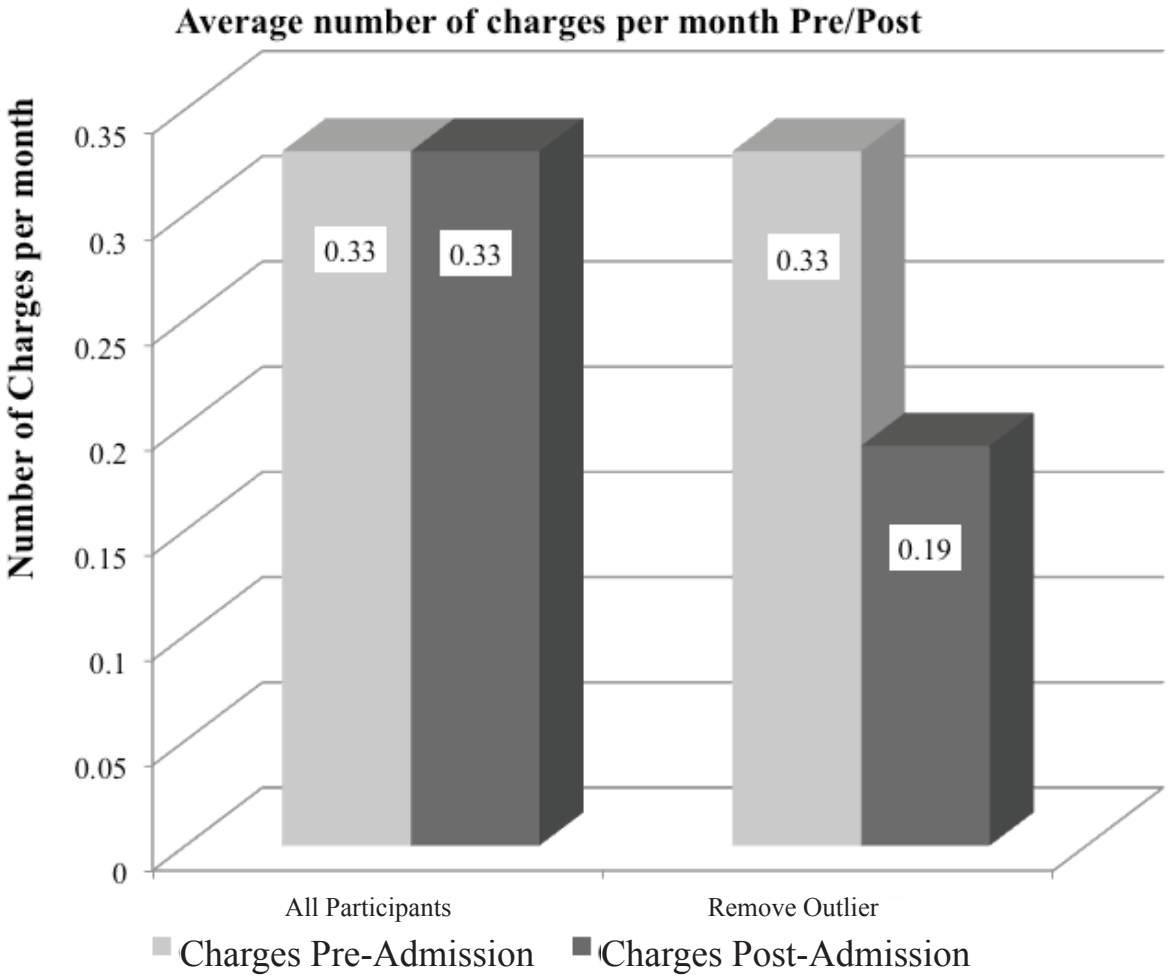
Subsequent to placement in the MHC, charges were few, as were post-admission program days in custody. However as participants only averaged 282 program days, they could not initially be compared to the 730 day (two year) pre-program period. We provide the following analysis for descriptive purposes. We found that a minority of participants (26%) had been charged (but not convicted) with a new crime while they were in the program (including administrative breaches). Of those criminally re-involved, charges varied from 1–34, with a mean of 1.9 charges and one participant having more than 11 charges. Most of the charges, however, were directly related to MHC program violations (bail conditions). Out of the nine individuals accruing charges after admission, six were charged with administrative offences alone. Of the three clients who had committed new predatory offences, two had property-related charges as well as administrative breaches (predatory includes offences with demonstrable harm such as violence, property or fraud charges, but would not include administrative breaches or drug charges). One individual was charged with a domestic violence assault. Only one participant had been convicted for an administrative offence (at discharge) which stemmed from non-compliance in the program. At the time that the study was completed no participants had been *convicted* of a predatory crime such as violence, theft, or drug trafficking, though some had charges pending.

We compared client charges per month two years prior with a pro-rated (per month) charge rate after program admission. The monthly rate of about 0.33 was almost identical between the pre-program and post-program admission periods, and of course was not statistically significant (Figure 1). But this comparison does not tell the whole story—many of the post-admission new charges were administrative breaches incurred by one individual, thus inflating the supposed reoffence rate. If we take out the outlier, the new monthly rate is only 0.19 per month, almost a 50% reduction. This difference is in the predicted direction, but due to variability (*SD* = .48) and the small sample size, it does not quite achieve statistical significance at the .05 level ($t = 1.47$, $p<.07$).

Given the youthfulness of the program, we calculated days in custody as a monthly rate in order to make more accurate pre- and post-admission comparisons. In other words, we divided the days in custody

Figure 1

Client prior risk and pre-post admission criminal involvement



post-admission by the number of months of exposure to the program. Results demonstrated a reduction of more than 50% from 6.4 days in custody per month prior to the program to 2.8 days per month post admission (Figure 2). Reductions in custody days were substantial and statistically significant ($t = 7.39$, ***p<.001).

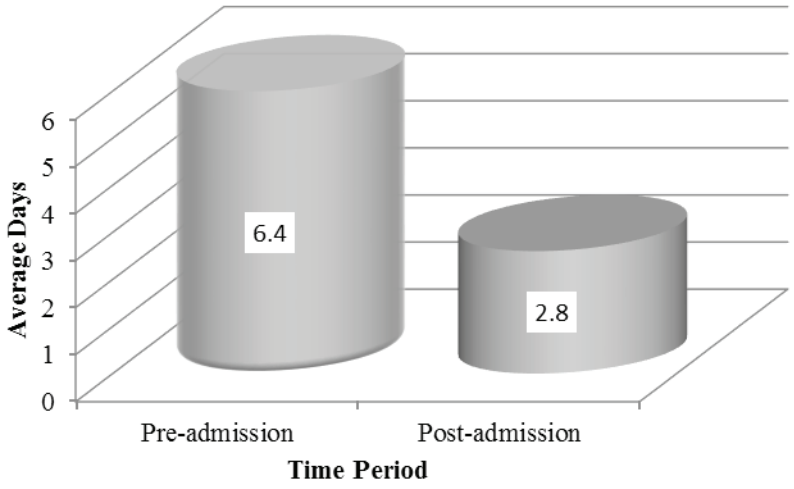
It is still too early to draw conclusions regarding overall efficacy of the program, but it appears as if, thus far, the Winnipeg MHC has several reasons to be optimistic.

DISCUSSION

Mental health courts have been operating in Canada for some time but have received resistance from some critics, who are concerned that custody of those with mental health conditions is not being reduced, and indeed resources are being directed away from the healthcare system and into the criminal justice system. This study provides at least partial support for the operation of mental health courts in Canada. While findings are preliminary in nature, Winnipeg's MHC appears to have admitted only individuals with serious mental health conditions and included a number involved in violent crimes, indicating that the probability of incarceration was likely being reduced for these individuals. The program retained a high proportion of clients, observed reductions in days in custody, and most participants saw reductions in charges. Despite these positives, there are areas for improvement (e.g., indigenous referrals). Our results illustrate some interesting differences and similarities between the Winnipeg study sample and other MHCs. To provide context for our results, we comment on these below.

Figure 2

Average Number of Days Spent in Custody per Month Pre- and Post-Admission



Note: t(34) = 7.39***p<.001

Source: Michael Weinrath; The Winnipeg Mental Health Court: Preliminary Findings on Program Implementation and Criminal Justice Outcomes.

Winnipeg's 89% retention rate may not be maintained, but the Canadian experience of some courts suggests a high completion rate is achievable. Nova Scotia researchers found that 86% of admissions finished (Nova Scotia, 2014), data from New Brunswick indicated that 90.3% of admits were retained (Campbell et al., 2011), while 85% of Durham, Ontario cases completed or partially finished and were referred on. US graduation rates are not as high; Ray, Hood and Canada (2015) estimated an average of 61% graduation from 10 studies reporting this outcome.

There were some local client differences in the Winnipeg study sample compared to other mental health courts. Winnipeg clients averaged 39 years of age, a bit on the high side for most mental health courts. New Brunswick admissions from 2000–2009 averaged 36 years (Campbell et al., 2015), Nova Scotia referrals' mean ages were 35 for men and 37 for women (Ennis et al., 2016), while in Durham, Ontario a sample of participants averaged 35 (Verhaaf & Scott, 2015). In the US, Sarteschi and her colleagues (2011), summarizing 11 studies where age was available, reported a range of 32.2–39.8, while more recent studies by Dirks-Linhorst and Linhorst (2012), Keator, Callahan, Steadman, and Vessilinov (2013) and Canada and Hiday (2014) also report ages within that interval.

Male (74%) was the predominant gender of the Winnipeg study sample, which is similar to the proportion found in Manitoba probation admissions (Perreault, 2009). Thus, Manitoba females did not appear to be over-represented in the Winnipeg MHC program; their numbers were consistent with probation proportions. Similarly, MacDonald et al. (2014) reported only 18% of referrals were females in Montreal, while higher proportions of females were observed elsewhere: 32% of court attendees over three months in Toronto (Bain, 2013), 40% in the Durham, Ontario study; 32.6% over five years in Nova Scotia (Ennis et al., 2016), and finally, 28% from 2000–2008 by Campbell and her colleagues in New Brunswick (2011). This trend is not replicated in the US, however. Sarteschi et al. (2011) found only 3 of 12 programs where females did not exceed 50% of the study group; similar findings were reported more recently by others (Canada & Hiday, 2014; Dirks-Linhorst & Linhorst, 2012; Keator, Callahan, Steadman, & Vessilinov, 2013). Females are clearly over-represented in US mental health courts.

In the Winnipeg MHC sample Caucasians represented almost two thirds (63%) of the study population and, somewhat surprisingly, indigenous cases (First Nations and Metis peoples) made up only 29%. A recent study using census and criminal justice data found that Aboriginal Canadians made up 12% of Manitoba's population, but were involved in the justice system at highly disproportionate rates: five times as high for provincial custody (66% remand, 69% sentenced) and four times as high (56%) for probation offender populations (Perreault, 2009). Thus, a rate of 29% appears to *under-represent* the indigenous offender group that should be placed in the MHC, meaning Caucasian Manitobans with mental health conditions are more likely to be diverted from custody than Aboriginal offenders. In Canada, high proportions of Caucasian admissions were reported in New Brunswick (97%) and Nova Scotia (84%), although to be fair, correctional populations there are mostly white. In Toronto and Montreal studies, Caucasian numbers were not as high but minority representation was disproportionate: Black men were referred at a higher than expected rate in Toronto (28%) while in Montreal immigrants (22%) appear over-represented (Bain, 2013; Campbell et al., 2015; Ennis et al., 2016; MacDonald et al., 2014). Regrettably, this discordant rate of referral has also been observed with minorities such as African-Americans who are incarcerated disproportionately but are not well-represented in most US mental health courts. In 12 of 19 studies reviewed by Sarteschi and her

colleagues, they found over 50% white representation, rather than more African Americans, and this trend has continued in recent MHC studies (Canada & Hiday, 2014; Dirks-Linhorst, & Linhorst, 2012; Keator et al., 2013). Racial bias remains a significant issue for mental health courts.

Comparison of other demographic characteristics with MHC programs was difficult because most Canadian and US studies focus on age, gender and race exclusively. The overwhelming majority of Winnipeg MHC participants were single (85.7%), higher than the 53% recorded in New Brunswick (Campbell et al., 2015) and generally higher than the three US studies we found that reported this characteristic: a range of 46.0% to 69.7% (Canada & Hiday, 2014; Keator et al., 2013; Sneed et al., 2006). More than two-thirds of individuals who entered the Winnipeg program were classified as unemployed with the possibility of working, meaning that they were not retired or on disability when entering the program. About 74% of Durham, Ontario cases were also unemployed on admission (Verhaaf & Scott, 2015). The large number of unemployed is similar to the range of 68.7% to 95% reported by four US programs (Burns et al., 2013; Canada & Hiday, 2014; Rossman et al., 2012; Sneed, Koch, Estes, & Quinn, 2006).

Mental health diagnoses are reported inconsistently in the literature or are organized into different categories. Also, we only had 26 of 35 clients reporting, making comparisons suspect. While not directly comparable, Nova Scotia reported fewer referrals for the big three Axis I. For example, they collapsed bipolar/mood and reported this at 38% males, 28% for females, while it was 53.9% for both genders in Winnipeg. The Winnipeg MHC recorded 46.1% of all referrals for schizophrenia, while in Nova Scotia, only 35% of men and 22% of women were referred for psychosis (mostly schizophrenia). Nova Scotia tended to include a number of less serious conditions such as developmental, medical, anxiety, and eating disorders. US data indicated considerable variability in mental health diagnosis. In their study of four mental health courts Steadman et al. (2011) reported an average of 40.3% for schizophrenia, 46.3% for depression, and 22.2% for bipolar disorder, while recently Canada and Gunn (2013) reported a much higher proportion of bipolar disorder (47%) referrals, but much lower rates for schizophrenia (23%) or depression (2%). Similar to the Winnipeg sample, Cosden, Ellens, Schnell, & Yaminia-Diouf (2005) found their study group averaged a GAF score of 50, while Broner, Lang, and Behler (2009) reported a comparable participant mean of 56.9. This is in the mid-range of what has been reported by MHC programs that take more serious offenders incurring felonies (like Winnipeg, see below).

There is considerable variation in allowable offence criteria amongst other MHCs in North America, but at 80%, the clientele at the Winnipeg MHC are unmistakably at the high end of crime severity for admissions. In Canada, the Montreal study reported a proportion of 43.4% violent referrals and Campbell and her colleagues (2015) observed 52% crimes against the person; unfortunately other Canadian studies did not identify a specific overall proportion, they just reported violent offence groupings. In the US Steadman et al. (2005) first reported a range of 0%–15.9% admission rates for crimes against the person (mean 7.3%) amongst seven mental health courts. Six years later, in another multi-site study, Steadman et al. (2011) identified four mental health courts that were more willing to take offenders with assaultive crimes, but they still reported a lower range of 17.7% to 53.7% (mean 31.1%). More recent studies by Burns and her colleagues (2013), Dirks-Linhorst and Linhorst (2012) and Canada and Hiday (2014) showed a roughly similar interval of 28% to 45.7% referrals for violence. No US jurisdiction had nearly as high a rate as 80% participants for crimes against the person. This partially reflects that Manitoba is the Canadian province with the highest rate

of violence (Boyce, Cotter, & Perreault, 2014), but also speaks to the willingness of the program to take on individuals charged with crimes against the person.

The Winnipeg MHC does manage a relatively high risk group, and their more open criteria likely increases the probability that they are providing a true alternative to custody, rather than simply giving additional services to low risk offenders. Their willingness to accept violent offenders outstrips the tolerance level of all Canadian and US mental health courts who reported on this statistic.

Canadian and US courts share many common features, but there are some differences that bear consideration. Canadian programs appear to be more willing to consider violent offences and report higher retention and completion rates. US mental health courts appear biased towards accepting a higher rate of female cases. Both still seem to struggle to proportionately represent disadvantaged minorities and immigrants. We appreciate that variation in eligibility criteria, program processes, and measurement make comparisons uncertain, but there are some clear consistencies and differences evident in the literature.

Our findings are promising and make a modest contribution to the still small literature on Canadian mental health courts. The use of multiple criminal justice system indicators like crime type and days in custody, a careful scrutiny of referral times, and use of DSM and GAF measures of mental health are strengths of this study. Limitations include the small sample size, relatively short follow-up periods and no random or matched comparison group. The true test of the program will come after a few years of operation, but it is still important to get data to policy makers to ensure proper program implementation and to address emergent issues.

CONCLUSION

With the expansion of mental health courts in Canada and around the world, information and research is starting to accumulate. We acknowledge that our results (while promising) are still preliminary and demand follow-up. Positive features thus far of the Winnipeg program include a focus on severe mental health conditions, a willingness to take clients charged with violent crimes, good initial retention rates and reductions observed in jail time for participants. Improvement is needed, however, to increase the referral rate for Aboriginal offenders with mental health conditions to avoid unnecessary incarceration.

REFERENCES

Aas, I. (2010). Global assessment of functioning (GAF): Properties and frontier of current knowledge. *Annals of General Psychiatry, 9*: 20–31. doi:10.1186/1744-859X-9-20

Almquist, L., & Dodd, E. (2009). *Mental health courts: A guide to research-informed policy and practice*. New York, NY: Council of State Governments Justice Center. Retrieved from https://www.bja.gov/Publications/CSG_MHC_Research.pdf

Bain, A. E. (2013). The impact of therapeutic jurisprudence: A critical study of Toronto's mental health court (Doctoral dissertation, University of Michigan).

Barron, K., Moore, C., Luther, G., & Wormith, J. S. (2015). *Process evaluation of the Saskatoon mental health strategy*. Centre for Forensic Behavioural Science and Justice Studies-University of Saskatchewan, Saskatoon, SK.

Boothroyd, R. A., Pythress, N. G., McGaha, A., & Pertila, J. (2003). The Broward mental health court: Process, outcomes and service utilization. *International Journal of Law and Psychiatry, 26*(1), 55–71. PII: S0160-2527(02)00 203-0

Boyce, J., Cotter, A., & Perreault, S. (2014). *Police reported crime statistics in Canada, 2013*. Canadian Centre for Justice Statistics, Ottawa, ON: *Juristat*, Statistics Canada.

Broner, N., Lang, M., & Behler, S. A. (2009). The effect of homelessness, housing type, functioning, and community reintegration supports on mental health court completion and recidivism. *Journal of Dual Diagnosis*, *5*(3–4), 323–356. doi:10.1080/15504260903358801

Burns, P., Hiday, V. A., & Ray, B. (2013). Effectiveness 2 years post-exit of a recently established mental health court. *American Behavioral Scientist, 57*(2)*,* 189–208. doi:10.1177/0002764212465416

Campbell, M. A., Canales, D. D., Wei, R., Moser, A., & Joshi, V. (2011). Multidimensional evaluation of the Saint John mental health court: A research summary. Saint John, NB: Centre for Criminal Justice Studies, University of New Brunswick..

Campbell, M. A., Canales, D. D., Wei, R., Totten, A. E., Macaulay, W. A. C., & Wershler, J. L. (2015). Multidimensional evaluation of a mental health court: Adherence to the risk-need-responsivity model. *Law and Human Behavior, 39*(5), 489–502. doi:10.1037/lhb0000135

Canada, K. E., & Gunn, A. J. (2013). What factors work in mental health court? A consumer perspective. *Journal of Offender Rehabilitation*, *52*(5), 311–337. doi:10.1080/10509674.2013.801387

Canada, K. E., & Hiday, V. A. (2014). Procedural justice in mental health court: An investigation of the relation of perception of procedural justice to non-adherence and termination. *The Journal of Forensic Psychiatry, 25*(3)*,* 321–340. doi:10.1080/14789949.2014.915338

Cosden, M., Ellens, J., Schnell, J. L., & Yaminia-Diouf, Y. (2005). Efficacy of a mental health treatment court with assertive community treatment. *Behavioral Sciences and the Law, 23*(2)*,* 199–214. doi:10.1002/bsl.638

Davis, K. M., Peterson-Badali, M., Weagant, B., & Skilling T. A. (2015). A process evaluation of Toronto's first youth mental health court. *Canadian Journal of Criminology and Criminal Justice*, *57*(2), 159–187. doi:10.3138/cjccj.2014.E10

Dirks-Linhorst, A. P., & Linhorst, D. M. (2012). Recidivism outcomes for suburban mental health court defendants. *American Journal of Criminal Justice, 37*(1)*,* 76–91. doi:10.1007/s12103-010-9092-0

Ennis, A. R., McLeod, P., Watt, M. C., Campbell, M. A., & Adams-Quackenbush, N. (2016). The role of gender in mental health court admission and completion. *Canadian Journal of Criminology and Criminal Justice*, *58*(1), 1–30. doi:10.3138/cjccj.2015.E08

Frailing, K. (2011). Referrals to the Washoe County mental health court. *International Journal of Forensic Mental Health, 10*(4), 314–325. doi:org/10.1080/14999013.2011.625592

Hiday, V. A., Ray, B., & Wales, H. W. (2014). Predictors of mental health court graduation. *Psychology, Public Policy, and Law, 20*(2), 191–199 doi:10.1037/law0000008

Keator, K. J., Callahan, L., Steadman, H. J., & Vesselinov, R., (2013). The impact of treatment on the public safety outcomes of mental health court participants. *American Behavioral Scientist*, *57*(2)*,* 231–243. doi:10.1177/0002764212465617

Lane, S., & Campbell, M. A., (2009). *Representing the client perspective of the Saint John mental health court.* St. John, NB: Centre for Criminal Justice Studies & Department of Psychology, University of New Brunswick.

Luskin, M. L., & Ray, B. (2015). Selection into mental health court: Distinguishing among eligible defendants. *Criminal Justice and Behavior*, *42*(11), 1145–1158. doi:10.1177/0093854815601158

MacDonald, S. A., Bellot, C., Sylvestre, M. E., Dumais-Michaud, A. A., & Pelletier, A. (2014). *Mental health courts: Processes, outcomes and impact on homelessness.* Montreal, QC.

Macdonald, S. A., & Dumais, A. A. (2015). Social exclusion in a mental health court? *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, *4*(2), 51–75. ISSN 1925-1270

Nova Scotia. (2014). *Nova Scotia mental health court report*. Government of Nova Scotia. Retrieved from http://courts.ns.ca/News_of_Courts/news_docs/NS_MHC_Report_2014.pdf

Perreault, S. (2009). The incarceration of Aboriginal people in adult correctional services. Ottawa, ON: *Juristat,* Statistics Canada..

Ray, B. (2014). Long-term recidivism of mental health court defendants. *International Journal of Law and Psychiatry, 37*(5)*,* 448–454. doi:10.1016/j.ijlp.2014.02.017

Ray, B., Hood, B., & Canada, K. H. (2015). What happens to mental health court noncompleters? *Behavioral Sciences and the Law, 33*(6)*,* 801–814. doi:.org/10.1002/bsl.2163

Redlich, A. D., Steadman, H. J., Monahan, J., Petrila, J., & Griffin, P. A. (2005). The second generation of mental health courts. *Psychology, Public Policy, and Law, 11*(4): 527–538. doi:10.1037/1076-8971.11.4.527

Reich, W. A., Picard-Fritsche, S., Cerniglia, L., & Hahn, J. W. (2013). *Predictors of program compliance and re-arrest in mental health courts*. New York, NY: Center for Court Innovation.

Rossman, S., Willison, J., Malik-Kane, K., Kideuk, K., Debrus-Sherrill, S., & Downy, P. (2012). *Criminal justice interventions for offenders with mental illness: Evaluation of mental health courts in Bronx and Brooklyn*. New York, NY: The Urban Institute.

Sarteschi, C. M., Vaughn, M. G., & Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative review. *Journal of Criminal Justice, 39*(1)*,* 12–20. doi:10.1016/j.jcrimjus.2010.11.003

Slinger, E., & Roesch, R. (2010). Problem-solving courts in Canada: A review and a call for empirically-based evaluation methods. *International Journal of Law and Psychiatry, 33*(4)*,* 258–264. doi:10.1016/j.ijlp.2010.06.008

Sneed, Z., Koch, D. S., Estes, H., & Quinn, J. (2006). Employment and psychosocial outcomes for offenders with mental illness. *International Journal of Psychosocial Rehabilitation, 10*(2)*,* 103–112. ISSN 1475-7192

Steadman, H. J., Redlich, A. D., Griffin, P., Petrila, J., & Monahan, J. (2005). From referral to disposition: Case processing in seven mental health courts. *Behavioral Sciences & the Law, 23*(2), 215–226. doi:10.1002/bsl.641

Steadman, H. J., Redlich, A. D., Callahan, L., Robbins, P. C., & Vesselinov, R. (2011). Effect of mental health courts on arrests and jail days: A multisite study. *Archives of General Psychiatry, 68*(2)*,* 167–172. doi:10.1001/archgenpsychiatry.2010.134

Verhaaff, A., & Scott, H. (2015). Individual factors predicting mental health court diversion outcome. *Research on Social Work Practice, 25*(2), 213–228. doi:10.1177/1049731514523507

Weinrath, M., & Coles, R. (2003). Third generation prison classification: The Manitoba case. *Criminal Justice Studies, 16*(4), 305–316. doi:10.1080/0888431032000183506