Evaluation of the Salt Lake County Mental Health Court

Final Report

June 2008

THE UNIVERSITY OF UTAH

Utah Criminal Justice Center

COLLEGE OF SOCIAL WORK
COLLEGE OF SOCIAL & BEHAVIORAL SCIENCES
UTAH COMMISSION ON CRIMINAL AND JUVENILE JUSTICE
S.J. QUINNEY COLLEGE OF LAW

Evaluation of the Salt Lake County Mental Health Court

Final Report

Russell K. Van Vleet, M.S.W.
Audrey O. Hickert, M.A.
Erin E. Becker, M.C.J.
Chelsea Kunz, M.S.W.

June 2008

Utah Criminal Justice Center, University of Utah

Table of Contents

Acknowledgments

We would like to thank Gary K. Dalton, Division Director of Salt Lake County Criminal Justice Services (CJS) for his ongoing support and for allowing us the opportunity to provide this evaluation. We would also like to thank the entire Mental Health Court team for their cooperation throughout the evaluation, and for the valuable insight they each provided during the key informant interviews. We acknowledge the following agencies and individuals for providing valuable data, without which this evaluation could not have been conducted: Criminal Justice Services, especially Jeannie Edens, Conrad Carter, and Jill Rose; Valley Mental Health, especially Catherine Carter, Dave Justice, and Justin Hyatt; Housing Authority of the County of Salt Lake, especially Floyd Hair and Lu Johnson; Salt Lake County Detention Center, especially Keith Thomas; Utah Bureau of Criminal Identification, especially Laurie Gustin; Utah Department of Corrections, especially Cliff Butter; Christine Mitchell at the Utah Commission on Criminal and Juvenile Justice; National Alliance of Mental Illness (NAMI), especially Kim Haws; and Robert Brereton at Fisher House. Lastly we would like to extend our appreciation to University of Utah graduate research assistant Cynthia Brownell for her contributions.

Executive Summary

The Salt Lake County Mental Health Court (SLCo MHC) began operations in 2001. Although originally accepting only misdemeanor level cases, in 2002 it expanded the acceptance criteria to include felony charges. This expansion occurred when the City Prosecutor was cross designated as a Deputy District Attorney, thereby granting him authority over both felony (State) and misdemeanor (City) cases. CJS requested that the Utah Criminal Justice Center (UCJC) provide a process and outcome evaluation of the MHC. Answers to the seven research questions are as follows:

Who does the program serve?

The MHC has served 263 participants who have a long history of mental health problems and criminal justice system involvement. DSM-IV diagnoses revealed an average of 8.3 years with Schizophrenia and/or Bipolar Disorder diagnoses prior to MHC. Similarly, participants had an average of 10 years from first VMH admission to MHC start. Most (92.7%) had at least one arrest (BCI) in the three years prior to MHC, while 91.3% had a booking in the Salt Lake County jail in the two years prior to MHC. The age of MHC participants at intake ranged from 18 to 64, with median age being 34.3 years old. Most were male (67.3%), White (86.0%), single (88.3%), and unemployed (90.1%). Nearly a quarter of all MHC participants (59, 22.4%) experienced homelessness at some point while in MHC.

What services are MHC participants utilizing during participation?

MHC participants are receiving regular supervision through court hearings, case management, and probation officer contacts; various forms of mental health (MH) treatment; and additional housing and support services. MHC clients appear before the judge every 9.9 days (Median (Md)), have appointments with their case manager at VMH every 4.6 days (Md), and meetings with their probation officer every 18.6 days (Md) over the course of MHC participation. Most (86.6%) had service records at VMH. Of those, approximately 90% had case and medication management and outpatient treatment, while just over half had residential treatment, and one in ten received inpatient treatment (psychiatric hospitalizations). Just over half (59.4%) had drug testing and nearly half (47.5%) received some form of housing assistance or residential treatment while in MHC. Nineteen (19) participants have been served by the JDOT team since its inception in August 2007 and many have participated in NAMI's Bridges program.

What is the structure of the MHC?

The structure of the MHC closely adheres to the Bureau of Justice Assistance's (BJA) 10 Essential Elements of MHCs. Although program elements and procedures are not consistently defined in program documents, the MHC team has a thorough and consistent knowledge of the operation of the program. Practices for referral, screening, assessment, participant progress, rewards, sanctions, and graduation/termination were similarly described by most MHC team members.

Is MHC succeeding?

On the whole, participants are compliant with MHC requirements, experiencing reductions in offending and increased treatment participation and frequency both during and post-MHC. Clients attend most of their scheduled status hearings (93.3%); however, many clients do have some form of noncompliance, such as a failure to appear at court (Md = 3.3% of hearings per client) or absconding from the program for short periods of time (41.7% had at least one bench warrant). Participants with a new charge booking in the jail dropped from 66.9% in the year prior to MHC to 19.8% during MHC and 18.2% in the year following MHC exit, while only ten individuals were sentenced to prison after starting MHC (7 at exit; 3 post-MHC exit). This suggests that the reduction seen in jail bookings for new charges is due to an actual decrease in criminal involvement, rather than an artifact of increased incarceration. Lastly, use of VMH services ranged from 46% to 61% in the three years pre-MHC, but remained somewhat higher in the three years following MHC exit (71% to 60%).

Who has the best outcomes in MHC?

MHC clients who were most likely to graduate were older at MHC start and had less extensive criminal histories (total arrests, jail bookings, and charge degree severity). Similarly, clients who were less likely to recidivate (48.6% did not recidivate) following MHC exit also had fewer arrests pre-MHC. Furthermore, they were less likely to have experienced homelessness during MHC and more likely to have graduated. In fact, graduation status was one of the strongest protective factors against recidivism and time to re-arrest (grad, Md = 435 days to first new charge jail booking post-MHC; terminated, 262 days).

What program components and services lead to the best outcomes?

The most consistent MHC program predictors of exit status were program compliance variables, with increased noncompliance, failures to appear, and bench warrants all being associated with negative termination from MHC. However, these factors did not significantly predict post-MHC recidivism. Predictors of post-MHC recidivism were any jail bookings during MHC (regardless of reason, such as for a sanction, new charge, etc.) and total days in jail, with more days in jail increasing odds of re-arrest post-MHC. Although the sample size was small, NAMI Bridges participation was associated with graduation and decreased likelihood of re-arrest.

How does the SLCo MHC compare to the mental health court model?

The MHC as observed by the research team and described in program documents and by MHC team members compares quite favorably to the BJA's 10 Essential Elements of MHCs. Nevertheless, some recommendations for improvements include creating a MHC participant handbook and putting individualized terms of participation in writing for each client at intake. It is also suggested that the MHC continue to address the need for aftercare planning.

Introduction and Background

Mental Health Courts (MHC) have been proliferating across the United States since their establishment in 1997 (Steadman, Redlich, Griffin, Pertila, & Monahan, 2005). This movement was in response to inequities in the experiences of mentally ill offenders. The development of therapeutic jurisprudence and the drug court movement also influenced the formation of MHCs. A recent Bureau of Justice Statistics (BJS) survey found that 16% of state prison inmates, 7% of federal inmates, 16% of jail inmates, and 16% of probationers reported having a serious mental illness or a mental hospital stay at some time in their lives (Steadman et al., 2005). Jails have become hospitals of sorts and the need to develop an alternative to treating mentally ill offenders has clearly been supported in the literature. Despite this, little outcome research on the effectiveness of MHCs has been conducted.

The Salt Lake County MHC (SLCo MHC) began operations in 2001. Although originally accepting only misdemeanor level cases, in 2002 it expanded the acceptance criteria to include felony charges. This expansion occurred when the City Prosecutor was cross designated as a Deputy District Attorney, thereby granting him authority over both felony (State) and misdemeanor (City) cases. The MHC operates out of Salt Lake County Criminal Justice Services (CJS) in conjunction with Utah Third District Court and Valley Mental Health (VMH). SLCo MHC states several goals and objectives in their program documents. After a thorough review of these documents, it was determined that the court's goals are essentially the following:

Salt Lake County Mental Health Court Goals

Protect public safety by reducing criminal recidivism of offenders with an identified mental illness

This goal has been the primary goal of all MHCs under review, for example, Fort Lauderdale, FL; Seattle, WA; San Bernardino, CA; and Anchorage, AK. MHCs all give a high priority to concerns of public safety, in arranging for the care of mentally ill offenders in the community (Goldkamp & Irons-Guynn, 2000). This concern for public safety explains the predominant focus on misdemeanant and other low-level offenders and the careful screening or complete exclusion of offenders with histories of violence. King County MHC is open to defendants with a history of violent offenses which have been triggered by mental illness. However, it is believed that these defendants are provided with a level of supervision that is sufficient to protect the public.

In reviewing the available research on MHCs, it is apparent that MHCs are achieving public safety by reducing recidivism. Many courts have demonstrated no more risk of re-offending when compared to traditional courts. For specific courts see the following: Christy et al., 2005; Teller, 2004; O'Keefe, 2006; and Cosden et al., 2005. Other courts have gone farther and shown that MHC contributes to less risk of reoffending when compared to traditional court participation (see Trupin & Richards, 2003; Herinckx et al., 2005; McNiel & Binder, 2007; Morin, 2004).

Reduce jail use both during and after MHC participation by reducing criminal recidivism

Several MHCs in the literature have reported reductions in jail use and recidivism; at least while participants are actively participating in the MHC program. These include the following courts: Christy et al., 2005; Teller, 2004; O'Keefe, 2006; and Cosden et al., 2005. Although they have seen a reduction in offending, some courts note that these reductions are not significantly different than results obtained in traditional case processing (Trupin & Richards, 2003; Herinckx et al., 2005; McNiel & Binder, 2007; Morin, 2004). See the following "*The Effectiveness of Mental Health Courts"* section of this report for details on type and size of reductions in jail use and recidivism.

Increase mental health treatment compliance of MHC participants by connecting and re-connecting mentally ill persons with needed mental health services

MHC participation has been shown to increase defendant's access and utilization of mental health services. Two separate reviews of the Broward County MHC demonstrated that the use of behavioral health services by misdemeanants increased significantly when participating in MHC, whereas the likelihood of using services among similar defendants in a traditional criminal court was virtually unchanged. Additionally, MHC participants were not only seeking treatment more often than traditional court defendants, but were also receiving a greater volume of services. For specific study information see the following: Boothroyd, Calkins-Mercado, Poythress, Christy, and Pertrila, 2005; Boothroyd, Poythress, McGah, and Petrila, 2003.

While these results are encouraging, some concern has been raised that increased treatment access seen in MHC participation is short-lived (Boothroyd, Poythress, McGah, & Petrila, 2003). An additional concern is that while MHC participants may be getting more mental health services, they are not always showing psychiatric improvements (Boothroyd et al., 2005). However, this may not always be the case as participants in Brooklyn showed significant improvements in various psychosocial areas (O'Keefe, 2006).

Improve the likelihood of treatment success by addressing access to housing and linkages with other critical supports

Little research has been conducted regarding housing services and related outcomes. However, it has been demonstrated that MHCs can lead to decreased homelessness (O'Keefe, 2006). While no research specific to MHCs regarding the relationship between treatment success and stable housing has been conducted, extensive research exists demonstrating how the provision of secure housing contributes to treatment retention and improved mental health (Wasylenki, Goering, Lemire, Lindsey, and Lancee, 1993; Tsemberis, Gulcur, & Nakae, 2004; Morse, Calsyn, Klinkenberg, Trusty, Gerber, & Smith, 1997).

Continue a forum of providers, prosecutors, defenders, judges, and State Corrections officials to discuss mental health court issues

There is little description of these processes in the MHC literature on existing programs. However, the ten essential elements document from BJA does advocate for these forms of continued networking, cross-training, and sustainability efforts (Thompson, Osher, & Tomasini-Joshi, 2007). For more information, see the "*Essential Elements of Mental Health Courts"* section of this report, specifically elements #8, Court Team, and #10, Sustainability.

The Effectiveness of Mental Health Courts

Because of their relatively recent development, little data exists on the effectiveness of mental health courts. What we do know comes mainly from descriptive articles that rarely focus on MHC-related outcomes. The research that exists on MHCs will be presented and contrasted with the SLCo MHC in this section of the report.

Recidivism

Trupin and Richards (2003) compared mentally ill defendants who opted in or opted out of the two MHCs in Seattle. Those who participated in the MHC had significantly fewer bookings after nine months of participation, compared to those who chose not to participate.

A study of Broward County MHC found that the average number of arrests participants accrued after one year of participation was significantly less than during the year prior to MHC participation. However, when these participants were compared to similar defendants in a traditional court, MHC participants were not more improved on measures of re-arrest, felony arrest, and time to re-arrest. It should be noted, however, that MHC defendants spent significantly less time in jail for index offenses. Meaning, one way to account for the similar rates of re-arrests seen in both types of participants is that MHC participants had a greater risk for re-offending because they spent more time out of jail (Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005).

A review of the Clark County MHC found more improved outcomes among a sample of MHC participants. Measuring criminal activity prior to and one year after MHC participation, they found that the average number of arrests was significantly less post enrollment. They also found that those classified as "frequent offenders" due to an excessive amount of arrests, had significantly less arrests post enrollment. Probation violations were also significantly decreased post enrollment. Participants who graduated the program or were still enrolled after 12 months of participation were also significantly less likely to be arrested post enrollment (Herinckx, Swart, Ama, Dolezal, & King, 2005).

Arrest rates in the Akron Municipal MHC were similar to the above study. Tracking jail and state prison arrest rates prior to and after MHC participation found that after one year of MHC participation, county jail arrest rates decreased steadily. However, the incidents

leading to state prison, while rare, stayed virtually the same with or without MHC participation (Teller, Ritter, Salupo-Rodriguez, Munetz, & Gil, 2004). Results in Brooklyn were similar to that of Clark County and Akron Municipal MHC. Here, it was found that arrest rates decreased after 12 months of MHC participation by 11%. While suggestive, these results were not statistically significant (O'Keefe, 2006).

The most recent evaluation of an MHC was conducted by McNiel and Binder (2007). A retrospective observational design was used to compare the incidents of new criminal charges for participants who entered the San Francisco Mental Health Court to other defendants with mental disorders who were booked into an urban county jail during the same time period. In comparing all individuals who enrolled in the program (regardless of completion), it was found that mental health court participants showed a longer time without any new charges or new charges for violent crimes compared with similar individuals who did not participate in the program. Interestingly, it was also found that reductions in the likelihood of new charges were more substantial with follow-up of more than one year after enrollment in MHC. For example, after 18 months, the likelihood of MHC participants being charged with any new crimes was about 26% lower than those participating in regular jail treatment, and the likelihood of mental health court participants being charged with new violent crimes was 55% lower. Additionally, analyses showed that persons who graduated from the mental health court program maintained decreased recidivism after supervision by the court had ceased. This was not the case for similar participants in jail. After 18 months of treatment, the risk of MHC graduates being charged with a new offense was about 34 out of 100, compared with about 56 out of 100 for regular jail participants. Furthermore, the risk of mental health court graduates being charged with a new violent crime (6 out of 100) was about half that of jail participants (13 out of 100).

Cosden and colleagues (2005) went further than the previously mentioned studies by conducting an experimental design in Santa Barbara where subjects were randomly assigned to either MHC with assertive community treatment (MHTC) or to traditional court with less intensive case management (treatment as usual, or TAU). After one year, MHTC participants had fewer convictions for new crimes than TAU participants (charges for MHTC participants were usually related to probation violations while TAU participant's charges were usually new offenses). However, after two years, the proportion of participants sent to jail (while small) was about the same for both groups. Additionally, after two years, it was found that both MHTC and TAU participants had increased jail bookings. After two years, Cosden encountered a problem that most evaluative studies encounter; there was a small group of offenders that disproportionately accounted for the majority of bookings, convictions, and jail days (often known as "frequent flyers"). The problem with including this "frequent flyers" group in the participant pool is that it makes it more difficult for researchers to isolate the *actual* improvements seen in one court versus another for the majority of participants; recidivism rates are essentially weighed down by a few participants. By conducting a separate analysis excluding this type of chronic offender, it was found that both MHTC and TAU participants showed a significant decline in jail days from the two years prior to participation to the two years after study entry. However, the number of bookings did not

significantly decrease for either court. Additionally MHTC and TAU participants did not differ significantly on any of the aforementioned measures after two years (Cosden, Ellens, Schnell, & Yamini-Diouf, 2005).

Morin's (2004) dissertation evaluating the Hennepin County MHC dealt with issues similar to Cosden and colleagues (2005). After controlling for the few individuals who had a large number of arrests, results showed a correlation between court-ordered mental health treatment and a reduction in overall offenses. Such findings, however, were not statistically significant (Morin, 2004).

These studies are important in demonstrating that mentally ill offenders are at no more increased risk of re-offending when diverted from jail to a MHC compared to similar offenders seen in traditional court. Additionally, some studies show decreased arrest rates with the onset of MHC participation when samples are compared with similar defendants in traditional court settings. One study went so far as to demonstrate that graduating from a MHC put individuals at a substantially lower risk of re-offending. Thus, the studies show that MHCs are meeting their obligation of protecting public safety. However, when collectively analyzed, these studies do not clearly demonstrate the influence of MHCs on recidivism above that of traditional criminal courts.

Treatment and Related Outcomes

A review of the Broward County MHC found that that use of behavioral health services by misdemeanants increased significantly when participating in MHC, whereas the likelihood of using services among similar defendants in a traditional criminal court was virtually unchanged. The overall findings were that MHC enhances treatment access and involvement for its clients (Boothroyd, Calkins-Mercado, Poythress, Christy, & Pertrila, 2005).

An additional review of the Broward County MHC found that MHC participants (as compared to traditional court participants) had significantly more treatment utilization. However, this increase in services declined over eight months. While MHC participants still sought treatment more frequently than traditional court participants, the increase was no longer significant after 8 months. Nonetheless, the volume of service utilization (of those who got treatment, how much treatment they actually got) increased significantly when compared to traditional court participation. Another noteworthy result indicated that MHC clients' subsequent use of mental health services is independent of the court's expressed expectations about treatment. Meaning the type of services participants chose to seek out was typically different than the type of services the judge (and other MHC professionals) suggested. This finding reveals the possibility that the judge and other MHC professionals may not be as influential as expected (Boothroyd, Poythress, McGah, & Petrila, 2003).

Similar support for the finding that MHC leads to increased treatment was seen in a review of Clark County MHC. Tracking treatment participation prior to and one year following MHC participation, it was found that linkages to services were improved for

case management, medication management, group therapy, intake evaluation, and days of outpatient services. However, MHC clients had fewer days of crisis services, inpatient treatment, and individual therapy. These results generally indicate that MHC participation contributes to increased usage of most types of mental health services, except individual therapy. The lack of usage of crisis treatment and inpatient services could be interpreted as a positive finding as usage of these types of services is usually indicative of a highly distressed clientele (Herinckx et al., 2005).

All in all, these results are encouraging. They suggest that MHC participation can lead more people to seek out treatment and use it frequently. However, measures should be taken to retain such participants as results indicate that treatment gains may not be long lasting. An additional caution suggested through this research is that courts not rely too heavily on the persuasion of the judge, as their influence may not be as influential as initially thought.

Although MHCs have been found to increase defendants' access to mental health services, they have little control over the type and quality of services that defendants receive. This was clearly evident in the Broward County MHC. Symptoms of mental illness as indicated by the BPRS and administrative self report were measured in MHC participants and traditional court participants before and up to eight months after enrollment. It was found not only that MHC defendants did not show more improvements in symptom reduction than traditional court defendants, but that both types of defendants showed *increased* symptoms after eight months of court participation (Boothroyd et al., 2005). These results illuminate the concern that linkage to treatment does not necessarily equate to mental heath improvements. These findings support the suggestion made by the BJS that MHCs actively work to develop and improve the mental health services in a given area.

The lack of improvements seen in Broward may not be the case in all MHCs. In a program evaluation of the Brooklyn Mental Health Court, clinical staff completed the Health of the Nation Outcome Scale (HoNOS) at intake and after one year. The HoNOS is comprised of 12 scales that measure various health and social domains (psychiatric symptoms, physical health, functioning, relationships, and housing). After one year of participation, it was found that participants improved their functioning on nearly every scale. Specifically, participants showed statistically significant improvement on the scales measuring problems with cognition, depressed moods, living conditions, occupations, and activities (O'Keefe, 2006).

Cost Effectiveness

Cost effectiveness data for MHCs are sparse. The Rand Corporation, a non-profit research organization, attempted to evaluate cost data on the Allegheny MHC by comparing the cost of an arrest for MHC participants prior to their MHC participation to the cost of their current arrest which led to MHC treatment. They also made some hypothetical data comparisons by evaluating the expected cost for these participants had they not enrolled in a MHC. In all types of comparisons, it was found that the MHC program did not lead to overall cost savings. However, this finding should be interpreted

carefully. The finding was that MHC led to an increase in the use of mental health treatment services but a decrease in jail time for participants during the first year after entry. In comparing the costs, the decrease in jail expenditures almost offsets the increase in the outlays for treatment services. One way to interpret this is that because mental health treatment is primarily funded by Medicaid, when commonwealth costs are considered, the extra estimated cost of the MHC program for the commonwealth is eliminated. Additionally, using hypothetical sentences and cost data provided by the court system, it was estimated that, if there were no MHC program, the jail costs for these participants would have been almost double (Ridgely, Engberg, Greenberg, Turner, DeMartini, & Dembosky, 2007).

When looking at overall dollars spent, these findings indicate that in terms of all costs, MHC is not more cost effective than traditional courts. However, when looking at the specific areas by which costs were accrued, it is clear that MHCs' cost were similar to traditional court because more money was being spent on treatment as opposed to confinement. If MHC had not led to more treatment, it would be most cost effective. However, it is the general opinion of most professionals that the increased money spent for treatment is well spent and in keeping with the basic goals of most MHCs. Furthermore, when considering the cost to the general public, MHC costs were significantly less than traditional courts.

Hospitalizations

Few MHCs track the extent to which their participants are hospitalized. Attention to this outcome however has gained increased attention as it provides crucial insight into the relative function of clients within MHC treatment. There are many possible reasons for psychiatric hospitalizations, not all of them with negative connotations. However, a decrease in the percentage of participants hospitalized can be viewed positively as an indicator that participants were actively engaged in treatment

A review of Akron MHC found interesting distinctions between the hospitalizations of their clients in general hospitals versus psychiatric hospitals. By tracking hospitalizations before and after MHC treatment, they found that hospitalizations in general hospitals (typically through Emergency Services) *increased* in the first two years of MHC participation. However, the number of general hospitalizations decreased in the final year of MHC treatment. This result suggests that it may take several years to improve the overall functioning of clients. This finding is contrasted by the number of psychiatric hospitalizations seen over the three years in MHC. Interestingly, psychiatric hospitalizations stayed the same in the first year and decreased significantly in the second and third year (Teller et al., 2004). These results combined could suggest that while it may take up to three years to see improvements in functionality, necessitating visits to the emergency room, MHC participation after only one year improves functionality to the point that a longer and more restrictive stay in a psychiatric hospital may no longer be needed.

A different suggestion was found in the data presented from a review of the Brooklyn MHC. By tracking clients one year prior to and after MHC enrollment, a significant decrease in psychiatric hospitalizations (50% to 19 %) was seen after only one year. Additionally, the incidents of emergency room visits decreased from 44% to 25% after one year of MHC participation. This finding suggests something somewhat different from the above study; that decreases in hospitalization can be seen as early as one year after MHC enrollment and that psychosocial functioning can be improved to the point that even emergency room visits are no longer necessary. Both Akron and Brooklyn programs use Axis I diagnoses in their eligibility criteria. The Brooklyn MHC, in contrast to the Akron program, accepts felons. Discrepancies in hospital use changes across these studies suggest that additional research is required to better understand the impact of MHCs on hospitalizations (O'Keefe, 2006).

Substance Abuse

Brooklyn MHC participants also showed dramatic decreases in drug and alcohol use (per self report) after one year of participating in MHC. Additionally, a significantly higher percentage of participants were reportedly abstinent at follow-up than at MHC intake (O'Keefe, 2006).

Other research on clients with a dual diagnosis of mental illness and substance abuse has yet to be conducted. However, various MHCs endorse substance abuse disorders in their eligibility criteria including, Santa Barbara, California; Santa Clara, California; Allegheny County, Pennsylvania; and Orange County, California.

Homelessness

While it is presumed that many MHCs have services designated for assisting clients in obtaining housing, little has been written about such policies. The Brooklyn MHC, however, is known for their services geared towards securing housing. In Brooklyn, a primary emphasis of the clinical team is to work with treatment providers and family members to return detained participants to pre-arrest housing (either with a community-based provider or family members) if clinically appropriate and agreeable to the court. Clinical team members also find housing in residential substance abuse therapeutic communities and supported housing. In Brooklyn, supported housing is accessed through a New York State Office of Mental Health pilot program, Single Point of Entry (SPOE). The MHC has worked closely with the program to reserve a few beds specifically for MHC participants (O'Keefe, 2006).

Despite the provision of such services, the reviewers note that, for the Brooklyn MHC, obtaining housing for MHC participants is a continual struggle. In fact, the reviewers found that despite contracts made with various treatment facilities to reserve beds for MHC participants, MHC participants are continually denied housing and given the lowest priority when beds are available. Additionally, it was noted that through the SPOE program, very few beds are made available for defendants in need of supportive housing.

It is believed that this barrier largely exists because treatment facilities do not want individuals with a criminal history in their facilities.

While it is clear that securing housing is not an easy task, it has been determined in Brooklyn that housing services provided by the MHC contribute to decreased homelessness. Specifically, outcome data showed that homelessness rates improved with the onset of MHC treatment. A total of 16% of participants were homeless in the year preceding enrollment compared to 11% during their first year of enrollment. Additionally, the average number of days homeless declined from 60 to 35 days. However, none of these differences were significant statistically.

Evaluation Overview

The Salt Lake County Division of Criminal Justice Services (CJS) has requested that the Utah Criminal Justice Center (UCJC) provide a process and outcome evaluation of the Salt Lake County Mental Health Court (hereafter referred to as MHC). The objectives of the MHC evaluation are to answer the following research questions:

1. Who does the program serve?
2. What services are MHC participants utilizing during participation?
3. What is the structure of the MHC?
4. Is MHC succeeding?
5. Who has the best outcomes in MHC?
6. What program components and services lead to the best outcomes?
7. How does the SLCo MHC compare to the mental health court model?

Methods

Data Sources

Data for this study were collected from a variety of sources. Because of the collaborative nature of mental health courts, it was important to collect information from as many sources as possible. This section outlines the data that was received from each agency. Table 1 provides a brief snapshot of the MHC participant sample size that was obtained from agencies; some data on screened only participants were also requested and received. The following paragraphs further explain the data requested from each agency and the resulting data matches and samples obtained.

Table 1 Data Sources and Sample Sizes

	Sample Size Obtained	
	N	% of Total
Criminal Justice Services	263	100.0
Valley Mental Health	220	83.7
Salt Lake County Adult Detention Center	256	97.3

	N	% of Total
Utah Department of Corrections	200	76.0
Bureau of Criminal Identification	245	93.2
National Alliance on Mental Illness	110	41.8

Criminal Justice Services. Criminal Justice Services (CJS) periodically provided researchers with a regularly updated Excel spreadsheet containing program participation lists for MHC. Variables included current and former participant names, Sheriff's Office number (SO), date of birth, gender, status (e.g., active, graduated, terminated), treatment/residence location, intake date, plea date, probation expiration date, and exit date. CJS staff also took notes in a Word document at each MHC hearing (hereafter referred to as Court Notes). Court Notes described any actions taken by the court (e.g., booked in jail, released from jail, bench warrant issued, graduated), whether or not the participant was on the Rocket Docket, and notes about the participants' progress, as described by the participant and/or team members in court. Researchers obtained weekly Court Notes for all MHC hearings between June 2004 and April 2008 (145 participants). Court Notes were transferred into an Excel spreadsheet and recoded in an attempt to gain a better understanding of program components, such as the use of sanctions, bench warrants, and the Rocket Docket.

Valley Mental Health. Identifying information for 259 Mental Health Court individuals (244 participants, 15 screened only) was sent to Valley Mental Health (VMH) in early 2008 to locate in their database. The following selection criteria were employed by VMH research staff: Using the Excel file provided with a list of MHC participants, VMH used name and birth date of those participants to look them up in VMH files to see if they had a Valley ID number. Those MHC participants that did have a Valley ID were then entered into data runs which would pull the requested information, if available, for those participants. Some ID numbers, such as screening numbers, may not pull any requested data; however, those cases were rare. For example, for service data runs, the MHC participants with Valley IDs were entered into a data run that would pull services for all those participants whose ID number matched services associated with that particular ID. Some participants with a Valley ID may not have matched back to any services for a particular year. Services were sorted by service date and the number of service in order to pull all unique services for that client. This method was similar for matching back to the admissions, diagnoses, and client characteristics files. Of those searched in VMH records, a Valley ID was located for 233 individuals (220 participants), or 90.3% of those requested. VMH data presented in the Results section of this report are out of those 220 participants that were identified and queried from their datasets.

Salt Lake County Adult Detention Center. A query of the Salt Lake County Adult Detention Center (ADC, jail) JEMS database for all bookings between July 1, 2000 and May 22, 2008 was received in May 2008. MHC participants were identified in ADC bookings by several combinations of name, date of birth, and Sheriff's Office number (SO, the identifier used by ADC). Some SOs for MHC participants were also located in participant files for the various CJS programs. These data were used to examine pre- and

post-MHC bookings by charge types and booking types (e.g., warrant, new charge, commitment), as well as days in jail while participating in MHC. SOs were found for 256 of the 263 MHC participants (97.3%). The remaining seven MHC participants that were not located in JEMS files were either not booked into the ADC between July 2000 and May 2008, or were booked under an alias that did not match any of the search parameters. JEMS statistics presented in this report are out of the entire group of MHC participants (N = 263) searched for in JEMS data, unless otherwise noted.

Bureau of Criminal Identification. Over the course of the evaluation, attempts were made to locate and verify MHC participants' State ID numbers (SID), the identifiers used by the Bureau of Criminal Identification (BCI). SIDs came from several sources including the: Salt Lake County Adult Detention Center (ADC) database (JEMS), Utah Department of Corrections records, and CJS program files. These searches resulted in the identification of SIDs for 245 of the 263 MHC participants (93.2%) and 41 of 49 (83.7%) screened only individuals. These identifiers were sent to BCI for query of the state criminal history record in May 2008. The criminal history data was used to examine pre-MHC criminal histories, as well as recidivism for those who had a sufficient follow-up period following exit from MHC. Unless otherwise stated, descriptive statistics presented for BCI data are out of the 245 MHC participants who had BCI records. Additionally, BCI arrests for participants were not recorded for the time period during MHC, as inaccuracies in the BCI data have been identified. For instance, while participants are under AP&P supervision, probation/parole violations are sometimes recorded in BCI as a new offense. To avoid misrepresenting during-MHC offending, no BCI data were examined while participants were active in the program due to the majority (72.5%) also being under AP&P supervision.

Utah Department of Corrections. UDC records were hand searched for 244 out of the 263 MHC participants (92.8%) by various spellings and combinations of last and first names and date of birth. This resulted in 200 (82.0%) MHC participants that had O-track numbers, indicating involvement with UDC. UDC records provided information for these participants on legal status changes (e.g., probation, prison, parole), probation officer contacts, urinalysis testing, programming, and Level of Service Inventory (LSI) scores. Descriptive statistics on MHC participants' UDC involvement are presented as a percentage of the total 244 participants included in the data queries, unless otherwise specified.

Additional Sources. Identifying information for 110 MHC participants was sent to the Utah Chapter of the National Alliance on Mental Illness (NAMI) in March 2008 to locate in their program records. NAMI staff identified 46 out of the list of 110 MHC participants (41.8%) who participated in their Bridges program. Both Fisher House and the Housing Authority of the County of Salt Lake (HACSL) provided researchers with a list of previous and current participants in their programs as well as the intake and exit dates, and exit status for each. Researchers hand searched these lists to identify MHC participants by name.

Analyses

Quantitative. Descriptive and statistical analyses were conducted using SPSS 15.0®. Analyses were limited by availability of data, both in terms of sample size and follow-up periods. Statistical analyses were chosen based on the level and characteristics of the data. The use of the appropriate test based on the characteristics of the data and the assumptions of the test increase the "power," the ability to correctly identify group differences (Pett, 1997). Normally distributed data (e.g., days to failure event) were examined using parametric tests (e.g., t-test), while nominal variables (e.g., presence or absence of recidivism) and non-normally distributed variables were examined using nonparametric tests (e.g., Chi-Square, Mann-Whitney U Test). All statistically significant results are presented with their test statistic and p value in a footnote or table. The p value is compared to a standardized alpha (ά, significance level). Statistical significance was set at $\acute{\alpha} < .05$, which is standard in the social sciences. This means that the likelihood that the observed difference between groups is due to chance is less than five in 100. Primarily bivariate (comparisons between two variables) tests are reported; however, a multivariate analysis (logistic regression) was conducted to predict likelihood of recidivism.

Qualitative. Work flow analysis is designed to gain a qualitative understanding of how the work of a program is conducted. This model has been used in qualitative evaluations of other problem-solving courts (Byrnes, Hickert, & Kirchner, 2007a; Byrnes, Hickert, & Kirchner, 2007b). In this specific analysis, the focus was on how cases move through the MHC, what program components (e.g., the judge, attorneys, case managers, probation officers, clinical service providers, local law enforcement) are involved, and what inputs are important at these decision points.

UCJC staff interviewed nine key MHC team members. These team members included the judge, defense and prosecuting attorneys, clinician, case managers, and probation officers. Additional information was gathered through phone conversations with representatives of and document collection from partnering agencies, including Criminal Justice Services, Salt Lake Police Department Crisis Intervention Team (CIT), Valley Mental Health Jail Diversion Outreach Team (JDOT) and Community Treatment Program (CTP), Housing Authority of the County of Salt Lake (HACSL), Legal Defenders Association (LDA), Utah Chapter of the National Alliance on Mental Illness (NAMI), and Salt Lake County Jail Mental Health Services. Responses to a fixed set of interview questions were analyzed to identify trends and themes within the answers. These results were combined with additional information from program documents and input from partnering agencies.

Results

Who does the program serve?

Intake and Demographics

Since its inception in 2001, MHC has served a total of 312 participants. However, closer

review of court note records identified 49 of these participants who were screened for MHC, but exited the program prior to entering a plea. Most of these individuals were deemed ineligible for the program (75.5%), and the remainder chose not to participate (24.5%). Most individuals in this group spent limited time in MHC court with a median of 14 days between their first and last MHC appearances, compared to more than a year for participants. The 49 individuals who were only screened were compared to MHC participants (N=236) on gender, race, and age (see Table 2). No statistically significant differences were noted between the two groups. Additionally, screened only individuals did not differ statistically significantly from participants on criminal history either. Approximately three-quarters of screened only (71.1%) and participants (78.5%) had a new charge booking in JEMS in the two years prior to MHC. Of those with a new charge in BCI records in the three years prior to MHC, participants had 4.6 on average, compared to 3.7 for screened only individuals.

A small group (N=19) was identified as participating in MHC a second time. Most of these repeat participants (63.2%) were still active in MHC at the time of the last data query, but two had successfully completed the program the second time around. Individuals who were screened but never pled into MHC and participants' second time in MHC (if applicable) were excluded from the remainder of analyses. Therefore, the remaining analyses are based on the 263 first-time individuals who entered a plea.

Table 2 Comparison of Screened Only and Participants

	MHC Intake Status	
	Screened Only	Participated
N	49	263
White	91.1%	86.0%
Male	61.2%	67.3%
Age at Intake (Md.)	39.4	34.3

The age of MHC participants at intake ranged from 18 to 64, with 25% of participants 26 years old or younger, and 75% of participants 42 years old or younger. Median age for MHC participants was 34.3 years old. A majority of participants (67.3%) were male and White (86.0%). The remainder identified themselves as Hispanic (6.2%), Black (5.4%), Native American (1.2%), Pacific Islander (0.8%), or Asian (0.4%).

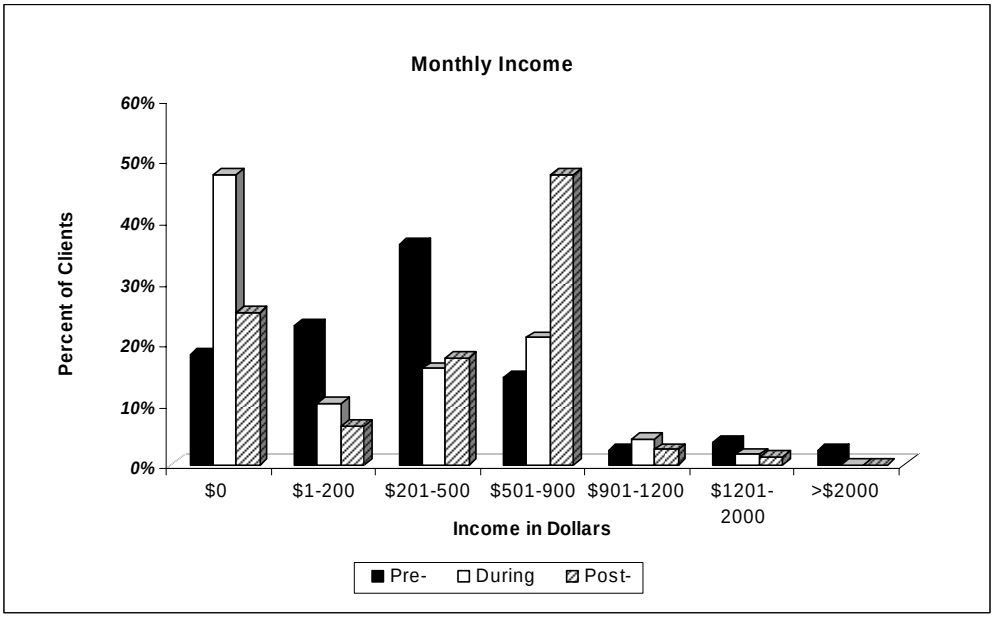
According to court note records, most participants (88.2%) were ordered to complete MHC as a condition of probation. The remaining individuals entered a plea in abeyance, which held the possibility of a dismissal of charges upon successful completion of the program. Length of probation ordered ranged from six to 36 months, with a median of 36 months on probation. However, the MHC judge has the option of shortening probation length by up to six months as a reward for program compliance.

According to Valley Mental Health (VMH) assessment records, 22.9% of participants were ever identified as disabled. A variety of sources including court notes, VMH assessment records, and JEMS data, were consulted to determine the number of

participants who were homeless at any time during MHC. By combining these sources, researchers determined that nearly a quarter of all MHC participants (59, 22.4%) experienced homelessness while in MHC. Participants who were identified as being homeless while in MHC were found to be more likely to receive housing assistance or residential treatment while in MHC.

Most participants were single (88.3%) and unemployed (90.1%) at least part of the time while in MHC. Although the number of people receiving services from VMH decreased slightly after MHC exit, the percent of participants identifying themselves as unemployed post-MHC was similar to that during MHC. Of those with reported income, many reported an increase in monthly income from during to post-MHC. Half of participants (52.5%) reported having no income while in MHC, although some participants' only form of income may have been public assistance. Figure 1, below, displays participants' monthly income pre- (N=166), during (N=120), and post-MHC (N=80).

Figure 1 Participants' Monthly Income



Mental Health History

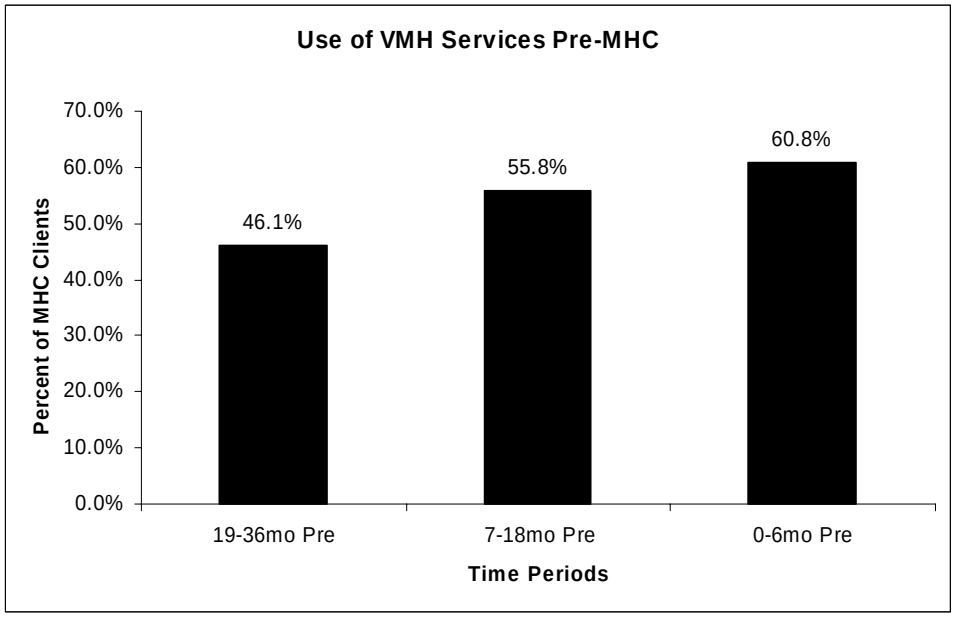
Mental Health and Substance Abuse Diagnoses. Participants' history of Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) diagnoses revealed a long history of MHC-eligible mental illnesses. Of the participants with diagnoses prior to MHC start (N = 169, 76.8%), nearly three-quarters (70.4%) met MHC diagnoses eligibility by having one of the following diagnoses: Schizophrenia and Other Psychotic Disorder or Bipolar Disorders. In addition, over half (57.4%) met criteria for a substance use disorder, while one quarter (27.2%) met criteria for depression. If participants who had a diagnosis within 180 days pre- or post-MHC start were included with those who had a diagnosis prior to MHC (N = 204, 92.7%), nearly all (86.3%) met MHC eligibility

criteria and 62.7% had a substance use disorder. These problems had been identified, on average, several years prior to MHC start (Median (Md) = 6.8, Mean (Mn) = 8.3 years for Schizophrenia and/or Bipolar Disorder; Md = 5.8, Mn = 6.7 for Substance Use Disorders). MHC criteria requires that all participants have a documented history of mental illness; therefore, those without records in VMH were either not identified due to the data querying techniques, or had diagnoses recorded at other mental healthcare providers.

Treatment History. MHC participants typically had a long history of MH treatment involvement at VMH. Of the participants whose information was sent to VMH for treatment data, 82.8% (N = 202) had at least one admission prior to MHC start. On average, these individuals had three admissions (Md = 3.0; Mn = 3.5) before MHC. The first of these admissions was generally several years (Md = 8.7; Mn = 10.0) prior to beginning MHC. Participants' age at this first admission was typically in the mid-20's (Md = 22.8; Mn = 24.6). Of those with admissions prior to MHC, type of admission included youth (23.3%), adult (72.3%), forensic (34.7%), and UMed (24.3%); of course, participants could have more than one admission type in the pre-MHC period.

Service records also indicate that individuals who later participate in MHC have substantial use of VMH services and resources in the years immediately prior to starting MHC. As shown in Figure 2, below, over half of future MHC participants received VMH services in the three years leading up to MHC participation.

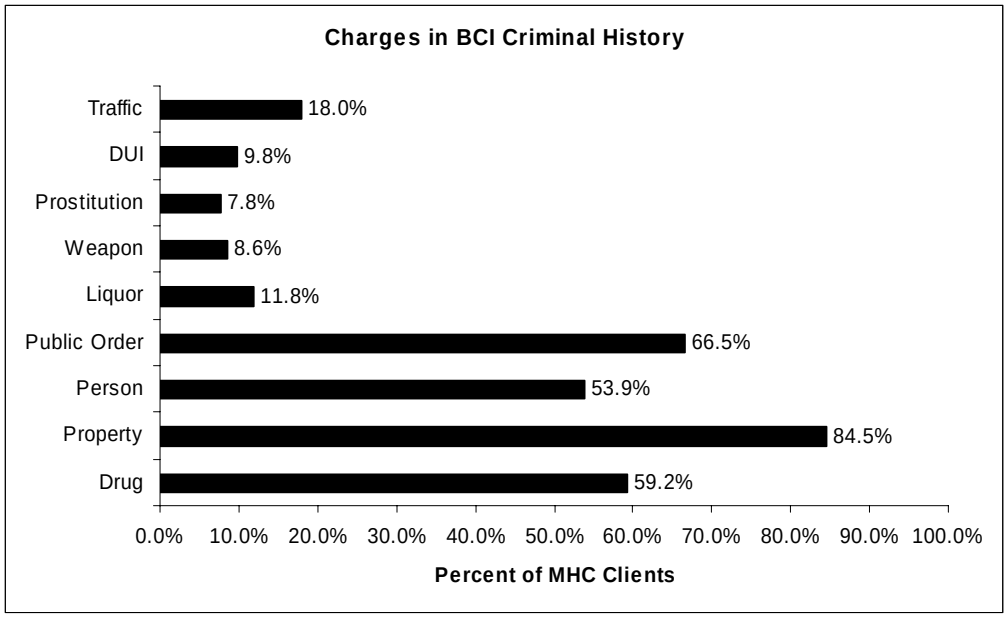
Figure 2 VMH Service Use Pre-MHC



Criminal Justice System Involvement

Bureau of Criminal Identification. MHC participants had extensive criminal histories recorded in the statewide criminal history record. Nearly every participant (92.7%) had at least one arrest in the three years prior to MHC, while they had on average nine (Mn, Md = 6) arrests prior to MHC. For those that had a new charge in the year prior to MHC (86.1%), median number of new arrest dates was 2.0 (Mn = 2.7). It should be noted that some inaccuracies have been identified in BCI data regarding probation violations being recorded as new offenses. As over one-quarter of MHC participants were on AP&P supervision prior to MHC, some of these recorded arrests could be probation violations, not unique new charges. With that caveat, Figure 3, below, displays the type of charges MHC participants committed prior to MHC. Most had at least one property crime in their criminal history, while over half had committed drug and person crimes. Prostitution offenses also included solicitation charges. Of those with a DUI, median time from DUI to MHC start was 8.5 years, meaning that the MHC policy of not accepting anyone with a current DUI offense is being met.

Figure 3 Types of Charges in BCI Criminal History Pre-MHC

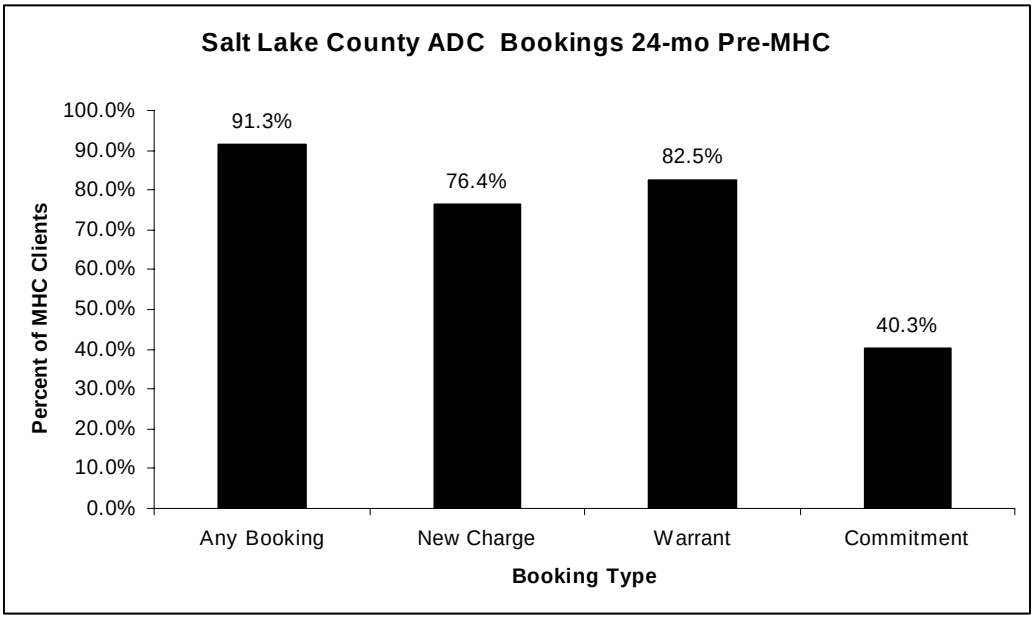


Adult Detention Center[1]. The MHC serves participants who are booked into the jail often and are therefore consumers of considerable criminal justice resources. Nearly every MHC participant (91.3%) had at least one jail booking in the two years prior to MHC, with an average of 3.0 bookings (Mn; Md = 2.0). As shown in Figure 4 the most common

[1] Reference to "jail bookings" only includes bookings into the Salt Lake County Adult Detention Center (ADC) and do not include bookings into any other jails.

types of bookings were for warrant and new charge bookings[2]. Median time from most recent jail booking to MHC start was 101 days (Mn = 145), while time from most recent new charge booking to MHC start was 151 days (Mn = 261). Of those with a booking in the two years prior to MHC, median days in jail was 70 per person (Mn = 98). A total of 21,765 jail days were utilized by MHC participants in the two years prior to MHC start.

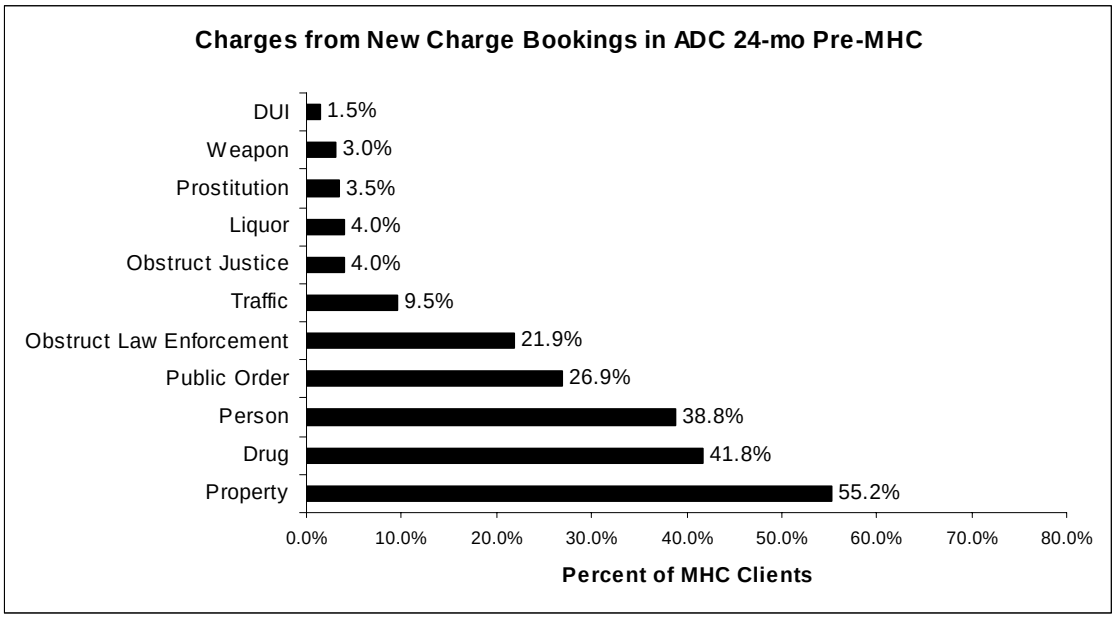
Figure 4 Type of Jail Bookings in 24-mo Pre-MHC



Of those with a new charge booking in the two years prior to MHC, most had a 2nd Degree Felony (37.0%) or 3rd Degree Felony (27.0%) as their most severe charge. The most common types of offenses were property, drug, person, and public order. Public order offenses included disorderly conduct, public intoxication, and disturbing the peace. Obstructing law enforcement offenses included interfering with or resisting arrest and providing false information to police. Figure 5, on the following page, shows the percent of MHC participants who had each type of new charge in the two years prior to MHC – out of those that had at least one new charge booking during that period.

[2] Each booking could be for more than one booking type. For example, an offender could be picked up on a new charge, but have two outstanding warrants at the same time. That booking would be flagged as both a warrant and a new charge booking

Figure 5 Types of Charges from New Charge Jail Bookings 24-mo Pre-MHC



Utah Department of Corrections. Some MHC participants have had past involvement with Utah Department of Corrections (UDC). Just over one-fourth (27.0%) had a placement on probation with Adult Probation and Parole (AP&P) prior to the one associated with MHC, while 8.2% had been in prison prior to MHC (and also on parole). Nearly three-quarters (72.5%) were on AP&P supervision during MHC (all probation, except one person on parole). Of those on AP&P supervision during MHC, 17.0% were already on probation when they entered MHC, 20.0% started probation and MHC on the same day, and 39.4% started probation within 30 days of beginning MHC. The remainder started probation more than 30 days after starting MHC. The risk level for MHC participants with Level of Service Inventory (LSI) screenings within 180 days pre- or post-MHC intake was 25 on average (Mn, Md = 25). An LSI score of 25 out of 54 is defined as high risk by UDC.

What services are MHC participants utilizing during participation?

Living Situation and Ancillary Services

Housing Assistance. Nearly half of participants (125, 47.5%) received some form of housing assistance or residential treatment while in MHC. More than half of these participants (60.3%) utilized two or more housing resources while in MHC. The majority of other participants resided in private residences during this time. Table 3, on the following page, provides a list of the housing units and residential placements most frequently used by MHC participants, as well as the median length of stay, when available.

Table 3 Most Frequently Used Housing Units/Residential Placements

Housing/Residential Treatment Option	N	Length of Stay (Md. days)
Fisher House	45	178.4
Master Leasing	20	------
Fremont	16	111.0
HARP	16	260.9
John Taylor House	13	------
Orange Street	13	147.0
Timmins House	13	------

Median length of stay was not available for all housing/residential placements and varied greatly, ranging from two to 376 days per participant. MHC participants spent an average of 140 days in these units, with the longest stays reported for participants in the HARP program. Exit status data was provided for those participants who exited HARP housing and Fisher House. Both programs reported mixed outcomes, with approximately half of MHC participants exiting the program successfully (HARP, 40.0%; Fisher House, 48.1%).

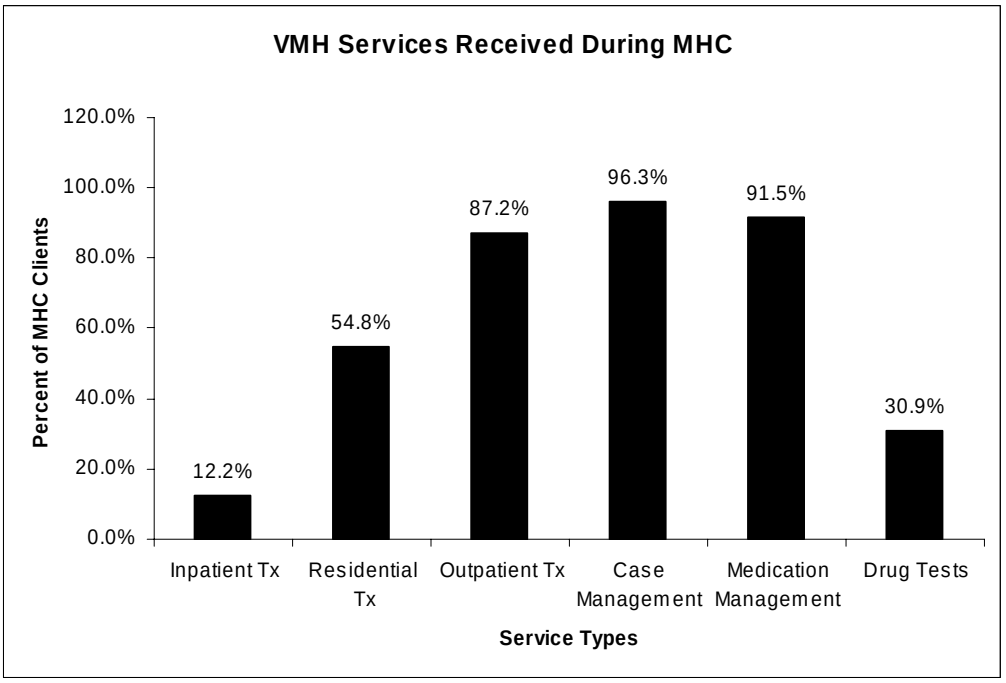
JDOT. The Jail Diversion Outreach Team (JDOT) was formed in August 2007 and as of April 2008, had served 19 MHC participants. Team members consider the group of individuals served by JDOT to be the most challenging and therefore in need of this increased level of assistance. Based on an examination of court note records, the amount of time individuals have been served by JDOT ranges from a few days for participants just placed on JDOT's caseload to 154 days for the longest served client. Additional analyses on this sub-sample were not conducted at this time due to the small sample size.

National Alliance on Mental Illness. A search of National Alliance of Mental Illness (NAMI) records identified 48 MHC participants (of 110 participant records queried, 43.6%) who had participated in NAMI's Bridges program. This number includes both the version conducted in the jail as well as the one offered in the community. Of those who participated in NAMI, records indicated that 41.7% graduated from the program. MHC participants often have contact with NAMI for reasons other than the Bridges program; however, records on these other contacts were not kept by the organization, and therefore can not be reported on. Additionally, as described further in the Participant Compliance subsection of "*Is MHC succeeding?*", many MHC participants are ordered by the court to complete community service as a sanction. NAMI is one of the sites where community service can be completed, creating another opportunity for MHC participants to make contact with this valuable resource.

Treatment and Case Management

While active in MHC, 86.6% of participants had service records at VMH[3]. Of those, Figure 6, below, shows the percent who received various types of treatment and services. It was most common that MHC participants received case management and medication management services from VMH and less common to receive drug testing[4] and inpatient treatment. Inpatient treatment was defined as psychiatric hospitalization and would include hospital stays at the University of Utah or University Neuropsychiatric Institute (UNI). Over half of MHC participants received residential treatment services through VMH at some point during MHC. Residential treatment included stays at Community Treatment Program (CTP), Safe Haven, Valley Plaza, and similar placements.

Figure 6 VMH Services Received During MHC



As well as being the most commonly utilized services, case management and medication management were also the longest used services during MHC participation, along with outpatient treatment. Among those that received inpatient treatment, stays were typically only two weeks long. Table 4, on the following page, displays the median days in each service type and between services for individuals who used these services during MHC. Not surprisingly, inpatient and residential treatment services were received daily for

[3] Individuals who did not have VMH services during MHC (N = 29) were hand checked. Of those, 18 (62.1%) were not found in the VMH database using the name, date of birth look-up query. Eleven were found in VMH records; of those, 9 had no services recording during the MHC years and 2 started MHC in spring 2008 so were not included in the service data query.

[4] Drug testing was also conducted by AP&P. A total of 59.4% of MHC participants had a drug test with either VMH or AP&P.

individuals in those treatment modalities, while outpatient treatment was received approximately weekly. Due to the calculation methodology used to compute average time between services, it is believed that the frequency of the longest-received services (case management, outpatient treatment, and medication management) is slightly underestimated.[5]

Table 4 Use of VMH Services During MHC

Service Types	N	Median Days In	Median Days between Services
Inpatient Tx	23	14	0*
Residential Tx	103	185	0*
Outpatient Tx	164	358	7.5
Case Management	181	364	4.6
Medication Management	172	358	10.4
Drug Tests	58	153	6.9
Overall	188	441	2.0

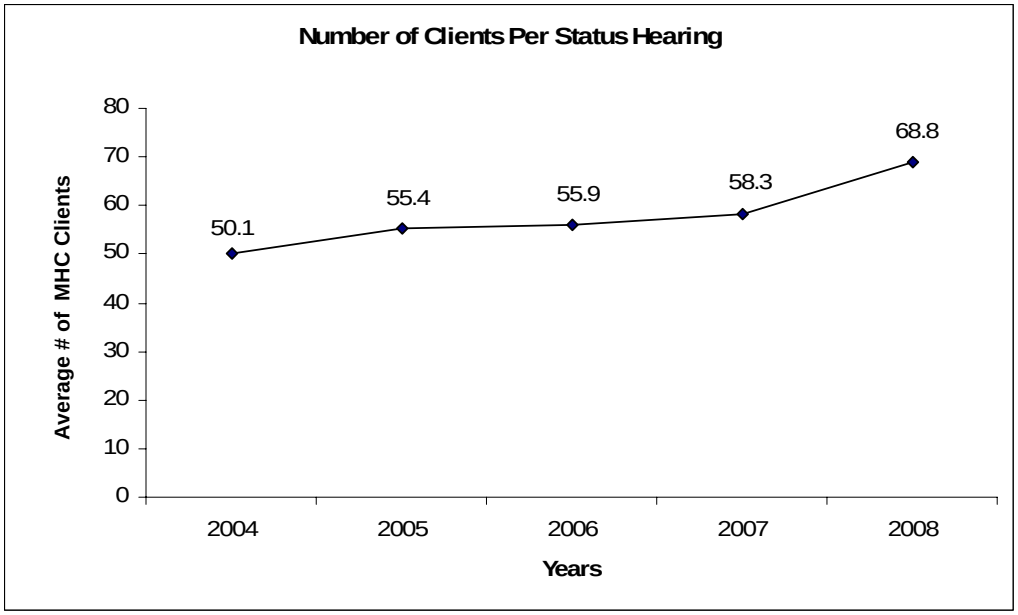
*Services were received daily

Court Appearances

An examination of Court Notes yielded information regarding the number of participants appearing at each status hearing. The average number of participants appearing before the judge per session has been slowly increasing over the years, and is currently about 70 participants per session (see Figure 7, on the following page). Court status hearings are held every Monday afternoon, with the exception of holidays, and participants are required to appear weekly for the majority of their time in MHC. Court Note records confirm this claim, with half of participants having status hearings every 9.9 days or more often, and three-quarters of participants with status hearings at least every 12.0 days. According to information gathered from key informant interviews (see the Clients' Progress, Rewards, and Sanctions subsection of the *"What is the structure of the MHC?"* section of the report), previous attempts at extending court appearances to less often than every two weeks had been unsuccessful. The vast majority of hearings were held post-plea (94.6%). This is not surprising, due to the fact that potential participants typically completed Orientation during their first court appearance and entered a plea at their second court appearance. This is in line with the program's policy giving potential participants a week, following Orientation, to think about whether or not to participate prior to entering a plea and signing the MHC Agreement.

[5] Frequency of services was computed by dividing the number of days from first to last service by total days of services. This means that if a MHC client had outpatient treatment recorded from January to December of one year, but did not participate during a 3 month period within that timeframe, the frequency of treatment would still be calculated for the entire year.

Figure 7 Changes in Number of Clients Per Status Hearing



AP&P Supervision

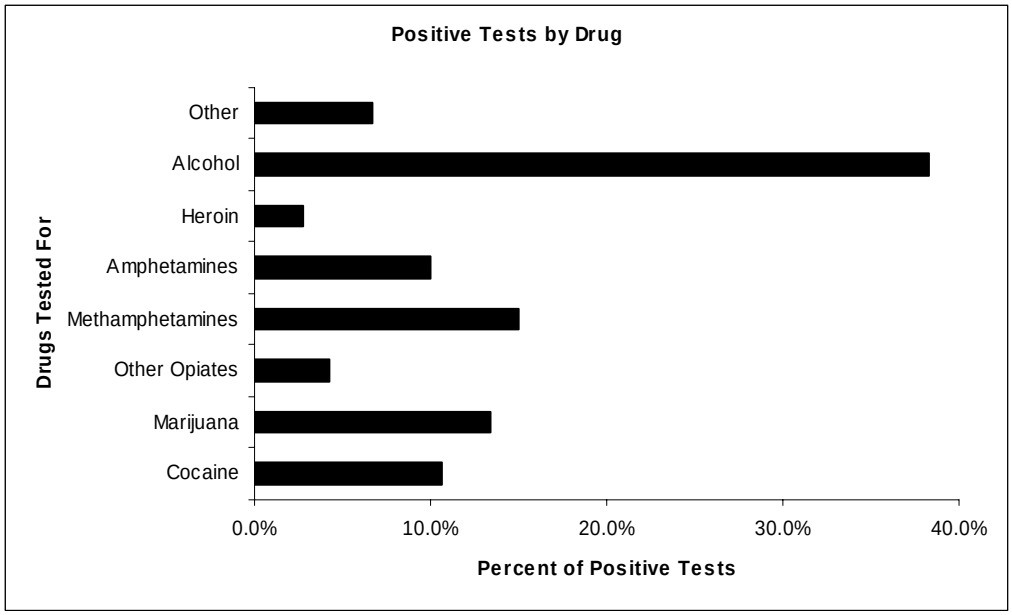
Probation Officer Contact. As previously noted, nearly three-quarters (72.5%) of MHC participants were on AP&P supervision while in MHC. Median days between completed probation officer (PO) contacts was 18.6 (Mn = 21). Scheduled but not completed contacts were not included in these calculations. Due to the methodology used to compute average time between PO contacts, the overall frequency may be underestimated.[6] However, a review of some individual case files indicated that participants met with their probation officers bi-weekly at the start of MHC and approximately monthly toward the end. These examples were consistent with the average frequency of every 2-3 weeks. The majority of each participants' visits were in the PO's office (Md = 78.6%), but a fair amount were home visits (Md = 14.3%). Only 16.9% of participants on supervision did not have a home visit recorded.

Drug Testing. Over one-third (37.7%) of participants included in the UDC record query had drug tests recorded with UDC. When drug testing from VMH and UDC were combined, over half (59.4%) of MHC participants had drug testing from at least one of those locations. Drug testing at AP&P was not very frequent (Md = 47.6 days between tests), but did result in a fair percent of tests per person being identified as high (Md = 14.3%). However, nearly half (45.3%) of those tested did not have a positive drug test on record. Figure 8, on the following page, shows the percent of tests identified as high out

[6] Frequency of PO contacts was computed by dividing the number of days from first to last PO contact by total completed PO contacts. This means that if a MHC client had PO contacts recorded from January to December of one year, but did not meet with their probation officer during a 3 month period within that timeframe, the frequency of treatment would still be calculated for the entire year.

of the total number of tests conducted for each substance. It was most common that alcohol tests would detect use, while heroin was the least detected substance.

Figure 8 Percent of High Drug Tests by Substance



What is the structure of the MHC?

Various sources were consulted in an attempt to develop an understanding of the structure of MHC. These sources included: participant and court note records, program documents, and academic literature. However, researchers were concerned that these sources were not providing an adequate picture of this particular MHC, and in some cases were creating more questions than answers. As a result, researchers decided to conduct semi-structured interviews with MHC team members and representatives from partnering agencies. The following questions were asked during the key informant interviews:

1. Could you describe your role in the MHC and how long have you been involved with the program?
2. How are potential participants referred to MHC?
3. How are potential participants screened for (legal) eligibility for MHC?
4. How are potential participants assessed for appropriateness for MHC?
5. How are participants oriented to MHC?
6. Can you describe the MHC program and how progress through the program is determined?
7. How is participants' progress rewarded while they're in MHC?
8. How does MHC address participants who are not making progress?
9. Do you think MHC is successfully treating its clients? Why, why not?
10. How does the MHC recognize successful completion of the program?
11. How does the MHC address unsuccessful participation in the program?
12. After a participant leaves MHC, what, if any, resources are available to them?

13. Are there current barriers to service delivery or are there any changes that need to happen within MHC?

Interviewers asked follow-up questions to clarify responses to these questions and elicit team members' opinions on the court's processes and functioning. Follow-up questions did not alter the substantive focus of the original questions posed.

The results are grouped here according to workflow categories of court team and partnering agencies; referral, screening, and assessment; clients' progress, rewards, and sanctions; graduation and termination; aftercare; and challenges.

Court Team and Partnering Agencies

More than half of the current MHC team has been involved with the program either during its planning stages or since its inception. Only one member has recently joined the team. The team has a thorough understanding of the MHC model and related issues. For example, nearly every member independently described the "individualized" nature of the program and the importance of this feature. Additionally, more than half described the clientele using clinical terms, including seriously persistently mentally ill (SPMI) and co-occurring disorders/dual diagnosis. Furthermore, several described non-traditional roles taken on by various team members, such as the prosecutor advocating for increased treatment options or the treatment provider suggesting criminal justice responses (i.e. jail) to non-compliance. This was also witnessed by researchers during pre-court staffings and status hearing observations. In fact, observations suggest that the prosecutors were equally likely as the judge or treatment team to offer the clients praise and support for their accomplishments. Team members also described the function of the MHC within the broader context of addressing mental illness within the criminal justice system and the need for reform and innovations. A couple noted the use of a "harm reduction" model in the MHC, where incremental gains are acknowledged and the program seeks to decrease likelihood of harmful behaviors while understanding it may not be possible to completely eliminate recidivism or relapse.

In addition to the core MHC team, several ancillary agencies provide valuable input and necessary services to the program. For instance, representatives from the Housing Authority and Jail Mental Health Services attend pre-court staffings and status hearings weekly. They also provide important updates to team members regarding clients, as well as help problem-solve any issues clients may be having. Nearly every team member identified the availability of housing options as a key component of the MHC program. A few expressed the belief that housing is the number one resource for clients, while a couple viewed housing as a reward for participation. In contrast, some team members said that safe, decent housing was a right, not a reward for clients' participation.

Representatives from the Jail Diversion Outreach Team (JDOT), Community Treatment Program (CTP), and Utah Chapter of the National Alliance on Mental Illness (NAMI) also often attend court to inform the team about clients' progress and challenges. JDOT is a relatively new resource, implemented in August 2007, yet it has become a critical

component of the MHC. JDOT provides the most at-risk clients with daily medication monitoring, home visits, and case management following the Assertive Community Treatment (ACT) model that has been shown to be highly effective with a multi-need mentally ill population. More than half of the MHC team specifically mentioned JDOT as an important resource for the program. CTP has a 16-bed residential unit that the MHC utilizes when patients need to be stabilized following release from jail or in lieu of jail. Although it is a limited resource, it has become invaluable to the MHC in addressing clients who are in crisis. A couple team members noted the need for additional resources like CTP to help stabilize clients without the use of jail. NAMI provides classes for MHC clients (Bridges, Gathering) and families (Family to Family) in a peer-directed environment where clients take an active role in their recovery. One team member suggested that more peer-to-peer support would benefit the MHC clients. Clients also complete some court-ordered community service hours at NAMI, as well as at VMH and other MHC partners.

Although they do not have representation in court every week, the Salt Lake Police Department Crisis Intervention Team (CIT) is another critical resource for the MHC program. CIT was developed around the same time as the MHC. This team of certified officers is specially trained to respond to mentally ill offenders, as well as build a system where law enforcement is part of a continuum of entities that deal with mental health (MH) issues. The CIT team makes referrals to the MHC and also responds to requests from the MHC to intervene with clients who may be getting into trouble or putting themselves or others at risk. A few MHC team members mentioned that MHC clients are a vulnerable population that can be easily victimized. CIT has been identified as a valuable resource to deal with these issues.

Referral, Screening, and Assessment

There was a consensus in describing the referral process. Nearly every team member told researchers that the referral process begins with a MH screening by the staff at Legal Defenders Association (LDA). Consistent with program documents, most team members indicated that referrals can come from several sources, including private attorneys, LDA, judges, law enforcement, the jail, and other specialty programs (such as drug court). However, LDA was identified as the primary referral source. After a referral is made, the potential client signs release forms for the requisite MH and legal records so that eligibility can be determined. Two components of legal eligibility were noted by the team. The attorneys indicated that legal competence was a pre-requisite for voluntary participation, while both legal and non-legal team members listed the following charge-related criteria: no sex, weapons, or active DUI offenses. Violent offenses are considered on a case-by-case basis, examining the type and level of violence involved. Although the entire team staffs cases for potential clients, it was noted that the prosecutors make the final decision on meeting legal criteria for participation, since they are ultimately accountable for ensuring public safety. Most team members also described the requirement of meeting MH criteria for participation, while a couple indicated that an Axis I diagnosis, specifically, is required.

Nearly everyone indicated that the orientation is conducted by the prosecutors, legal defender, and clinician, although some team members were not aware of what steps comprise the orientation. Of those team members who were familiar with the process, it was noted that the orientation consists of: attending court hearings prior to intake, reviewing an agreement, and returning a week after the orientation to sign the agreement and enter a plea. Many team members indicated that the reward for successful completion, either a 402 reduction of charges or dismissal through a plea in abeyance, is specified to the client upon intake.

Clients' Progress, Rewards, and Sanctions

The weekly structure of status hearings was the primary response of the MHC team when asked to describe the MHC program and how progress is determined. Nearly every member indicated that clients are required to attend court weekly, at least at first, and that this structure becomes very important in the lives of clients. At these weekly hearings, clients are reminded of their responsibilities, offered praise for their progress, and given reprimands or sanctions for non-compliance. One team member indicated that the routine of the weekly status hearings may be a more powerful influence on the clients than was actually intended. Several respondents noted that when frequency of court appearances has been reduced to every two weeks clients seem to have more issues of relapse and non-compliance. Other main components of progressing through the program are drug testing, housing, and medication. As previously mentioned, many team members noted that requirements, progress, and success are all determined on an individual basis. Some other program components mentioned by members were weekly in-office meetings with probation officers and VMH case management staff, monthly home visits by probation officers, classes and treatment groups at VMH, and assignments. The length of MHC participation is limited by the maximum probation length for the severity of clients' charges at intake. Although some team members indicated that probation can be revoked and reinstated to extend their probation period in order to provide clients with more opportunities for success.

The primary reward, mentioned by every team member, was placement on the "Rocket Docket" and verbal praise. Clients who are compliant and making progress are placed on the Rocket Docket, which means they are acknowledged for their hard work and are allowed to appear before the judge at the beginning of the status hearings and leave court earlier than those who are in custody or non-compliant. The Rocket Docket and verbal praise were considered by the court team to be very effective means of rewarding clients. Several stated that clients look forward to their weekly interaction with the judge and the positive comments they receive from team members both in and out of the courtroom. Several team members noted that the ultimate rewards for participation are a shortening of probation length by 3-6 months and a reduction or dismissal of charges upon successful completion of MHC. Some other types of rewards that were less frequently identified were a lessening of program structure (groups, supervision) for good behavior, the opportunity to be in MHC in lieu of jail, have housing and medications provided, and developing new skills. Again, in contrast, some team members were clear that housing and medications are not rewards, but rights of MHC participants. Lastly, a couple of team

members indicated that tangible rewards had been tried in the past, but were met with little success. It was expressed that the current reward options are sufficient for the program.

Several MHC team members specifically mentioned "sanctions" and "graduated sanctions" when asked how the MHC addresses clients that are not making progress. The most frequently identified sanctions were changing program structure and jail. The next most commonly noted sanction was community service. Less frequently mentioned sanctions were removal from the Rocket Docket, verbal warnings, temporarily holding clients in custody during court, and drug testing during court. Observations of status hearings and review of court notes indicate that the most frequently mentioned sanctions by the court team were not necessarily the most frequently utilized. For example, verbal warnings and removal from the Rocket Docket are the most often used sanctions for minor non-compliance. The next most commonly used sanction was a change in program structure, which was mentioned by the team. Clients are often given additional assignments, classes, or groups; a change in housing; or stricter supervision. It should be noted that nearly every team member who indicated that jail was a sanction, qualified that statement by saying that jail is actually used as a way to stabilize clients on their meds and ensure their safety, rather than to punish them. However, one team member said that jail was also sometimes used specifically as a punishment and another noted that although jail was used to stabilize clients it was still a punishment.

Graduation and Termination

The most common response to "How does the MHC recognize successful completion of the program?" was "graduation." Graduation ceremonies are held approximately once a month at the beginning of the weekly status hearings. Graduates are called to the front of the court where they are addressed by the clinician, judge, and prosecutor who all offer the client praise for his/her accomplishments. The client is then presented with a certificate and reminded by all that they are welcome to visit the court any time. The client is then given the opportunity to address the court. During the graduation observed by the researchers, the clients generally thanked the judge and program for their support and the opportunity to participate. Once the client is through addressing the court, the prosecutor forwards a motion to either reduce or dismiss the client's charges (based on the agreement at intake). If there are no objections by the defense, the motion is granted, and everyone in the courtroom claps for them.

When probed for details regarding what comprises successful completion, nearly all team members noted it was "individualized," while a few said it was remaining mostly compliant for the probation period. Observations suggest that progress is routinely assessed at the pre-court staffing and that all team members provide input on clients' progress. A consensus is reached prior to graduating or terminating clients. One team member defined success as everything but a probation revocation with return to jail or prison. This comment was similar to something mentioned by other MHC team members when asked how the court addresses unsuccessful participation. It was noted that clients are given multiple chances for success, often including revocation and reinstatement of

probation, prior to being terminated from the program. Several team members said that prison sentences had been used in the past, but that it was extremely rare (although team members listed different numbers of participants who had been sentenced to prison, all described it as being in the single digits). More frequently, they are sentenced to jail with credit for time served while in MHC. Another option mentioned was a neutral case closure for clients whose probation period was set to expire, but who had not earned graduation.

When asked if the MHC was successfully treating its clients, the overwhelming response was "Yes." The most commonly mentioned indicator of the program's success was an improvement in "quality of life" observed among clients. Over half of the team suggested that the program had a marked impact on clients' quality of life and that they had experienced more stability while in MHC than at any other time in their life. The other key indicators of the courts success noted by the team were the collaboration of the MHC team (great communication, supporting and trusting each other) and the integration of resources (especially housing and medications). Two somewhat dissenting opinions were offered. One respondent said that it isn't the court that is successful in treating clients, but that clients are ultimately responsible for their own success, the court simply provides the opportunity. Similarly, another team member said that the court itself is not in the business of providing treatment, but helps provide the authority that gets people into and remaining in treatment.

Aftercare

Most MHC team members noted that nearly every resource that clients have available to them during MHC remains available after graduation or termination; however, they described the difficulty of connecting clients with resources post-exit and keeping them engaged when they are no longer court ordered to do so. Specific resources that were mentioned included: VMH, NAMI, housing/RIO, JDOT, Department of Workforce Services (DWS), and the VMH Payee Program. Because of the difficulty of connecting former clients to existing resources, some team members noted that the MHC case manager is currently working on formalizing an aftercare process.

Challenges

A few challenges were consistently noted by the MHC team. Several noted issues of funding and capacity, specifically that MHC and partnering agencies, such as CTP and housing, were unable to serve more clients at this time. Because the team views the MHC as an important criminal justice option for mentally ill offenders, it was a frustration that more clients cannot be served. A related issue was securing long-term funding for mental health medications. Several agencies provide some medications, including the jail and AP&P, but long-term solutions are needed. To address this, Medicaid specialists at VMH and other partnering agencies have begun working on helping clients secure benefits. However, some team members noted that more education and advocacy are needed – specifically that clients should apply for Medicaid prior to Social Security benefits to decrease waiting times. A few respondents described the challenge of getting clients

stabilized on medications when they are booked into the jail. This process can take several days, requiring the client to be in jail at least a week. Team members indicated that it is important to use the least restrictive options with clients and this related to the limited capacity at CTP, JDOT, and other resources that may be used to stabilize clients in the community and avoid unnecessary jail stays. Observation of the pre-court staffing and status hearings do show that the jail representative is actively working with the MHC team to problem-solve issues regarding medication access in the jail.

Two issues were raised in relation to the program's target population: how can the court serve low-functioning (low IQ) mentally ill offenders and how can the court ensure that it is serving dual-diagnosis clients whose primary issue is mental illness rather than substance abuse. Only a couple of team members indicated that the court was having difficulty in identifying dual-diagnosis clients whose primary issue was mental illness. However, they did express that this was a key concern since the purpose of the court is to serve those most in need of mental health resources, specifically SPMI. These team members offered suggestions such as re-assessing clients after they have been stabilized in the program for a few months, as well as working more closely with the drug court to transfer inappropriate clients to them. In contrast, nearly every team member indicated the challenge of working with developmentally disabled or low-functioning clientele. The general sentiment was that "if we don't serve them, who will?" Some progress has been made by partnering with the Utah Division of Services for People with Disabilities (DSPD) to get this population services. Although there is no clear policy on how the MHC will serve low-functioning clients, the team indicated that they will continue to do so on an ad hoc basis.

Workflow Summary

An analysis of the MHC program's operations indicates that the court is operating efficiently. The team is experienced and knowledgeable about the MHC model and a wide array of quality resources are being utilized. However, as often noted by innovative programs, increased resources and capacity would be welcomed. Team member interviews, court and staffing observations, and document reviews all indicate that the program is operating largely in compliance with the Bureau of Justice Assistance's (BJA) essential elements of MHCs. See the "*How does the SLCo MHC compare to the MHC model*?" section of this report for a detailed comparison of the Salt Lake County MHC to BJA's ten essential elements. However, some challenges noted by the program, such as identifying the target population and linking participants to post-exit resources, could be addressed through the creation and documentation of more formalized policies and procedures.

Is MHC succeeding?

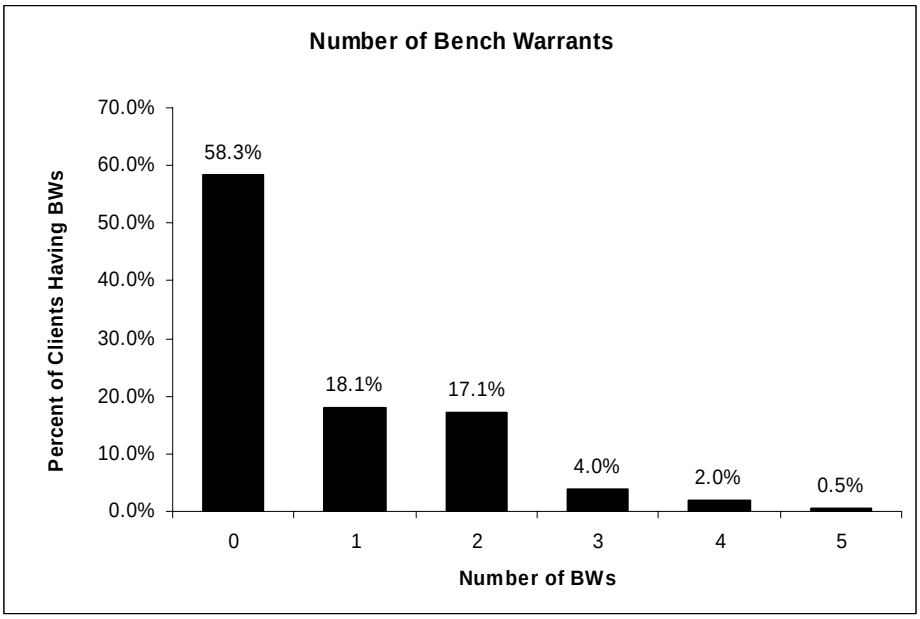
Participant Compliance

Court Attendance. MHC participants appeared for a majority (Md = 93.3%) of their scheduled status hearings and nearly a quarter of participants (41, 20.9%) attended all of

their scheduled status hearings. On average clients only failed to appear (FTA) at 3.3% (Md) of scheduled hearings. Additionally, participants were on the Rocket Docket for slightly more than half (52.3%) of their status hearings (see the Clients' Progress, Rewards, and Sanctions subsection of the *"What is the structure of the MHC?"* section of this report for a description of the Rocket Docket). Half of participants had their first unexcused absence from court within the first 83 days. Not surprisingly, the time between last "failure to appear" in court and program exit was much longer for graduates than unsuccessfully terminated participants (grad, Md = 206.5 days; term, Md = 77.0 days).

Bench Warrants. Bench warrants (BWs) are issued by the court for participants who fail to appear in court or fail to comply with court orders. BWs are most frequently issued in MHC when a participant misses a scheduled status hearing and, in many cases, absconds from the program for a period of time. However, the decision of whether or not to issue a BW is at the discretion of the judge. As was noted above, court attendance was very high for this sample, and half of participants missed 3.3% of their scheduled status hearings or less. As you can see in Figure 9, below, nearly 60% of participants had no BWs. Of those participants with any BWs, nearly half (43.4%) had only one while in MHC and participants averaged two BWs per person. Most BWs took place post-plea (90.2%).

Figure 9 Number of Bench Warrants Per Client



As shown in Figure 10, on the following page, nearly half (42.9%) of all bench warrants ended when participants turned themselves in. Likewise, on an individual level, 31.3% of participants with at least one BW always turned themselves in and 41.7% were always arrested on their BW(s). The amount of time spent out on BW varied, but three-quarters of BWs lasted no more than 17 days and half lasted 7 days or less. Half of participants with at least one BW had their first BW within their first 133 days in the program. As would be expected, the time from last BW to program exit was substantially longer for graduates (Md = 245 days) than unsuccessfully terminated participants (Md =140.5

days). Figure 11, below, shows the distribution of the number of days between participants last BW and exit date for both graduates and unsuccessfully terminated participants.

Figure 10 Reasons for Bench Warrants Ending

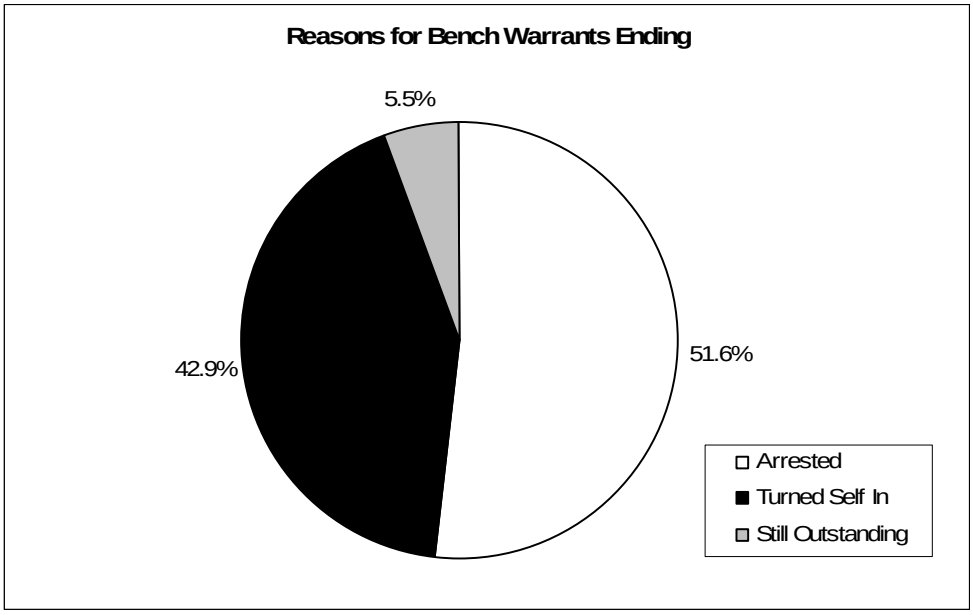
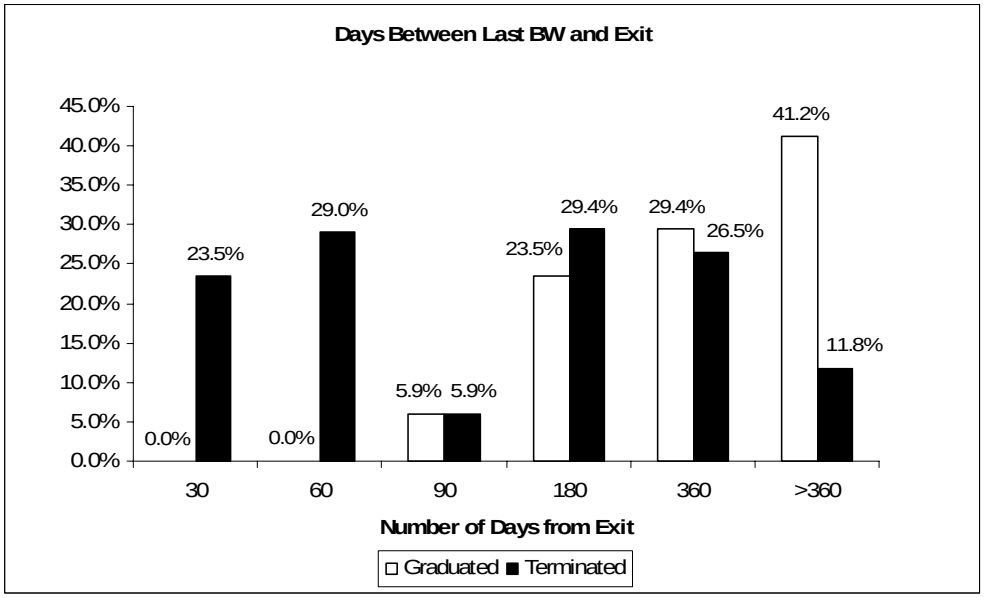


Figure 11 Number of Days Between Last Bench Warrant and Exit Date by Exit Status



Sanctions. Since June 2004, a total of 1,346 sanctions were given in response to non-compliant events. Non-compliant event were defined as violations of the participant's MHC Agreement and/or Probation Agreement. For the purposes of this study, non-

compliant events were coded into the following categories: missed or misused medications, violation(s) at residential placement, missed appointments (including doctor, treatment, groups, classes, etc.), missed drug tests, drug use (including positive UAs and admitted use), alcohol use (including positive UAs/breathalyzer, or admitted use), missed court, new charge(s), contact with restricted person(s), missed check-in with AP&P, and other. As you can see in Table 5, the most common non-compliant events were missed appointments, missed/misused medications, drug use, and missed court.

Table 5 Frequency of Non-Compliant Events

Non-Compliant Event	Frequency	% of Total
Missed Tx/Appts	574	28.8
Drug Use	260	13.1
Missed/Misused Meds	239	12.0
Missed Court	231	11.6
Missed UAs	191	9.6
Violation(s) at Residential Placement	123	6.2
Missed Check-In w/ AP&P	114	5.7
Other	82	4.1
Alcohol Use	72	3.6
New Charge(s)	55	2.8
Contact w/ Restricted Person(s)	36	1.8
Missed Breathalyzer	13	0.7

A majority (84.9%) of participants had at least one non-compliant event noted in their Court Notes, and 83.9% were sanctioned at least once. For those participants with sanctions, number of sanctions per participant varied, ranging from one to 42, with three-quarters having ten or fewer. The median time to first non-compliant event was 70.0 days from first court appearance. Not surprisingly, median time from last non-compliant event to MHC exit was longer for graduates than for unsuccessfully terminated participants (grad, 105 days; term, 18.5 days).

Sanctions varied greatly in type and severity, ranging from verbal reprimands from the judge to termination from the program, and in many cases jail incarceration. A full list of type and frequency of sanctions used is provided in Table 6, on the following page. The most common sanction was a verbal reprimand from the judge. This code was only used in the absence of any other sanction. As you can see, a few non-compliant events were noted that resulted in no sanction and were not even verbally acknowledged in court. However, it is possible that these issues were resolved prior to court and therefore there was no need to address them in court. Some participants were ordered to complete community service as a sanction for non-compliance. A total of 1,014 hours were ordered as a sanction, with half of participants ordered to complete 5 hours or less per sanction, and 75% ordered 10 hours or less per sanction.

As seen in Table 6, the third most frequent sanction imposed was jail; however, it still only represented 14.7% of all sanctions ordered. Nonetheless, the use of jail as a sanction

accounted for a total of 8,273 jail days served by MHC participants while in the program. This figure does not include any additional days served in jail post-exit. The non-compliant events most often associated with a jail sanction were drug use (45.3% of jail sanctions), missed court (33.3%), missed appointments (22.8%), and missed/misused medication (21.4%). As was described in the "*What is the structure of the MHC?"* section of this report, jail is often used to stabilize participants who have gone off of or are misusing their medications. Some team members claimed that the use of jail to stabilize a person on their medications is not considered a sanction by the team; however other team members acknowledged that serving jail time is a sanction, regardless of intent of the program. Therefore, due to the unpleasant and disruptive nature of incarceration, researchers decided to include these bookings as a sanction. On the individual level, jail sanctions ranged in length from one to 204 days, with a median of 17 days, and 75% of jail sanctions lasting 33.8 days or less. Some of the bookings were extended in length due to residential placement or CTP waiting lists.

Table 6 Frequency of Sanctions Used

Sanction Type	Frequency	% of Total
Verbal Only	494	26.0
Off Rocket Docket	443	23.3
Jail	280	14.7
UA in Court	227	12.0
Community Service	132	7.0
Increase Groups	61	3.2
No Sanction Noted	44	2.3
Increase Tx	41	2.2
Daily Monitored Meds	40	2.1
Termination	31	1.6
Revoke & Reinstate	27	1.4
Hold & Release	21	1.1
Increase UAs	15	0.8
Other Sanction	14	0.7
Breathalyzer Tests	12	0.6
Increase Court	7	0.4
Meet with NAMI Mentor	5	0.3
Not Graduate as Set	4	0.2
Jail + CATS	1	0.1

Exit Status

At the time data was queried for the final report (late April 2008), there were 67 active MHC participants. This group includes participants who may be in jail or out on bench warrant, but have not officially exited the program. Most participants who were on bench warrant at the time of this report were included in the active group because this status is considered temporary. However, a few participants who had been on bench warrant for

multiple years were coded as "other" due to the extended length of absence. Three people who died while in the program were also coded as "other" and four former participants were coded as "missing" because no data was available regarding their exit status. Participants coded as "missing" or "other" were excluded from the remainder of analyses. The rest of participants who exited MHC were coded as having a positive (graduated), negative (unsuccessfully terminated), or neutral exit status.

Figure 12, below, presents the percent of participants who graduated (93, 52.6%), were unsuccessfully terminated (70, 39.5%), or exited for neutral reasons (14, 7.9%). Court notes were examined to confirm that negatively terminated participants were both non-compliance during MHC and had a non-compliant event recorded in conjunction with their termination from the program. Most negatively terminated participants were referred back to the regular court calendar (22, 31.4%) or sentenced to jail (28, 40.0%) or prison (7, 10.0%) by the MHC judge. Neutral exit statuses included cases where a participant's probation expired before they could graduate, transfers to other programs or jurisdictions, commitments to State Hospital, and instances where participants' case(s) were dismissed shortly after MHC start. Table 7, below, shows the minimum, maximum, and median number of days in MHC for each group. Length of time in program was determined by calculating the difference between the first and last court appearances.

Figure 12 Participant Exit Status

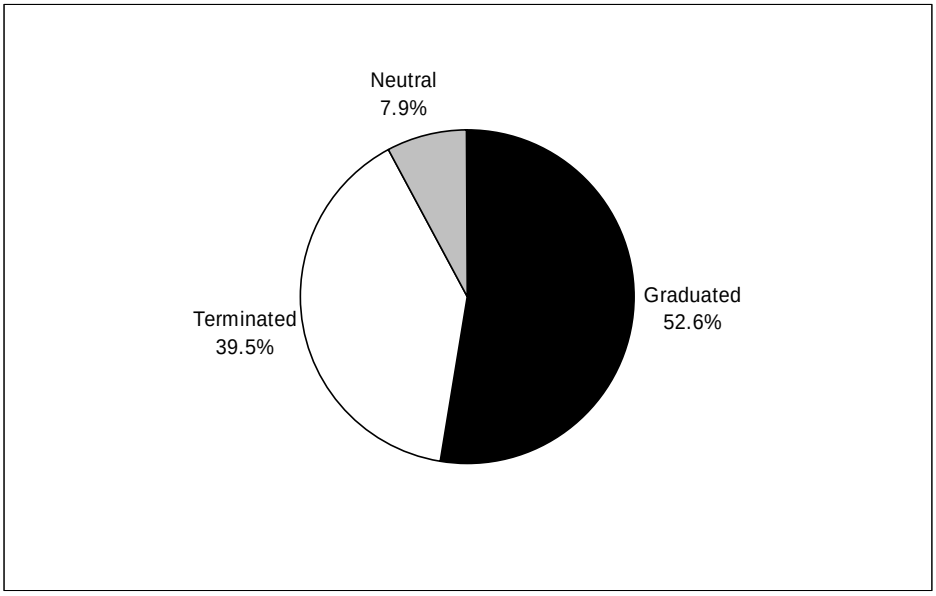


Table 7 Days in Program by Exit Status

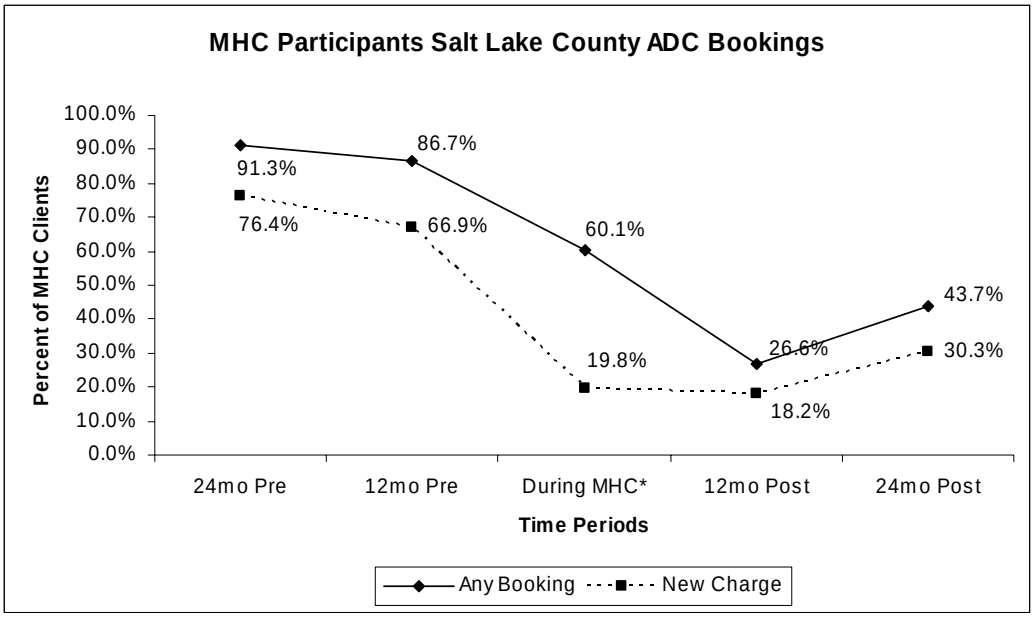
Exit Status	Min	Max	Md
Graduated	126.0	1431.0	518.0
Terminated	0.0	1402.0	388.5
Neutral	28.0	805.0	427.0

Criminal Justice System

Utah Department of Corrections. The rate of successful completion of probation mirrored the graduation rate of MHC. Of the participants under AP&P supervision while in MHC, over half (54.8%) had their probation terminated near their MHC exit date (within 30 days pre- and post-MHC exit). Of those, just over half 56.7% were successfully terminated from probation, while 43.3% were unsuccessfully terminated from probation. All but one graduate who were on probation had a successful discharge, while all but two terminated participants who were on probation had an unsuccessful discharge. Of the participants who exited MHC on a neutral status, two-thirds (66.7%) had an unsuccessful discharge from probation. Seven (7) MHC participants were sentenced to prison at MHC exit, while three additional participants went to prison following MHC exit. Of those who went to prison post-MHC, median days from MHC exit to prison was 331 (Mn = 387). For all ten participants who went to prison, median time in prison on the first placement was 254 days (Mn = 299), while total time in prison[7] was a median of 651 days (Mn = 650).

Adult Detention Center. The percent of MHC participants with jail bookings, especially new charge bookings, decreased significantly following MHC start and remained low following MHC exit (regardless of exit status). As shown in Figure 13, below, nearly every MHC participant had at least one jail booking in the two years prior to MHC (91.3%; 76.4% with a new charge booking), while less than half had a new booking in the two years following MHC exit (43.7%, 30.3% for new charge bookings).

Figure 13 Total Jail Bookings and New Charge Bookings by Time Period

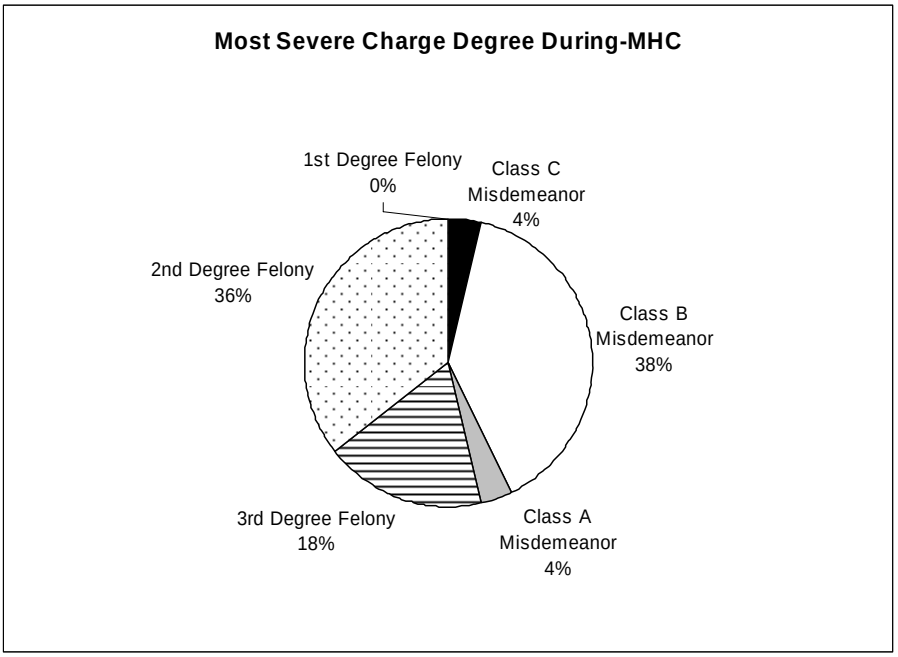


[7] Could be more than one prison placement or a move from prison new inmate status to prison incarcerated status. This is the measure of total days in prison from first prison status start date following MHC start.

The during MHC new charge booking statistic shown in Figure 13 (19.8%) includes any new charge booking recorded in JEMS while a participant was active in MHC (excluding in jail charges). When those bookings were checked against MHC notes for confirmation, only 42.3% were confirmed. However, an additional group of offenses were noted in MHC records (from court notes) that did not correspond with a new charge jail booking (most often charges/citations that did not result in a jail booking). If confirmed new charge bookings are combined with new charges only found in MHC notes, the during-MHC recidivism rate for participants was 16.0%. Due the slight discrepancy in the data sources, it is believed that between 15-20% of MHC participants recidivated (new charges) while active in the program.

Charge severity remained fairly high for those who offended during MHC. Figure 14 shows the most severe charge degree per person for participants who had a new charge confirmed during MHC or detailed in the court notes. The type of charges committed during MHC remained similar to the types committed prior to MHC. For example, property, drug, person, and public order offenses remained the most common (in that order), while only one person had a DUI during MHC and none had prostitution or weapon offenses.

Figure 14 Most Severe Charge Degree During MHC



Median time from MHC start to the first during MHC booking was 101 days (Mn = 164). This is not surprising, as jail is often used as a sanction and a way to stabilize participants who are off of their medications. Median time from MHC start to the first during MHC new charge booking was 150 days (Mn = 203). Of those new charge bookings that were confirmed in the MHC court notes, median time from MHC start to the first new charge booking was 161 days (Mn = 219). Median time from the final during MHC jail booking

to MHC exit was 70 days (Mn = 146). Time from final during MHC jail booking to MHC exit varied statistically significantly[8] by exit status. For graduates there was a median of 224 days between final during MHC jail booking and graduation; whereas terminated participants had only a median of 28 days from final during MHC jail booking to termination (see Table 8, below).

Table 8 Median Days from Last Jail Booking to MHC Exit

Days to Events	All Participants	Exit Status	
		Graduated	Terminated
Last During MHC Jail Booking to MHC Exit	70	224*	28
Last During MHC New Charge Booking to MHC Exit	229	454*	97
Last During MHC Confirmed New Charge Booking to MHC Exit	343	435	262
*Graduates significantly different than Terminated Participants ($p < .05$)			

Of those participants who had a new charge booking in the year following MHC exit, the most common types of charges remained consistent prior to and during MHC. Property, public order, and person offenses (in that order) were the most common charge types post-MHC. Drug offenses dropped to the fourth most common charge type. Most severe charge degrees for recidivists were 2nd Degree Felonies for 22.6% of re-offenders and Class B Misdemeanors for 25.8% of re-offenders.

The final examination of jail data demonstrated the frequent and extensive use of jail resources by MHC participants. As shown in Table 9, on the following page, MHC participants utilized over 21,000 jail days in the two years prior to MHC. While active in MHC, participants used just over 16,000 days. While this is not a substantial decrease from pre-MHC levels, closer examination of during-MHC jail stays indicate that most of these days are not because of a new charge booking. During-MHC bookings were further divided into those instances where participants were on a program wait list (which may have delayed their release from jail), and those who were not. Although only a small proportion of participants were on a program's wait list while booked into the jail, their mean and median days in jail were slightly longer than for those who were not on a wait list. However, it should be noted that participants were not necessarily on the wait list for their entire booking. In fact, in most of these cases, these individuals were not placed on a wait list until after they had already spent a significant amount of time in jail.

Nonetheless, the use of jail resources during MHC remains considerable. In the period following MHC, the number of jail days utilized dropped dramatically from 16,000 days during MHC to 5,200 in the year following MHC and 7,600 in the two years following MHC. Although not all former MHC participants have accrued the full 12- and 24-month follow-up periods, this substantial decrease in jail days is consistent with the decrease in percent of MHC participants with jail bookings following MHC, as shown in Figure 13 on page 35. As explained in under the Utah Department of Corrections Heading in the "*Is MHC Succeeding?*" section of this report, only 10 MHC participants went to prison following MHC start. This suggests that the decrease in jail use (both overall bookings

[8] $t = -8.538$, $p < .01$

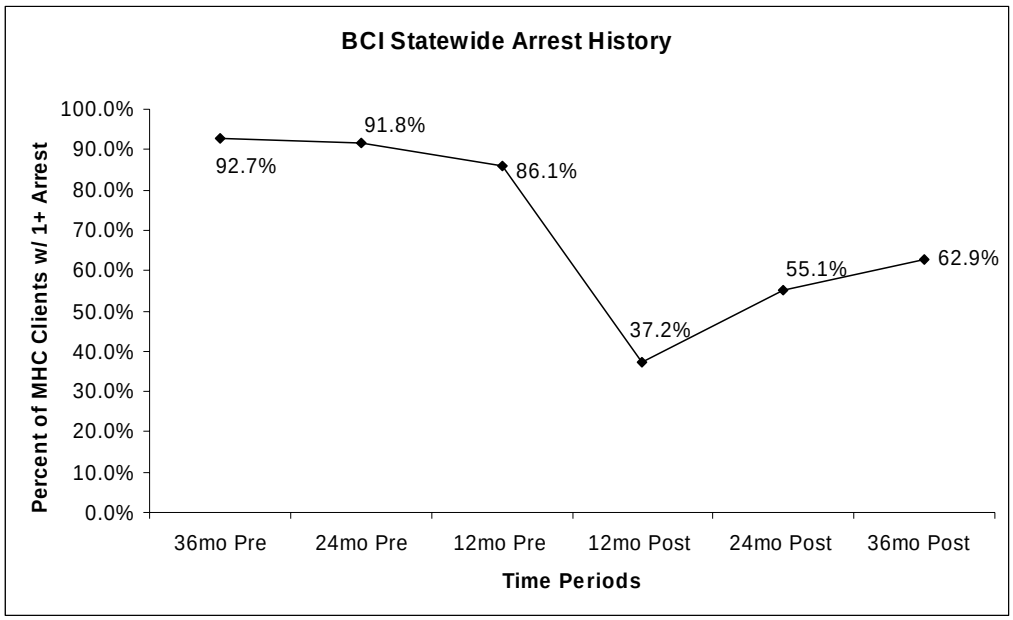
and days in jail) represents a true decline in incarceration, rather than being an artifact of a higher prison incarceration rate.

Table 9 Jail Days by Time Period

Days in Jail	N	Mean	Median	Sum
24-mo Pre-MHC	221	98	70	21,765
12-mo Pre-MHC	210	72	59	15,098
During MHC	191	84	63	16,023
-During - New Charge - Confirmed	17	45	12	761
--During New Charge - no wait	11	15	6	167
--During New Charge - waitlist	6	99	117	594
-During - No Charge	191	80	60	15,262
--During No Charge - no wait	168	61	38	10,277
--During No Charge - waitlist	74	67	55	4,985
12-mo Post-MHC	66	79	41	5,207
24-mo Post-MHC	78	98	50	7,612

Bureau of Criminal Identification. Statewide criminal history records indicate that arrest rates for MHC participants are lower following MHC than they were prior to entering MHC. As shown in Figure 15, below, nearly every MHC participant had an arrest during the three years prior to MHC; however, only 37.2% of participants were arrested in the year following MHC exit. After three years post-MHC exit, 62.9% of former MHC participants (who had three full years of follow-up) had a new arrest. This level remained below pre-MHC criminal involvement. Not surprisingly, arrest rates following MHC exit differed by exit status, see Figure 20 on page 44.

Figure 15 BCI Arrests by Time Period

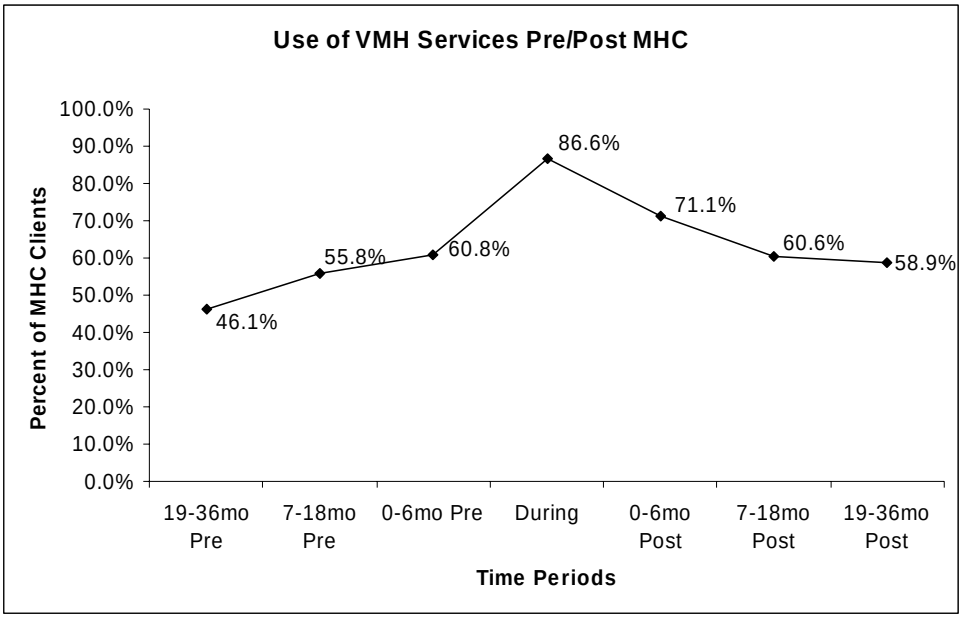


Of those with new arrests in the year following MHC exit, the average was 2.6 arrests (Md = 1.5), compared to 2.7 arrests on average (Mn; Md = 2.0) for those with a new charge in the year prior to MHC. For those who continued to offend following MHC, the average number of arrests remained similar to pre-MHC averages. Lastly, for any MHC participant with a new charge in the BCI record following MHC exit, median days from exit to the first new charge was 262 days (Mn = 350).

Treatment Retention

Following MHC exit, use of VMH services remains higher than it was prior to MHC participation. As shown in Figure 16, below, use of VMH services increased from just under half of participants in the 19-36 months pre-MHC, to nearly 60% in the 19-36 months post. All post-MHC statistics are for those individuals who had the full length of follow-up period available (no recently exited participants). Although the use of VMH services following MHC was higher for all former participants than it was prior to MHC, there were some group differences. In the first six months following MHC exit, graduates were statistically significantly[9] more likely to utilize MHC services (77.3%) than terminated participants (60.0%). Additionally, graduates continued to have a slightly higher percent of involvement with VMH services both at 7-18 and 19-36 months after exiting; however, these differences were not statistically significant.

Figure 16 Use of VMH Services by Time Period

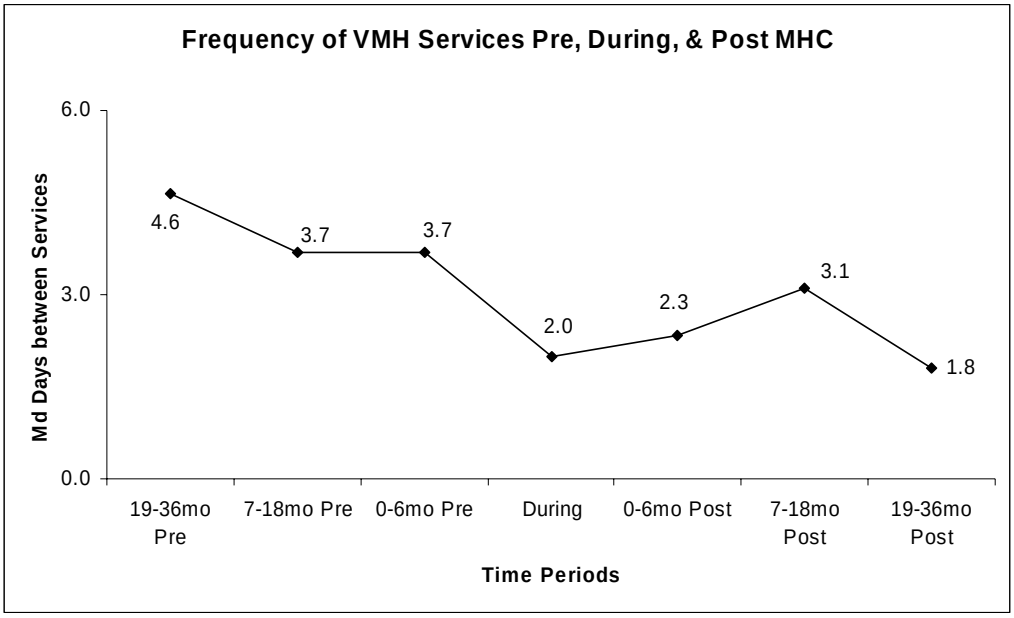


Of those who received VMH services during each time period, services were received more frequently during the post-MHC periods than prior to MHC. Figure 17, on the following page, displays the frequency of VMH service utilization by time period. For those participants who remained in services up to three years following MHC exit, the

[9] $\chi^2 = 4.216$, $p < .05$

frequency of services was at least as often as during MHC. Retention in VMH services (which included three types of treatment (inpatient, residential, and outpatient), case and medication management, and drug testing) is viewed as an indicator of continued stability following MHC exit.

Figure 17 VMH Frequency of Service Use by Time Period



Who has the best outcomes in MHC?

Exit Status

As reported in the *"Is MHC succeeding?"* section of this report, 196 of 263 participants (74.5%) have exited the MHC program. Of those, the greatest number (93, 47.4%) were graduates, followed by negatively terminated participants (70, 35.7%), other (15, 7.7%), neutral (14, 7.1%), and unknown (4, 2.0%). In this section we will be primarily focusing on two outcomes: graduates and negatively terminated participants. As shown in Figure 18, on the following page, when examining just these two outcomes groups, the MHC's success rate was 57.1%. Where sample size is sufficient, graduates and terminated participants will also be compared to those with a neutral exit status.

Not surprisingly, less criminally involved participants were more likely to graduate. Graduates and terminated participants were compared on several participant characteristics, including demographics, criminal history, and mental health history. As shown in Table 10, on the following page, the two groups did not differ statistically significantly on most of the participant characteristics. One exception was criminal history, where participants who were eventually terminated unsuccessfully from MHC were typically more criminally involved prior to MHC than participants who went on to graduate from the program. Graduates had significantly fewer lifetime prior arrests,

arrests in the three years pre-MHC, total jail bookings in the two years pre-MHC, and less severe charges in the two years pre-MHC. Charge degree, presented in Table 10, is scored as 1 = Class C Misdemeanor and 6 = 1st Degree Felony. Therefore, most severe charge for graduates pre-MHC was just above a Class A Misdemeanor, compared to just over a 3rd Degree Felony for terminated participants.

Figure 18 MHC Exit Status for Outcome Analyses

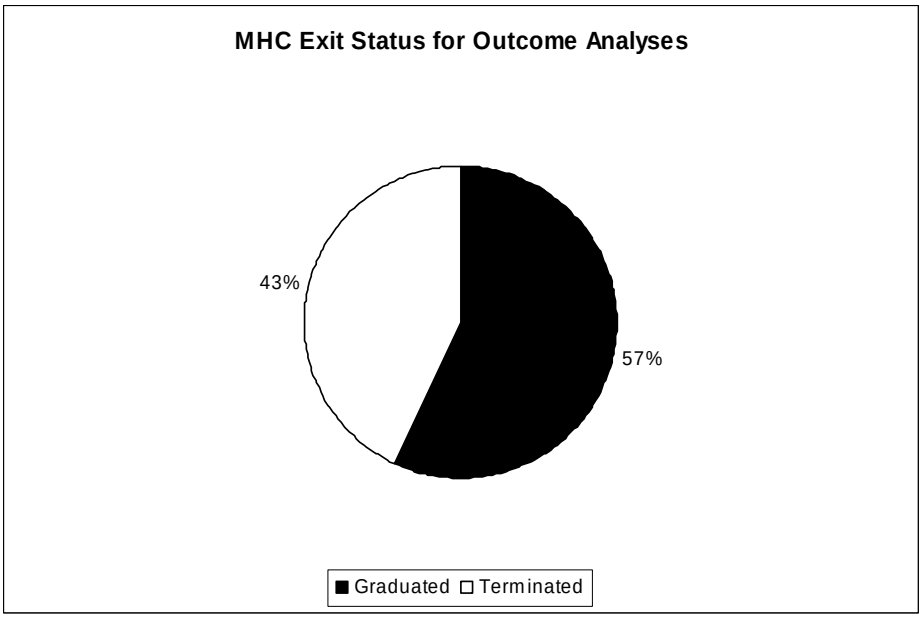


Table 10 Participant Characteristics by MHC Exit Status

	Graduated	Terminated
DEMOGRAPHICS		
Minority	14.3%	10.0%
Male	73.1%	60.0%
Ever Homeless During MHC	19.4%	24.3%
Age at MHC Start (Mn)	35.4*	32.3
CRIMINAL HISTORY		
Lifetime BCI Arrests Pre-MHC (Mn)	6.8*	9.4
BCI Arrests 3 years Pre-MHC (Mn)	3.2*	4.3
LSI Risk Score at Intake (Mn)	23.5	25.6
Jail Booking 2 years Pre-MHC	92.1%	95.7%
Total Jail Bookings 2 years Pre-MHC	2.1**	2.9
New Charge Jail Booking 2 years Pre-MHC	74.2%	80.0%
Total New Charge Bookings 2 years Pre-MHC	1.2	1.5
Most Severe New Charge Degree 2 years Pre-MHC	3.7*	4.1
MENTAL HEALTH HISTORY		
Youth Admission at VMH	22.1%	28.3%
Age at First VMH Admission	25.0	23.4
Number of VMH Admissions Pre-MHC	3.5	3.5

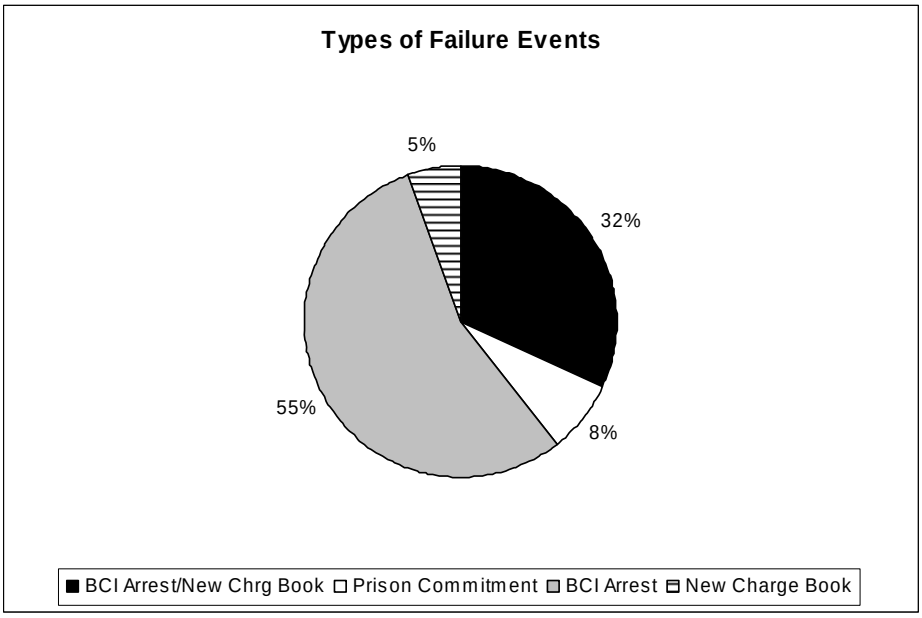
	Graduated	Terminated
MENTAL HEALTH HISTORY CONT.		
Years with Schizophrenia/Bipolar Disorder Pre-MHC	8.5	6.5
Drug Use Disorder Diagnosis Pre-MHC/At Start	59.3%	66.7%
Years with Drug Use Disorder Pre-MHC	6.8	6.3
Depression Diagnosis Pre-MHC	29.2%	28.0%
*Statistically significant at p < .05		
**Statistically significant at p < .01		

Recidivism

Recidivism can be defined in several ways, including jail bookings post-MHC, new charge jail bookings during or post-MHC, new arrests in the statewide criminal history file post-MHC, or new prison commitments. All of these recidivism outcomes were examined. In this section the recidivism variable will be the first "failure event" defined as the presence or absence of any of these events: 1) prison post-MHC start, 2) new charge jail booking post-MHC exit, or 3) new BCI arrest post-MHC exit. If a MHC participant has more than one of these events, the first one is captured and subsequent ones are ignored.

Just over half (91 of 177 exited participants (with graduate, neutral, or terminated exit status), 51.4%) had a failure event. Figure 19, below, shows type of first failure event for exited participants. Very few exited participants had a prison commitment, but most had a new arrest that was recorded in BCI only, new charge jail booking, or both. Median time to first failure event was 221 days (Mn = 300), meaning of those with a failure event, first new arrest/prison commitment was between 6 months and a year following MHC exit.

Figure 19 Types of Failure Events



MHC participants who had a failure event were quite similar to those who did not recidivate on most participant characteristics, including demographics, mental health history, and criminal history (see Table 11, below). However, exited participants who had more arrests prior to MHC, were ever homeless during MHC, or did not graduate from MHC were all more likely to recidivate. As shown in Table 11, just over one-third of graduates recidivated versus over half of neutral exit participants and 70% of terminated participants. Additionally, survival analyses demonstrated that time to failure event varied statistically significantly[10] by exit status. Graduates had an estimated 1,341 days (Md) from MHC exit to first failure event (recidivism), compared to 559 days estimated for neutral exit status participants, and only 243 estimated days for terminated participants.[11] These comparisons indicate that graduates have less recidivism and when they do have a new charge or prison commitment, it is after a longer delay.

Table 11 Participant Characteristics by Failure Event

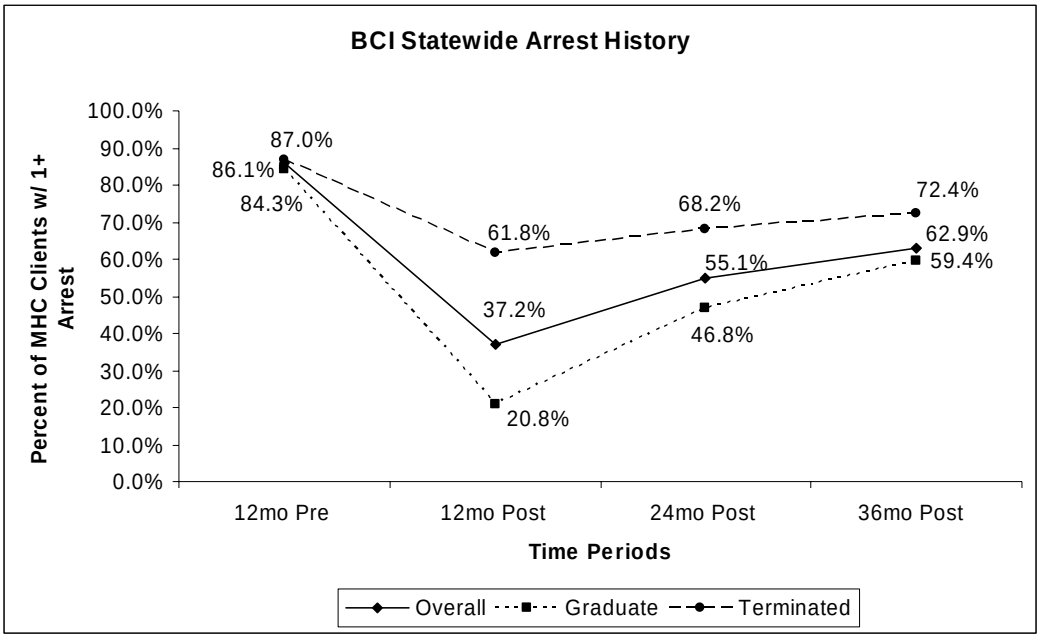
	Failure Event	
DEMOGRAPHICS	No	Yes
Minority	10.7%	14.3%
Male	61.6%	70.3%
Ever Homeless During MHC	17.4%	29.7%*
Age at MHC Start (Mn)	33.6	34.5
CRIMINAL HISTORY		
Lifetime BCI Arrests Pre-MHC (Mn)	6.7	9.3*
BCI Arrests 3 years Pre-MHC (Mn)	3.7	3.8
LSI Risk Score at Intake (Mn)	23.7	25.3
Jail Booking 2 years Pre-MHC	96.3%	91.2%
Total Jail Bookings 2 years Pre-MHC	2.3	2.7
New Charge Jail Booking 2 years Pre-MHC	76.8%	74.7%
Total New Charge Bookings 2 years Pre-MHC	1.4	1.4
Most Severe New Charge Degree 2 years Pre-MHC	3.8	3.9
MENTAL HEALTH HISTORY		
Youth Admission at VMH	24.6%	23.1%
Age at First VMH Admission	23.6	25.0
Number of VMH Admissions Pre-MHC	3.1	3.8
Years with Schizophrenia/Bipolar Disorder Pre-MHC	8.7	7.2
Drug Use Disorder Diagnosis Pre-MHC/At Start	56.9%	66.7%
Years with Drug Use Disorder Pre-MHC	5.8	7.0
Depression Diagnosis Pre-MHC	24.1%	32.3%
EXIT STATUS		
Graduated	63.4%	36.6%**
Neutral	42.9%	57.1%**
Terminated	30.0%	70.0%**
*Statistically significant at $p < .05$		
**Statistically significant at $p < .01$		

[10] Mantel-Cox $\chi^2 = 28.558$, $p < .01$

[11] Estimated time to recidivism is from Kaplan-Meier Survival Analysis, which estimates time to event based on those who have the event (e.g., recidivism) and those who do not have the event for the entire follow-up period.

Graduation status was consistently linked to better post-MHC criminal justice outcomes. For example, comparisons made by exit status showed that graduates and terminated participants did not differ on BCI arrests at intake, but differed on new BCI arrests post-MHC (see Figure 20, below). In the year prior to MHC start, there were no statistically significant[12] differences between graduates, terminated participants, and those with neutral exit status (78.6%, not shown in Figure 20) on arrest rates. In the year following exit, however, terminated participants were statistically significantly[13] more likely than neutrally exited participants (41.7%, not shown in Figure 20) and graduates to have a new arrest. The difference between terminated participants and graduates on new arrests remained statistically significant[14] at the two year follow-up, but failed to reach statistical significance[15] after three years. Time to recidivism varied by exit status as well, with terminated participants recidivating statistically significantly[16] sooner (Mn = 271 days) following MHC exit than graduates (Mn = 468 days). Therefore, not only were graduates recidivating less often than terminated participants, but even when they were picking up new charges it was significantly delayed compared to terminated participants. It should be noted that sample size decreased across each follow-up period, as fewer former participants had accrued the entire length of longer follow-up periods. Due to this, participants with neutral exit status were only included in the 12-month follow-up analyses.

Figure 20 Comparison of BCI Arrests by Exit Status



[12] χ^2 =.687, p > .05
[13] χ^2 = 22.091, p < .01
[14] χ^2 = 4.239, p < .05
[15] χ^2 =1.146, p > .05
[16] t = -2.607, p < .05

Graduates had more days between MHC exit and new jail bookings (overall and for new charges); however, these differences failed to reach statistical significance. Table 12, below, displays time to booking events from MHC exit for all participants and for the subgroups: graduates and terminated participants. Median time from MHC exit to first new jail booking for neutral exit status participants (not shown in Table 12) was 269 days, which was similar to that for terminated participants. However, neutral exit status participants' time to a new charge booking (Md = 541 days) was more in line with that of graduated participants.

Table 12 Median Days from MHC Exit to First New Jail Booking

Days to Events	All Participants	Exit Status	
		Graduated	Terminated
MHC Exit to First Post-MHC Jail Booking	291	429	261
MHC Exit to First Post-MHC New Charge Booking	343	435	262
*Graduates significantly different than Terminated Participants ($p < .05$)			

What program components and services lead to the best outcomes?

Exit Status

MHC program compliance and services received were examined in relation to exit status (graduated vs. terminated). As shown in Table 13, on the following page, participants who graduated from MHC differed most from terminated participants on program compliance variables, but did not differ much on services received. Not surprisingly, graduates had more days in the program (Mn = 567) than terminated participants (Mn = 462); however, terminated participant were in the program for more than a year on average (Md = 389). Fewer graduates than terminated participants had a jail booking during MHC (for any reason, including sanctions, warrants, or new charges), new charge jail bookings (total and confirmed), total days in jail, failures to appear in court, or bench warrants. All of these measures suggest that graduates were more compliant with MHC while active in the program, which confirms that the appropriate participants (non-compliant ones) are being terminated from the program. However, as shown in Table 13, a fair percentage of graduates had jail bookings during MHC (42.7%), failures to appear (52.9%), and bench warrants (24.3%). Of those who had at least one bench warrant, graduates did not differ from terminated participants on total number of bench warrants or days away from the program while out on bench warrant. This finding indicates that these forms of non-compliance are not necessarily grounds for termination and that MHC participants are given several opportunities to succeed. These data reflect the harm reduction policies of the MHC as described by team members. Graduates had court hearings that were slightly more frequent than terminated participants, but this difference was not statistically significant. It should be noted that this comparison of frequency of court hearings was for all scheduled hearings, whether the participant appeared or not.

Table 13 Program Components by Exit Status

	Graduated	Terminated
PROGRAM COMPLIANCE		
Days in MHC (Mn)	567*	462
Any Jail Booking During MHC	42.7%**	91.4%
New Charge Bookings During MHC (Mn)	.12**	0.46
New Charge Bookings During MHC (Confirmed) (Mn)	0.03*	0.28
Days in Jail During MHC (any reason) (Mn)	46.4**	117.1
Failure to Appear (at court)	52.9%**	85.1%
Bench Warrant	24.3%**	76.6%
Days between Scheduled Court Hearings (Mn)	10.6	12.5
Noncompliance Events (of those w/ 1 or more) (Mn)	7.1	10.3
Total Bench Warrants (of those w/ 1 or more) (Mn)	1.7	1.9
Days out on Bench Warrant (of those w/ 1 or more) (Md)	14.0	23.5
SERVICES RECEIVED		
Housing Assistance and/or Residential Tx	44.1%	58.6%
Drug Testing	67.5%	74.2%
AP&P Supervision	66.7%	78.6%
Inpatient Treatment	10.1%	13.1%
Residential Treatment	55.7%	59.0%
NAMI Bridges	58.6%*	23.8%
Days between Outpatient Treatment Services (Md)	8.6	6.7
Days between Case Management Services (Md)	4.6	4.6
Days between Medication Management Services (Md)	12.6	10.0

*Statistically significant at $p < .05$
**Statistically significant at $p < .01$

Graduates and terminated participants were equally likely to receive housing assistance, drug testing, AP&P supervision, inpatient treatment, and residential treatment. Significantly more graduates participated in NAMI's Bridges classes than terminated participants; however, this comparison was limited to the 50 MHC participants who had both exited MHC and had their records queried at NAMI. Lastly, there was no difference in frequency of outpatient treatment, case management, or medication management services for graduates and terminated participants who received those services during MHC (nearly every participant received these services; see Figure 6 on page 20, in the "*What services are MHC participants utilizing during participation?"* section). A logistic regression was conducted to look at the relationship between both participant and program characteristics and likelihood of graduation; however, sample size was too small to report on the results.

Recidivism

The only program compliance variables significantly related to a failure event[17] (recidivism) were jail use measures (see Table 14, below). More MHC participants who recidivated had at least one jail booking during MHC (for any reason, including sanctions and warrants) and new charge booking(s). Furthermore, participants who recidivated following MHC spent significantly more days in jail during MHC (Mn = 104.6 days) than those who did not re-offend post-MHC (Mn = 67.9 days). These measures may indicate that use of jail during MHC should be limited as presence of bookings for any reason (including when participants do not have a new charge) and increased days in jail during MHC are associated with post-MHC recidivism.

Several of the program compliance measures that were significantly related to exit status (i.e. days in MHC, failures to appear, bench warrants) were not significantly related to recidivism. This suggests that individuals who are not compliant will not succeed in the program, but they may still benefit from reduced recidivism following MHC exit. As shown in the comparisons of graduated and terminated participants on recidivism measures in the "*Who has the best outcomes in MHC?*" section, graduates do have better outcomes than terminated participants. However, all MHC participants, regardless of during program compliance and exit status, show reductions in criminal involvement following MHC participation.

The only program services variable significantly related to recidivism (failure event) was participation in NAMI's Bridges program, where non-recidivists had a significantly higher rate of Bridges participation. It should be noted that this analysis was only for 53 MHC participants who had exited MHC and had their NAMI records queried.

Table 14 Program Components by Failure Event

	Failure Event	
PROGRAM COMPLIANCE	No	Yes
Days in MHC (Mn)	559	476
Any Jail Booking During MHC	54.9%	75.8%**
New Charge Bookings During MHC (Mn)	0.13	0.38*
New Charge Bookings During MHC (Confirmed) (Mn)	0.05	0.21
Days in Jail During MHC (any reason) (Mn)	67.9	104.6**
Failure to Appear (at court)	63.8%	70.2%
Bench Warrant	37.1%	51.7%
Days between Scheduled Court Hearings (Mn)	11.7	12
Noncompliance Events (of those w/1 or more) (Mn)	8.4	8.8
Total Bench Warrants (of those w/ 1 or more) (Mn)	1.9	1.8
Days out on Bench Warrant (of those w/ 1 or more) (Md)	20.5	19.0

[17] Failure event "recidivism" is defined as having any of the following a) a prison commitment at MHC exit or post-exit, b) a new charge booking in JEMS post-MHC exit, or c) a new arrest in the BCI record post-MHC exit

	Failure Event	
SERVICES RECEIVED	No	Yes
Housing Assistance and/or Residential Tx	41.9%	53.8%
Drug Testing	69.9%	70.5%
AP&P Supervision	72.1%	70.3%
Inpatient Treatment	14.1%	14.1%
Residential Treatment	57.7%	59.0%
NAMI Bridges	54.1%	25.0%*
Days between Outpatient Treatment Services (Md)	8.4	7.2
Days between Case Management Services (Md)	4.7	4.4
Days between Medication Management Services (Md)	11.6	12.3

*Statistically significant at $p < .05$
**Statistically significant at $p < .01$

Participant and program predictors of recidivism. A logistic regression was conducted to look at the relationship between both participant and program characteristics and likelihood of failure event. The variables significantly related to recidivism in the bivariate analyses (lifetime pre-MHC arrests, homelessness during MHC, presence of jail booking during MHC, and exit status), as well as days in MHC were included in the model. Although not significant in the bivariate analyses, length of time in MHC was included to examine whether time in MHC program and exit status were both significant in predicting recidivism, or if one was more important than the other.

When all of the factors were considered together, the statistically significant[18] predictive model demonstrated that having a jail booking during MHC and length of time in MHC both were significantly related to recidivism. As shown in Table 15, below, having any jail booking during MHC was associated with a 23% increased likelihood of post-MHC recidivism, while each additional day in MHC was associated with a decreased likelihood of recidivism (of 0.2% per day). Because time in MHC remained significantly related to likelihood of failure event, but MHC exit status did not, it is believed that the strong relationship between exit status and recidivism seen in the bivariate analyses is an artifact of length of time in the program. Where graduates spend more time in MHC than terminated clients, they see increased benefits post-exit. This interpretation is consistent with the overall positive findings for reduced recidivism for all MHC participants, considering that even terminated clients spend a substantial amount of time in the program.

Table 15 Significant Predictors of Failure Event from Combined Logistic Regression

Variable	B	Wald	p	Exp(B)
Any Jail Booking During MHC	.207	4.50	0.03	1.23
Days in MHC	-.002	8.37	< 0.01	0.998

[18] Model $\chi^2 = 27.263$, $p < .01$; Nagelkerke $r^2 = .205$; Hosmer & Lemeshow $\chi^2 = 9.995$, $p = .265$

How does the SLCo MHC compare to the mental health court model?

The Essential Elements of Mental Health Courts

Introduction

In a recent national survey of MHCs, Erickson, Campbell, and Lamberti (2006) found that little consistency in the policies and procedures of MHCs exist. The implications of such variability are vast when attempting to evaluate the effectiveness of a MHC. To address this and other concerns regarding the implementation of MHCs, the Bureau of Justice Assistance (BJA), in collaboration with various MHCs and professionals in the fields of criminal justice, mental health, and substance abuse, identified 10 essential elements of mental health courts (Thompson, Osher, & Tomasini-Joshi, 2007)**.** The following section gives a brief summary of each element and how each compares to current research available on MHCs and the Salt Lake County Mental Health Court, specifically. A table in Appendix B further contrasts the basic elements of the most commonly documented MHCs in the literature.

1. Planning and Administration

The development and operation of a MHC should encompass a broad-based group of stakeholders from systems including: criminal justice, mental health, substance abuse treatment, and the community. All systems should take part in guiding the planning and administration of the court. All MHCs should identify agency leaders and policymakers to serve on an "advisory group" responsible for tasks such as, monitoring the court's adherence to its mission and supporting the "court team," that is involved with day-to-day operations. MHCs are advised to operate the MHC within the "context of broader efforts to improve the response" of the criminal justice system to mentally ill offenders.

Salt Lake County. A review of the SLCo MHC's history shows that the planning and pilot operation of the MHC began with collaboration from key stakeholders in the judicial, mental health, police, and corrections fields, as well as political leaders. The SLCo MHC has participation from a diverse set of professionals including a county clerk, case managers, Utah Chapter of the National Alliance on Mental Illness (NAMI) representatives, law enforcement agencies, the Legal Defenders Association, jail personnel, and Valley Mental Health (VMH).

Interviews with the court team indicate that several current team members have been involved with the court since its inception. Additionally, several team members acknowledge the importance of operating the MHC within the broader context of the criminal justice system and advocate for improved responses to mentally ill offenders throughout the system in accordance with the BJA recommendations.

2. Target Population

A great deal of consideration and emphasis should be placed upon the target population, with clearly defined clinical eligibility criteria. MHCs should target defendants whose current offenses are a result of their mental illness and only consider a client if their specific need for mental health treatment can be met with existing treatment options. However, the MHC team should improve access to treatment and advocate for increased capacity whenever possible. MHCs should also coordinate closely with drug courts and other problem-solving courts as clients may overlap.

Other MHCs. A review of eight MHCs: 1) Broward County, FL; 2) King County, WA; 3) San Bernardino, CA; 4) Anchorage, AK; 5) Santa Barbara, CA; 6) Clark County, WA; 7) Seattle, WA; and 8) Marion County, IN found that seven of the eight courts focus primarily on misdemeanor cases (Redlich, Steadman, Petrila, Monahan, & Griffin, 2005). Additionally, in a survey of over 100 MHCs it was found that most (98%) indicated that they accept misdemeanant defendants, while 27% accept those charged with felonies, and only 4% accept defendants charged with violent felonies (Erickson et al., 2006).

It is apparent that the majority of courts require mental illness as a prerequisite (Redlich et al., 2005). This, however, does not provide much insight into the types of illness typically seen in MHCs. In a survey of over 100 MHCs, it was found that 28% of MHCs required *any* diagnosis of ‘‘mental illness” while another 38% required that participants have an ‘‘Axis I’’ diagnosis for admission. Only 21% require the presence of a severe and persistent mental illness (SPMI) and 18% of courts did not provide any diagnostic eligibility criteria (Erickson et al., 2006). These findings clearly indicate that while a “mental illness” diagnosis is generally a prerequisite for participation, the way the illness is defined for eligibility varies across courts.

Lastly, three out of eight courts included defendants with developmental disabilities and all eight courts allowed defendants with substance abuse disorders (Redlich et al., 2005). One study indicated that MHC clients are more likely to be older, white, and female when compared to individuals in traditional courts; however, this over-representation occurs at the point of referral, rather than at the point of the court’s decision of eligibility (Steadman et al., 2005). These findings clearly indicate that there is a wide variation in the types of clients served through MHCs. Such variations are implicated heavily in the findings of recidivism and public safety and should be considered when evaluating the effectiveness of any MHC. It should also be noted that the differences among MHCs may be a product of financial and logistical constraints.

Salt Lake County. In regards to BJA’s essential elements, SLCo MHC’s clinical criterion for inclusion is clearly defined: presence of a DSM Axis I diagnosis of Schizophrenia, Bi-Polar Disorder, or Schizo-Affective Disorder. Also in accordance with the BJA recommendation on target populations, the MHC team described a thorough review of clients’ historical records and a complete clinical assessment prior to acceptance into the court. Similarly, the team discussed the practice of only accepting clients that can be

served with existing treatment resources and also mentioned several efforts to improve treatment and service options. Team members provided examples of MHC clients transitioning into and out of the local drug court as either substance abuse or mental illness are identified as a client's primary problem.

In comparison to other MHCs, SLCo's MHC clinical criterion (Axis I, Schizophrenia, etc.) are similar to MHCs in Clark County, WA; Marion County, IN; and Akron, OH. Similar to other courts reviewed in the literature, they also serve several dual-diagnosis clients with substance abuse issues. SLCo MHC team members discussed that the court has occasionally tried to serve lower-functioning and developmentally disabled individuals; however, there is no clear policy on this.

SLCo MHC's acceptance of both misdemeanants and felons differentiates them from the majority of other MHCs. As previously mentioned, in a survey of over 100 MHCs, only 27% of courts accepted offenders charged with felonies for participation. It seems that a new trend is arising with the acceptance of low-level felons (e.g., property crimes) but that the majority of courts still only address misdemeanants. This finding is noteworthy as the acceptance of felons is accompanied with increased responsibly regarding supervision and attention to public safety. Other courts that accept felons include: San Bernardino and Santa Barbara, CA; Orange County, NC; Washoe County, NV; and Bonneville County, ID.

Lastly, the SLCo MHC is similar to all courts, and in compliance with BJA guidelines, in their requirement that participants be mentally competent and participate voluntarily.

3. Timely Participant Identification and Linkage to Services

MHCs have a duty to identify participants quickly and should welcome referrals from many sources (such as, law enforcement, jail staff, defense, judges, and family members), but select one or two agencies to be primary referral sources. Additionally, primary referral sources must be well educated on procedures and eligibility criteria.

The other best practice guidelines outlined by BJA are:

- Prompt review by the prosecutor, defense counsel, and a licensed clinician for eligibility.
- Ensuring that the time required to accept someone into the program does not exceed the length of the sentence that the defendant would have received in a traditional court.
- Final determination of eligibility by the team.
- Minimize the time needed to identify appropriate services.

Other MHCs. In reviewing various courts in practice, it was found that each court identifies possible participants within the first 24 to 48 hours of arrest, although the actual review process may take longer (Redlich et al., 2005). Additionally, a review of Fort

Lauderdale, FL; Seattle, WA; San Bernardino, CA; and Anchorage, AK; found that all four MHCs seek to expedite early intervention through timely identification of candidates. In these courts, screening and referral of defendants takes place within timeframes ranging from immediately after arrest to a maximum of three weeks after the defendant's arrest, depending on the jurisdiction (Goldkamp & Irons-Guynn, 2000).

A somewhat different finding was seen in a review by Steadman and Redlich (2005). In their review they found that the length of time that elapsed from referral to disposition varied widely, ranging from an average of one day to more than 45 days. In 39 cases, courts were found to make the dispositional decision on the same day as the referral. When removing these cases from consideration, the average length of time from referral to disposition was 32 days (Steadman & Redlich, 2005).

One factor that influenced timely intake into MHC programs was acceptance rate. In a review of seven MHCs, it was also found that the courts differed significantly in terms of dispositional decisions**.** In regards to dispositional decisions, the proportion of all referrals ultimately accepted by the courts ranged from 20 to 100%. Bonneville County, ID and Orange County, CA MHCs had the lowest rate of acceptance (approx. 20%). Three MHCs accepted approximately half of the cases referred to their court, while the remaining two courts accepted all or nearly all of their referrals. It is important to note the Bonneville MHC has a low acceptance rate because they are linked with an ACT team that can only accommodate a maximum of 20 defendants at a time (Steadman & Redlich, 2005).

Salt Lake County. During individual interviews, the MHC team members identified a variety of referral sources, including defense (private and Legal Defenders Association (LDA)) attorneys, judges, jail personnel, law enforcement, and AP&P. The consensus was that LDA is the primary referral source. LDA attorneys get ongoing education about MHC criteria and have in-house personnel to assist with the evaluation of potential clients for legal and clinical criteria. Team members have expressed some challenges with getting clients into the court in a timely manner. One option they are exploring to speed up the process is helping clients apply for treatment funding (Medicaid) while they are in the jail awaiting placement in MHC. This would allow for treatment resources to be made available to them immediately following release from jail. In cases where it has not been possible to thoroughly determine a client's clinical appropriateness for MHC within one to two months (e.g., out-of-state records), their case is sent back to regular court. Lastly, the team provides input on acceptance into the MHC, but final approval rests with the prosecutors, as they are ultimately responsible for public safety.

4. Terms of Participation

Parameters for legal agreements, program duration, supervision conditions, and the impact of successful and unsuccessful program exit should be clearly defined. Best practices include:

- Individualized plans put in writing prior to decision to enter the program
- Informing potential clients of consequences of noncompliance and potential effects of a criminal conviction
- Keeping the length of MHC within the maximum period of incarceration or probation received if found guilty in a traditional court
- Use of the least restrictive supervision conditions
- Providing successful participants with positive legal outcomes, such as plea in abeyance, reduction or dismissal of charges, or early terminations of supervision

Plea Agreements & Other MHCs. Some variability was observed in the way the courts deal with the criminal charge(s) against an individual. While no courts under review dropped criminal charges at the time a defendant voluntarily agreed to participate in the mental health court, courts varied considerably in terms of how they managed the disposition of criminal charges. Marion County, Seattle, and Broward County MHCs employed pre-adjudication mechanisms for disposition of charges, whereas other courts required guilty pleas as an eligibility criterion.

Additionally, some courts are not fixed in their adjudication and have either changed their model due to prosecutor's preferences or have shifted between two different models depending on the participant. For example, Clark County uses pre-adjudication methods for City of Vancouver cases but requires a guilty plea for non-residents of their city (because of county prosecutor preferences). Additionally, Santa Barbara began with a pre-adjudication approach but has shifted to a greater emphasis on a post-plea approach due to prosecutor preference. It is interesting to note that this shift has resulted in increased recruitment into their mental health court (Redlich et al., 2005).

While these findings suggest that there is considerable variability in MHC courts, a review of over 100 courts found that plea bargains were required for admission in nearly half (43%) of the courts surveyed (Erickson et al., 2006). Thus, these studies indicate that while there is some variability in the plea agreement policies seen in MHC courts, a considerable amount of courts rely on a pre-adjudication strategy for eligibility. It should also be noted that changes in the plea agreement policies are possibly due to logistical factors.

The Decision to go to Trial & Other MHCs. The implications of a participant's decision to go to trial also differ across MHCs. In King County, during the first year of operations, defendants were required to waive their right to a trial in order to participate in MHC. Therefore, the option to participate in MHC was no longer available to defendants following conviction. Currently, defendants are not required to waive this right and admission can be granted following a trial that led to conviction. Many other MHCs have no strict policy against accepting individuals who have opted for a trial, been convicted, and then requested admission to the MHC. However, in these cases, admission is not guaranteed, and is decided on a case-by-case basis (Steadman & Redlich, 2005).

Resolving Criminal Charges & Other MHCs. In the resolution of criminal charges, a review of several courts found that 26% dismissed criminal charges upon completion of

the program; while 15% used probation and 13% employed suspended sentences (Redlich et al., 2005).

The nation's first four MHCs differ in their method of resolving criminal charges. Successful participants in Broward often have no conviction on their records, as charges are generally resolved through a "withheld adjudication" or a dismissal of the charges. In King County, a significant policy adjustment has recently been made. As such, deferred prosecutions and deferred sentencing are now granted liberally, increasing the likelihood that successful completion will result in a dismissal of charges. The remaining two MHCs generally require pleas of guilty or no contest in order to enter the program, with the option of deferred disposition or deferred adjudication offered rarely to defendants with few or no prior contacts. In Anchorage, only these few defendants may end up without a conviction. In San Bernardino, however, successful completion may result in a withdrawal of the plea and expungement of the participant's criminal record (Redlich et al., 2005).

Supervision & Other MHCs. For most courts, the duration of mental health treatment and court supervision is determined by the state's maximum sentence allowed for misdemeanors—one year in the case of Broward County and Marion County and two years in the case of King County, Seattle, San Bernardino, and Clark County. San Bernardino has a fixed duration of three years for felony cases and Santa Barbara has a fixed duration of 18 months for all cases (Redlich et al., 2005).

In this review, three primary models of supervision used by MHCs were identified. The first uses existing community treatment providers, with reports back to the court when there are difficulties (Broward County, Anchorage, and most Clark County cases) or on a regular basis (Marion County). The second model uses staff from the MHC or the probation or parole office to monitor care in the community (Seattle has specialized mental health probation officers, King County has probation officers, and Anchorage has a Jail Alternative Services Project caseworker). The third model (San Bernardino and Santa Barbara) combines the use of probation and mental health staff to provide supervision.

Finally, the literature indicates that most MHCs provide supervision of participants that is more intensive than would otherwise be available in regular court participation. All types of supervision have an emphasis on accountability and monitoring of the participant's performance. For example, four representative MHCs share the core role of the judge at the center of the treatment and supervision process. Here the judge has overall accountability for the treatment direction and process (Griffin, Steadman, & Pertila, 2002).

Salt Lake County. SLCo MHC follows most of the BJA recommendations for terms of participation. Legal outcomes for successful participation are clearly defined at the time of intake into the program. Clients are informed by the defense attorney of the consequences of noncompliance and ramifications of unsuccessful participation. The MHC uses the least restrictive treatment and supervision options necessary and tailors terms of participation to each client. They have a formalized process for presenting

general terms of participation to potential clients in writing, but do not individualize these signed MHC Agreements. It is recommended that the MHC explore options for individualizing the signed agreements if possible. It is also suggested that they provide clients with a complete MHC Handbook/Policy Manual at intake. This reference document would provide a single source of program information, such as requirements, sanctions, incentives, and contact information for partnering agencies. An Example Participant Handbook was compiled from other MHCs is provided in Appendix C. Additionally, SLCo ensures that clients are not held in MHC longer than they would have been incarcerated or in an alternative program. In fact, the length of participation in MHC is restricted by the length of probation that is required for the presenting charges.

In comparison to the other MHCs reviewed, SLCo accepts clients post-plea. Most clients participate under the conditions that their charges may be reduced or probation supervision terminated early upon successful participation. Team members indicated that plea in abeyances are used less frequently. SLCo MHC's supervision model is most similar to that of San Bernardino and Santa Barbara, using both treatment staff and probation agents to report clients' compliance and progress to the court.

5. Informed Choice

MHC participation should be voluntary and informed, which requires legal competency. It is recommended that individualized terms of participation be put in writing and reviewed with defense counsel.

Other MHCs. The importance of competency and voluntary participation in the context of MHCs is well document in the literature (Poythress, Petrila, McGaha, & Boothroyd, 2002; Redlich, 2005; Stafford & Wygant, 2005). However, research on competency and voluntary participation in MHCs is limited (Redlich, 2005). Existing research does demonstrate the need to better document and formalize these processes (Boothroyd, Poythress, McGaha, & Petrila, 2003). Research on voluntary participation and mental health treatment outcomes typically demonstrates that voluntary participation leads to better outcomes (Winick, 1997). A thorough review of these issues and how they have been addressed in other MHCs is provided in Appendix A.

Salt Lake County. The SLCo MHC's procedures follow the BJA recommendations closely. Attorneys on the MHC team indicated that legal competency was required for participation in the program and that the state hospital is used to restore a person to competence, when necessary. In some instances, clients have been found competent at intake, but later decompensated and were sent to the state hospital until their competence was restored. The state hospital is used by the MHC for this purpose during all phases of the program. There was consensus among the team that participation is informed and voluntary. This is ensured through several processes, including the attorneys (defense and prosecution) and treatment representative discussing the program with potential clients and gauging their interest and awareness of the risks and benefits. Most importantly,

nearly all clients are required to wait until a week after orientation before entering a plea and signing the MHC agreement.

6. Treatment Supports and Services

Courts need to ensure access to a wide variety of treatment options, including medications, counseling, substance abuse treatment, benefits, housing, crisis intervention services, and peer support groups. Ongoing and frequent communication between the court and treatment is necessary. Case management, with appropriate caseload size, is also essential. Additionally, the MHC and case manager should help prepare clients for exit by linking them to resources that will be available to them after they leave MHC.

Other MHCs. Several MHCs, such as Orange County, NC; Brooklyn, NY; and Bonneville County, ID, provide treatment through the Assertive Community Treatment (ACT) model. ACT provides team-based intensive services in a community setting for people with mental illness. The ACT team consists of outreach providing psychiatric and nursing services, case management, peer counseling, and family support. The literature has consistently shown ACT as being one of the most effective treatment modalities for people with mental illness. For more information on ACT, see the following studies: Tsemberis, Gulcur, and Nakae, 2004; Dixon, Friedman, and Lehman, 1993; Dixon, Krauss, Myers, and Lehman, 1994; Morse, Calsyn, Klinkenberg, Helminiak, Wolf, and Drake, 2006; Calsyn, Klinkenberg, Morse, and Lemming, 2006.

The research indicated that courts differ significantly in terms of caseload size. The Bonneville County, ID MHC serves approximately 20 defendants at a time while Santa Clara County, CA allows more than 600 in at a time (Steadman & Redlich, 2007). Appropriate caseload size has been consistently correlated to the effectiveness of treatment programs (Rapp, 1998).

When assessing the strategies of treatment provisions in MHC courts, it was found that a core ingredient of the MHC approach is an emphasis on creating a new and more effective working relationship with mental health providers and support systems. Goldkamp and Irons-Guynn (2000) noted that the absence of such relationships, in part, accounts for the presence of mentally ill offenders in the court and jail systems. This relationship can take form in many ways. Steadman and Redlich (2005) observed MHC staff developing individualized treatment plans, reviewing and adjusting such plans regularly, attending scheduled court review hearings, meeting with vocational training officers, assisting in finding and maintaining employment, and assisting in various other tasks.

Salt Lake County. The SLCo MHC provides the variety of services and supports recommended by BJA. Funding for medications has been provided by several sources, including VMH and AP&P. Specialized staff at VMH immediately begin working with MHC clients to access benefits (e.g., Medicaid & Social Security) to help pay for their medications, treatment, and other needs. Mental health and substance abuse treatment is

provided through several VMH programs, including the Forensic Unit, JDOT, and CTP. JDOT follows the ACT model which has been identified as an effective practice for serving the mentally ill in the community. CTP at VMH provides crisis intervention services, while NAMI provides peer supports. Case management is provided by dedicated MHC staff at both CJS and VMH. Some team members indicated that the caseload size at the MHC is becoming too large; however, the addition of the JDOT team, that provides extra support to the most difficult MHC cases, may help alleviate some of this stress. As suggested by BJA, all members of the treatment and supervision teams frequently communicate with one another and the court. One area along the continuum that the MHC is currently struggling with is developing a sufficient transition plan and resource linkages for exiting clients. Several team members identified a number of resources, such as VMH and NAMI, that are still available to clients after exiting MHC; however, they have found it difficult to keep clients engaged once they are no longer court ordered to participate. The team is currently working toward improving this transitional piece, with the case manager at CJS spearheading the movement.

7. Confidentiality

"A well-designed procedure governing the release and exchange of information is essential to facilitating appropriate communication among members of the mental health court team and to protect confidentiality" (Thompson, Osher, & Tomasini-Joshi, 2007, p. 7). Release forms should be used, but only necessary information should be provided. Additionally, courts should keep criminal and clinical files separately.

Salt Lake County. It appears that the SLCo MHC fulfills the above criterion in ensuring confidentiality. A review of the various release of information forms appear to be in compliance with this goal. The release forms allow for safe exchange of information between key players in Salt Lake, including the Salt Lake County Metro Jail Mental Health Services, Valley Mental Health, and Criminal Justice Services. Of particular importance is the section of SLCo's release of information that requires a designation of the type of information disclosed. Requiring informants to authorize the separate disclosure of: 1) mental health diagnosis and treatment, 2) medical diagnosis and treatment, 3) legal issues/records, 4) jail/custody data, and 5) alcohol and substance abuse treatment, appears to be an effective means of fulfilling the above recommendation; that only necessary information be provided.

8. Court Team

The court team must work collaboratively and should include the following: judge, treatment provider or case manager, prosecutor, defense attorney, and, perhaps, a probation officer. A court coordinator can help the court's operations, but the judge's role is central to the success of the MHC. It is recommended that team members are willing to adapt to non-traditional roles and cross-train.

Other MHCs. The majority of courts rely on a court team for various court-related tasks including the determination of eligibility. For example, in a review of ten courts, all courts reported relying on a court team to inform the judge regarding decisions of eligibility. Additionally, in San Bernardino, a consensus by all court team members is required for eligibility (Goldkamp & Irons-Guynn, 2000; Redlich et al., 2005). These finding highlight the important role court teams play in MHC processes.

Additionally, many courts have been identified as making use of a dedicated team approach. These MHCs rely on representatives of the relevant justice and treatment agencies to form a cooperative and multidisciplinary working relationship with expertise in mental health issues. Key players often include the judge, prosecutor, court monitor, court clinician, case manager, and mental health court liaisons (Goldkamp & Irons-Guynn, 2000).

Salt Lake County. As recommended by BJA, the SLCo MHC team is comprised of a diverse group of professionals, including the judge, defense attorney, two prosecutors (misdemeanor and felony), clinician, case managers, additional treatment staff, probation officers, a representative from the jail MH services, county housing representative, NAMI mentors, court clerk, and administrative staff. A specialized law enforcement team that deals with the mentally ill also collaborates with the team regularly. These individuals are involved with all of the recommended tasks, from referring and screening cases through supervision and preparing clients for exit. The SLCo MHC does not have a specialized court coordinator. Team members indicated that the judge's role and dedication to the program is central to its success.

Observations of pre-court staffings and interviews with the team members make it abundantly clear that they work collaboratively and are comfortable with taking on non-traditional roles. It is not uncommon for the prosecutors to advocate for more creative treatment options, while the treatment staff suggest criminal justice responses to a client's noncompliance. Additionally, several of the court team members have been involved with the MHC since the planning stages and its inception. The team is viewed as a major asset of the local court.

9. Monitoring Adherence to Court Requirements

Monitoring compliance should begin with information sharing from a variety of sources. Regular status hearings will allow the court to respond to participants' behavior and apply incentives or graduated sanctions as necessary. Modification of treatment plans should often be the first response to noncompliance and use of jail should follow specific protocols. Options for incentives should be as broad as the range of graduated sanctions, and should include things such as praise, coupons, phase completion certificates, and decreased frequency of appearances. All incentives and sanctions should be individualized.

Status Hearings & Other MHCs. Schedules for court review of individual participants' progress vary. Seattle and Anchorage hold status review hearings as needed, depending on the participants' needs, compliance, and stability. Marion County reviews every month. Broward County and King County review at regular intervals and as needed. Participants in San Bernardino are seen every three to four weeks. Clark County and Santa Barbara see participants weekly and then less frequently if they are stable. However, schedules for court reviews are more a product of limited court resources than a preference of frequency (Redlich et al., 2005).

Incentives & Other MHCs. It was found that many of the courts use dismissal of charges after successful completion of the mental health court program as an incentive to participate in community treatment and avoid reoffending. Clark County allows the plea to be withdrawn and charges dismissed upon successful completion of the program. Santa Barbara may terminate probation early or dismiss the probation violation with successful completion. San Bernardino dismisses charges, and the defendant may petition for an expungement of the charges from their record. A common incentive is for the court to provide verbal praise, such as a congratulatory announcement by the judge in open court (Steadman & Redlich, 2005). Such forms of incentives can be very reinforcing to participants and encourage further success.

Use of Sanctions & Other MHCs. A review of eight MHCs under operation since the late 1990's shed some light on the typical procedures employed by longstanding MHCs to address noncompliance. The courts differed in their use of sanctions; however, it was found that jail time as a sanction was used sparingly. Only one court, which targets felony cases, reported frequently using jail as a sanction. Other sanctions include returning the person to court for hearings, reprimands, and admonishments, as well as stricter treatment conditions and changes in housing. San Bernardino is different from the other courts in its use of community service as a sanction (Redlich et al., 2005).

In the aforementioned survey of over 100 MHCs, findings were that sanctions for treatment noncompliance varied as well, with 24% using incarceration as a sanction; 22% modifying treatment plans; 14% using other methods, such as community service; and 14% terminating them from the program and sentencing them on their original charge (Erickson et al., 2006).

Lastly, in their review of four primary MHCs, Goldkamp and Irons-Guynn (2000) also found that mental health courts can differ significantly in their handling of noncompliant participants. While each court accepts relapse as a part of the treatment given the population of mentally ill offenders, courts vary in the way they impose sanctions for noncompliance. The most severe sanction is generally seen as program termination followed by jail confinement. The use of this sanction is reportedly least likely in Broward and Anchorage, somewhat more likely in King County, and relatively commonplace in San Bernardino. The authors note that the difference in approach is accounted for in part by philosophical differences among the sites regarding the appropriate response to noncompliance; however, it is also related to differences in the

type of candidate admitted to the courts. San Bernardino is the only site that accepts low-level felony offenders.

Salt Lake County. The SLCo MHC monitors compliance through regular and thorough staffing of each client's case. Observations of pre-court staffing demonstrated that the entire court team is very knowledgeable of clients' compliance, successes, and challenges in all aspects of their lives (e.g., treatment, housing, family). Regular status hearings, with the clients present, are also held in the courtroom. Reducing the frequency of status hearings from every week to every two weeks is used as an incentive. However, team members noted that they have not had much success when decreasing the appearances to less often than once every two weeks. Regular court appearances and interactions with the judge become very important to the clients. Other MHCs that serve felony offenders generally have more frequent review hearings than courts that serve misdemeanors only.

It appears that SLCo is similar to most courts in their use of verbal praise as an incentive. Nearly every court team member also indicated the use of the "Rocket Docket" as a powerful incentive for clients. At the beginning of each court session, clients who are doing well are called on the Rocket Docket list. These clients get to go before the judge before the clients who are not doing as well and get to leave court earlier. They also receive individual praise during the interaction, followed by applause from the judge, team members, clients, and spectators. Some team members indicated additional resources provided to clients, such as paying for medications or housing options, as other forms of reward for participation. However, other team members indicated that these supports and services were "rights" and not rewards. Other types of tangible rewards had been tried in the past (such as coupons, certificates), but team members expressed that they had found that these were not as effective with the MHC population. As with the other MHCs reviewed in the literature, the ultimate reward for participation can be the dismissal (if plea in abeyance) or (more frequently) reduction of charges upon successful completion of the program. Clients may also have three to six months cut from their probation upon successful completion. It appears that the range of incentives may not be as broad as the options for sanctions; however, the team expressed that the current incentives are sufficient.

Several team members used the phrase "graduated sanctions" when describing the court's response to participants who are not making progress. Removal from the Rocket Docket and increased structure and treatment are often the first responses to noncompliance. Depending upon the infraction, community service can be utilized next. Clients often complete their community service at MHC partnering agencies, such as treatment and housing providers or NAMI. This allows them to contribute back to the program and remain connected with supporting agencies while completing their sanction. The next level of sanctioning can include in-court drug testing and taking a client into custody during the court hearing, but releasing them at the end of the session. Jail is the final sanction that the team tries to use sparingly; however, data suggest it is the third most commonly used sanction after verbal warnings and removal from the Rocket Docket. One problem with booking MHC clients into the jail is that they have to stay at least three days and up to a week just to get their medications to them and to get them re-stabilized

before release. This was a frustration voiced my many team members, as jail cannot be used as a brief sanction. It was also noted that jail may not be an effective sanction for some MHC clients "if there is no difference to clients between 5 and 50 days" for them. Most team members viewed the use of jail, and all sanctions, not as punishments, but as a way to stabilize clients. The team is also careful to reward incremental success and acknowledges that relapse and set backs are a normal part of working with this population.

10. Sustainability

To ensure long-term sustainability, courts should have detailed policies and procedures and document the court's history, goals, eligibility criteria, information-sharing protocols, referral and screening procedures, treatment resources, sanctions, and incentives. Another aspect is collecting quantitative data on outputs (i.e., number of persons served) and outcomes (i.e., recidivism), complementing it with qualitative evaluations of the program. Also essential to sustainability are securing and cultivating relationships with long-term funders and outreach to the community and key stakeholders.

Salt Lake County. A review of program documents shows that the SLCo MHC has formalized and documented goals; eligibility criteria; partnering agencies; referral, screening, and information sharing protocols; client MHC Agreement; and a list of typical program requirements. It is recommended that they document treatment and support service resources as these have expanded and changed recently. It would also benefit the program to have a more formalized array of sanctions and incentives. Good record keeping on the program's components is essential for sustainability, especially if key team members depart. This evaluation is the first comprehensive study of the program. It includes quantitative data on outputs and outcomes, as well as a qualitative analysis of the courts processes.

Recommendations

Some suggestions for program improvements resulted from the process of conducting this evaluation, as well as from the results obtained. The recommendations divided into two general areas: a) program operations and b) records and future evaluations.

In regards to program operations, it is suggested that the MHC consider the following eight suggestions for improvements.

1. Continue to refine and document their target population. Although the data suggest that the MHC is serving the appropriate clientele (criminally involved with long history of mental illness), some team members expressed concern regarding serving low functioning clients (DSPD) and dual diagnosis clients whose primary issue is substance abuse, and not mental illness.

2. Improve timely placement of potential participants in MHC by working to access treatment and medication funding (such as Medicaid) as early as possible.

3. Formalize policies and procedures for clients and document these in a participant handbook that is given to clients upon screening into the program. There is a great consensus among MHC team members regarding the policies and practices of the MHC; however, it would benefit clients to have this information in a written format.

4. Create individualized participant agreements. Clients currently sign a standardized MHC agreement, but best practices suggest that individualized agreements be signed by clients so they are aware of the specific requirements for participation and successful completion.

5. Update partnering agency listings, including treatment and support service listings, as new partners have been recently added (i.e. JDOT). BJA best practices for MHCs suggest that good documentation of MHC operations is essential to garner additional support (funding) and ensure sustainability (especially when team members leave the program).

6. Formalize policies regarding sanctions and incentives. Although responses to clients' non-compliance and successes in the program will always be individualized, it would benefit the program to have a formalized list of possible incentives and graduated sanctions. This document would serve a couple of purposes. First, a list of graduated sanctions may help the MHC team to choose less restrictive options when responding to non-compliance. Currently MHC team members indicated that jail was the last resort sanction, but data from court notes indicated that it is the third most frequently used sanction following the least severe responses of verbal warnings and removal from the Rocket Docket. Secondly, a formalized list of incentives may help the team to develop more creative options of rewarding clients and an array of incentives that is comparable to the breadth of sanctions currently used. BJA recommends that at least as many incentives as sanctions be offered in a MHC program.

7. Carefully consider the use of jail as a sanction. As previously noted in item # 6, jail is the third most commonly used sanction. However, data indicate that any jail bookings during MHC (regardless of reason, including for sanctions or warrants) and increased number of days in jail during MHC are associated with post-MHC recidivism. Although jail needs to remain available as an option for both non-compliance and stabilizing clients on their medications, it may have a detrimental effect on participants that is not realized until after exit from the program.

8. Continue efforts to improve transition and aftercare plans for exiting clients. Several MHC team members raised this issue as a concern. Furthermore, although arrest rates remain lower post-MHC than pre-MHC and treatment usage remains higher, these figures could be enhanced with a more formalized aftercare plan.

The process of conducting this evaluation revealed several inconsistencies in data sources and a lack of various types of information on participants. With any program that is a collaborative effort between several agencies, it is difficult to find a single source of records. Nevertheless, the MHC should undertake the following recommendations to improve records on their program and provide more comprehensive data for future evaluations:

1. Identify a single agency to store primary program information.

2. Primary program information should include, at the very least, all names, demographics (date of birth, gender, ethnicity, race), unique identifiers from criminal justice and treatment agencies (e.g., SOs, SIDs), screening, intake, plea, and exit dates and statuses (intake status of plea in abeyance vs. probation, exit status of graduation, termination and reason).

3. Keep a database of participants' progress, similar to information already recorded in court notes documents.

It is believed that these record keeping recommendations can be implemented without too much effort, as the partnering agencies already have data sharing agreements and information kept in court notes documents could be entered into a database that has already been developed for this purpose by the research team. Consistent program records will both improve future evaluation efforts and requests for funding.

Discussion and Conclusion

Many studies of other MHCs found that MHC participants were no more at risk of re-offending than mentally ill offenders handled in the traditional courts (Morin, 2004; Cosden, Ellens, Schnell, & Yamini-Diouf, 2005; Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005). Additionally, a few noted a decrease in arrest rates post-exit among MHC participants (Herinckx, Swart, Ama, Dolezal, & King, 2005; McNiel and Binder, 2007). With this literature in mind, outcome analyses of the Salt Lake County Mental Health Court (SLCo MHC) participants is very encouraging.

The MHC serves participants who are booked into the jail often and are therefore consumers of considerable criminal justice resources. MHC participants utilized over 21,000 jail days in the two years prior to starting MHC. Although still high, this number dropped to just over 16,000 while this group was in MHC. It should be noted that few of these booking were for new charges, and only 19.8% of participants had a new charge while in MHC. In fact 8,273 jail days during MHC were for sanctions for non-compliance. Additionally the number of jail days used post-MHC dropped even further to 5,200 in the year following MHC-exit and, and although it increased slightly from the year prior, at two years post-MHC was still well below that of two years pre-MHC (7,600 days).

VMH records suggest that MHC participants have long histories of diagnosed mental illness prior to starting MHC. Most also had long histories of mental health treatment, and a trend of gradually increased treatment leading up to MHC start was observed. Type and frequency of mental health services received during MHC increased dramatically from the pre-MHC levels. Most participants (86.6%) received services through VMH; however, it is likely that the remainder received treatment services through a private provider. Some research has voiced the concern that increased utilization of mental health treatment through MHCs is short-lived and does not extend beyond MHC-exit (Boothroyd, R., Poythress, N., McGaha, A., & Petrila, J., 2003). The difficulty of keeping MHC participants engaged in treatment and various community resources once they exit the program was also noted by a number of team members during key informant interviews. Although services received through VMH did decrease some post-MHC, the percent of participants receiving services through VMH after exiting MHC was still higher than pre-MHC levels, often for multiple years.

Research supports the notion that the provision of secure housing contributes to treatment retention and improved mental health (Wasylenki, Goering, Lemire, Lindsey, and Lancee, 1993). A number of housing assistance options are available to MHC participants, and records indicate that nearly half (47.5%) of participants received housing resources or residential treatment while in MHC. Almost a quarter of all MHC participants (59, 22.4%) were identified as homeless at some point while in MHC; however, these individuals were more likely to receive housing assistance or residential treatment while in MHC. Additional resources to MHC participants include JDOT and NAMI. JDOT provides the most at-risk participants with daily medication monitoring, home visits, and case management following the Assertive Community Treatment (ACT) model that has been shown to be highly effective with a multi-need mentally ill population. The Utah Chapter of NAMI also provides classes for MHC participants and families in a peer-directed environment where participants take an active role in their recovery. Preliminary analysis found that more graduates participated in NAMI's Bridges classes than terminated participants; however, this was based on a relatively small sample.

One of the most promising findings of this study is the reduction in recidivism among participants. MHC participants have extensive criminal histories and nearly all (92.7%) had at least one arrest in the three years prior to MHC. This went down to 37.2% with new arrests in the year following MHC exit, and although it increased at three years post-MHC, it was still substantially lower (62.9%) than at three years pre-MHC. Similarly, the percent of clients with new charge bookings in the jail decreased from 66.9% in the year pre-MHC to 19.8% during MHC (16% from different record source) and 18.2% in the year post-MHC. These reductions compare favorably to other evaluations of MHCs. For example, Herinckx et al. (2005) showed a reduction from every participant having an arrest in the year prior to MHC to only 45.9% having an arrest in the year following MHC intake (during participation). Likewise, McNeil and Binder (2007) reported a 42% recidivism rate 18-months post-start (during MHC, all participants) and a 34% recidivism rate in the 18-months post-exit (for graduates only).

Graduation from MHC was associated with better post-MHC outcomes. Although not different in number of pre-MHC arrests, graduates had far fewer post-MHC arrests. In fact the difference remained statistically significant at two years following exit. Not only were graduates less likely to recidivate, but the length of time until recidivism (new charge bookings) was delayed (grad, Md = 435 days; term, Md = 262 days). Findings also suggest that individuals who are not compliant will not succeed in the program, but they may still benefit from reduced recidivism following MHC exit. Although graduates do have better outcomes than terminated participants, all MHC participants, regardless of during program compliance and exit status, showed reductions in criminal involvement following MHC participation.

References

Appelbaum, P. S., & Grisso, T. (1995). The MacArthur treatment competence study: I. Mental illness and competence to consent to treatment. *Law and Human Behavior, 19,* 105–126.

Bonnie, R. J. (1992). The competence of criminal defendants: A theoretical reformulation. *Behavioral Sciences and the Law, 10,* 291–316.

Boothroyd, R., Poythress, N., McGaha, A., & Petrila, J. (2003). The Broward Mental Health Court: Process, outcomes and service utilization. *International Journal of Law and Psychiatry, 26,* 55–71.

Boothroyd, R. A., Calkins-Mercado, C., Poythress, N. G., Christy, A, & Pertrila, J (2005). Clinical outcomes of defendants in mental health courts. *Psychiatric Services*, *56*, 829-834.

Byrnes, E. C., Hickert, A. O., & Kirchner, R. A. (2007). *Process and Outcome Evaluation of the Carbon County, Utah Adult Drug Court Program*. Annapolis, MD: Glacier Consulting, Inc.

Byrnes, E. C., Hickert, A. O., & Kirchner, R. A. (2007). *Process and Outcome Evaluation of the Grand County, Utah Adult Drug Court Program*. Annapolis, MD: Glacier Consulting, Inc.

Christy, A., Poythress, N. G., Boothroyd, R. A., Petrila, J., & Mehra, S. (2005). Evaluating the efficiency and community safety goals of the Broward County Mental Health Court. *Behavioral Sciences and the Law, 23*, 227-243.

Cosden, M., Ellens, J., Schnell, J., & Yamini-Diouf, Y. (2005). Efficacy of a mental health treatment court with assertive community treatment. *Behavioral Sciences and the Law*, *23*, 199-214.

Erickson, S. K., Campbell, A., & Lamberti, J. S. (2006). Variations in mental health courts: Challenges, opportunities, and a call for caution. *Community Mental Health Journal*, *42*, 335-344.

Goldkamp, J.S., & Irons-Guynn, C. (2000). *Emerging judicial strategies for the mentally ill in the criminal caseload: Mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage*. Washington, DC: Bureau of Justice Assistance.

Griffin, P. A., Steadman, H. J., & Pertila, J. (2002). The use of criminal charges and sanctions in mental health courts. *Psychiatric Services*, *53*, 1285-1289.

Herinckx, H. A., Swart, S. C., Ama, S. M., Dolezal, C. D., & King, S. (2005). Rearrest and linkage to mental health services among clients of the Clark County Mental Health Court Program. *Psychiatric Services, 56*, 853-857.

Hoge, S.K., Poythress, N., Bonnie, R.J., Monahan, J., Eisenberg, M., & Feucht-Haviar, T. (1997). The MacArthur adjudicative competence study: Diagnosis, psychopathology, and competence-related abilities. *Behavioral Sciences and the Law, 15*, 329-345.

Kaltiala-Heino, R., Laippala, P., & Salokangas, R. K. R. (1997). Impact of coercion on treatment outcome. *International Journal of Law and Psychiatry, 20,* 311–322.

McNiel, D. E., & Binder, R. L. (2007). Effectiveness of a mental health court in reducing criminal recidivism and violence. *American Journal of Psychiatry*, *164*, 1395-1403.

Morin, M. L. (2004). Effects of criminal court-ordered mental health treatment on offender jail term and recidivism. *Dissertation UMI #3153757*.

O' Keefe, K (2006). *The Brooklyn Mental Health Court evaluation. Planning, implementation, courtroom dynamics, and participant outcomes*. New York, NY: Center for Court Innovation.

Pett, M. (1997). *Nonparametric statistics for health care research*. Thousand Oaks, CA: Sage.

Poythress, N., Petrila, J., McGaha, A., & Boothroyd, R. (2002). Perceived coercion and procedural justice in the Broward County Mental Health Court. *International Journal of Law and Psychiatry, 25,* 517–533.

Rain, S. D., Williams, V., Robbins, P., Monahan, J., Steadman, H., & Vesselinov, R. (2003). Perceived coercion at hospital admission and adherence to mental health treatment after discharge. *Psychiatric Services, 54,* 103–105.

Rapp, C. A., (1998). The active ingredients of effective case management: A research synthesis. *Community Mental Health Journal, 34*, 363-380.

Redlich, A. D. (2005). Voluntary, but knowing and intelligent? Comprehension in Mental Health Courts. *Psychology, Public Policy, and Law, 11*(4), 605-619.

Redlich, A. D., Steadman, H. J., Petrila, J., Monahan, J., & Griffin, P. A. (2005). The second generation of mental health courts. *Psychology, Public Policy, and the Law, 11*, 527-538.

Ridgely, S. M., Engberg, J., Greenberg, M.D., Turner, S., DeMartini, C., & Dembosky, J. W (2007). *Justice, treatment, and cost. An evaluation of the fiscal impact of Allegheny County Mental Health Court*. Arlington, VA: The RAND Corporation.

Solomon, P., Draine, J., & Marcus, S. C. (2002). Predicting incarceration of clients of a psychiatric probation and parole service. *Psychiatric Services, 53,* 50–56.

Stafford, K. P., & Wygant, D. B. (2005). The role of competency to stand trial in mental health courts. *Behavioral Sciences and the Law*, *23*, 245-258.

Steadman, H., J., & Redlich, A.D. (2005). *An evaluation of the bureau of justice assistance mental health court initiative*. Washington, DC: National Institute of Justice.

Steadman, H. J., Redlich, A. D., Griffin, P., Pertila, J., & Monahan, J. (2005). From referral to disposition: Case processing in seven mental health courts. *Behavioral Sciences and the Law*, *23*, 215-226.

Swartz, M. S., Swanson, J. W., & Monahan, J. (2003). Endorsement of personal benefit of outpatient commitment among persons with severe mental illness. *Psychology, Public Policy, and Law, 9,* 70–93.

Teller, J. L., Ritter, C., Salupo Rodriguez, M., Munetz, M. R., & Gil, K. R. (2004). *Akron Mental Health Court: Use of services by participants during the first two years*. Kent, OH: Ohio Department of Mental Health.

Thompson, M., Osher, F., & Tomasini-Joshi, D. (2007). *Improving responses to people with mental illnesses: The essential elements of a mental health court.* New York: Council of State Governments Justice Center for the Bureau of Justice Assistance.

Trupin, E., & Richards, H. (2003). Seattle's mental health courts: Early indicators of effectiveness. *International Journal of Law and Psychiatry, 26,* 33–53.

Trupin, E., Richards, H., Wertheimer, D. M., & Bruschi, C. (2001). *Seattle Municipal Court Mental Health Court*. Seattle, WA: City of Seattle.

Winick, B. J. (1997). *The right to refuse mental health treatment.* Washington, DC: American Psychological Association.

Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the complex issue of mentally ill offenders. *Psychiatric Services, 52,* 477-481.

Wasylenki, D., Goering, P., Lemire, D., Lindsey, S., & Lancee, W. (1993). The hostel outreach program: Assertive case management for homeless mentally ill persons. *Hospital and Community Psychiatry*, *44*, 848-853.

Appendix A Importance of Competency and Voluntary Participation

Although few studies have examined the competency of MHC participants (Redlich, 2005; Stafford & Wygant, 2005), the importance of competency and voluntary participation is well understood. Bonnie (1992) notes the importance of competency in the legal system in general, citing three independent rationales for barring adjudication on grounds of incompetence: *dignity*, *reliability*, and *autonomy*. The *dignity* of the court is at risk when defendants who do not understand their wrongdoing or the punishment are prosecuted. The *reliability* of the court is at stake when the details of the case are incorrect or misleading due to the inability of the defendant to share relevant information. Lastly, the court system requires *autonomy* of the defendant to make decisions regarding representation, entering a plea, and testifying.

Assessing defendant competency in MHCs is especially important. First, because of the purpose of the MHC, they are more likely to serve defendants who are impaired and lack competence to stand trial (Redlich, 2005; Stafford & Wygant, 2005). Second, many MHCs, including Salt Lake County's MHC, specifically target clients with schizophrenia. Research has indicated that persons diagnosed with schizophrenia are more impaired than persons diagnosed with other mental disorders. For example, persons with schizophrenia scored lower than those with affective disorder, other psychiatric disorders, or no disorder on measures of competency, such as understanding, reasoning, and appreciation of the court process (Hoge, et al., 1997). These differences were present after controlling for factors such as age, socioeconomic status, criminal history, contact with attorney. Additionally, MHCs are informal by design and may require participants to give up some rights that are protected in the traditional court process (e.g., speedy trial, due process) (Poythress, Petrila, McGaha & Boothroyd, 2002; Redlich). Many MHCs also require clients to plead guilty to their charges in addition to agreeing to comply with court orders, treatment, medication, and other requirements. Because of the enormity of responsibility placed on clients, "voluntary, knowing, and intelligent decisions" to participate are especially important (Redlich). This issue was addressed by Stafford and Wygant who stated, "The defendant needs to understand the risks and the benefits of mental health court, and the constitutional rights waived by choosing mental health court, prior to making an informed decision about participation." Furthermore, Redlich posits that "the level of comprehension at entry may predict future success or failure in the court"; therefore adding a practical implication to the legal ones for assessing competency and voluntary participation.

Definition of Competency

Redlich (2005), citing Bonnie (1992) and Appelbaum and Grisso (1995), provides a concise definition of legal competency based on past studies. Legal competency is most often defined as comprising the following two constructs: competence to assist counsel and decisional competence (Bonnie). Several abilities comprise the construct of competency. Three abilities that are required for both competence to assist counsel and decisional competence are a) capacity for understanding the charges, the nature of the court, relevant information, etc.; b) capacity for reasoning as it relates to one's case

(recognizing pertinent information, weigh risks and benefits, etc.); and c) appreciating one's situation as a defendant. A fourth ability required for decisional competence is the ability to communicate a preference (Bonnie). Appelbaum and Grisso similarly define competency to make treatment decisions as comprising elements of understanding, reasoning, and appreciation.

MHC Research and Competency

As previously mentioned, there is a dearth of research regarding competency and voluntary participation in mental health courts. Redlich (2005) states that it is unknown if decisions to enter MHCs are made "knowingly and intelligently." There is little documentation on when (and if) the process and procedures of MHCs are explained, who provides this information, and whether practices are followed consistently.

The few studies of MHCs that have addressed competency and voluntary participation have shown that court procedures for informing clients and the percent of clients found competent to participate can vary widely. Stafford and Wygant (2005) examined trial competency evaluations from the Akron Ohio MHC and noted the surprisingly high percentage of MHC referrals who were identified as incompetent. Out of 80 evaluations, more than three-quarters (77.5%) were found incompetent to stand trial. Of the 18 (22.5%) found competent to stand trial, only two entered the MHC program. Out of the 62 initially found incompetent, mean time in the state hospital for competency restoration was 48.9 days and only 29 (46.8%) were restored to competence. Of those restored to competence, only two were placed in the MHC. Group differences showed that incompetent defendants were more likely to have a psychotic diagnosis, but less likely to have a personality disorder or substance abuse diagnosis, felony convictions, or a history of juvenile arrests. Characteristics associated with MHC referrals' competence may have implications for the population that these specialty courts target.

In a study of court processes in the Broward County MHC, it was found that official records of clients' competence-to-proceed was found in only 29.4% of cases (Boothroyd, Poythress, McGaha & Petrila, 2003). Of those, 73.3% of the defendants were declared competent, in contrast to the approximately 75% who were found incompetent in the Stafford and Wygant (2005) study of the Akron MHC. In regards to informed consent, only 28.4% of the Broward County cases had an explicit description of the court's purpose and focus in the transcripts, while only 15.7% of cases had specific mention of the voluntary nature of the court. However, the authors did note that in-court observations showed that the judge generally made a "blanket statement" at the beginning of the court session describing the treatment approach of the court and voluntary nature to all who were present. A higher percentage of MHC clients (53.7%) self-reported knowledge of the voluntary nature of the MHC; however, of those 54.7% said they were told about the voluntary nature after their first hearing. They reported getting information about the court's purpose and voluntary nature from a variety of sources: defense attorney (31.8%), judge (28.8%), and mental health professionals (25.8%). Nonetheless, the authors noted that the lack of discussion about voluntary participation in the official court record was troubling (Boothroyd et al.). In an earlier study of the Broward County MHC, it was

found that lack of awareness of the voluntary nature of the court was related to more feelings of coercion (Poythress et al., 2002). However, overall coercion ratings for the entire sample of MHC participants were still quite low.

Trupin and Richards (2003) studied the King County and Seattle Municipal MHCs. The procedures for informing clients of the voluntary nature of the court were more clearly defined in these MHCs than in Broward County. For both King and Seattle courts, the court monitory (clinical social worker) informs referred clients about the court, their responsibilities, risks, and the benefits of participation. During their initial hearing, the judge further explains that participation is voluntary and confirms that the defendant understands the court. Defendants "at some point" make a decision to opt-in or out of the MHC (Trupin & Richards, 2003). Although the process of information sharing is well documented for these courts, the exact timing of when defendants enter the court willingly and whether or not they meet criteria for legal competence are not detailed.

Slightly more research is available on voluntary participation and mental health treatment outcomes. Redlich (2005) reviewed several studies linking competence and voluntary participation to improved outcomes among the mentally ill. First, the Swartz, Swanson, and Monahan (2003) study found that positive endorsement of treatment (e.g., outpatient commitment mandates, OPC) at intake, was related to greater likelihood of positive mental health outcomes (improved GAF scores and fewer hospitalizations and violence). Second, Winick (1997) in his work on the right to refuse mental health treatment reported that patients who entered treatment with complete understanding and voluntarily had better treatment-related outcomes. Third, in a study of mentally ill probationers, Solomon, Draine, and Marcus (2002) found that those who believed their psychiatric medications were helpful were nearly five times less likely to be arrested for new charges and more than three times less likely to be jailed on technical violations than those who did not think medications were helpful. Lastly, Kaltiala-Heino, Laippala, and Salokangas (1997) showed that patients who initially felt coerced were less likely to take medications, use mental health services, and show improvements in functioning. In contrast, Rain, et al. (2003) did not find any relationship between perceptions of coercion and adherence to treatment. Although this research does not directly involve MHC populations, their findings may demonstrate the importance of competency and voluntary participation in a MHC environment, since better treatment and criminal justice outcomes are associated with increased awareness of mental illness and willingness to endorse treatment as a viable option.

Recommendations and Conclusion

Although the body of literature on competence, voluntary participation, and mental health courts is limited, there is near unanimous agreement within the field about the importance of these issues. In fact, Thompson, Osher, and Tomasini-Joshi (2007) list "informed choice" as one of the ten essential elements of a MHC. Potential clients should be determined competent to participate and fully understand terms of participation. Furthermore, choices should be informed both before and during program participation. These authors indicate that specific terms should be put in writing and reviewed with the

counsel. They also emphasize the important role the defense attorney plays at intake into the MHC as well as during status hearings where there is a risk of sanctions or dismissal.

Given the importance of competency to the court process in general, and to MHCs specifically, MHCs should strive to address these issues and carefully document their efforts so that future research can further examine the role these constructs play in individuals' success and the effectiveness of MHCs in general.

Appendix B Overview of Mental Health Courts in the Literature Table

MHC	Year Began	Average Active Caseload	Team Meeting Schedule	Degree of Mental Illness	Length of MHC	Types of Cases Accepted	Type of Adjudication Model	Use of Sanctions	Type of Supervision	Tx Approach
Broward County, FL	1997		daily	Axis I serious mental illness, brain impairment, or developmental disability	1 year max	Misdemeanors (w/ the exception of DV & DUIs). Battery eligible w/ victim consent only	most pre-plea	Extremely rare	Community tx providers	
King County, WA	1999	36	daily	Serious mental illness or developmental disability	2 years, DUIs extended to 5 years	Misdemeanors	most pre-plea	Sparingly	Probation	Community-based behavioral tx
San Bernardino, CA	1999		weekly	History of severe and persistent Axis I mental illness; previous diagnosis req.	2 years for misdemeanors, 3 years for felonies	Misdemeanors & low-level Felonies	post-plea	Liberally	Team, probation, MH staff	
Anchorage, AL	1998	80	Part time, as needed	Diagnosis or obvious signs of serious mental illness, or organic brain syndrome that contributed to crime	3-5 years, 10 year max	Misdemeanors	most pre-plea	After repeated non-compliance	Court monitor	
Santa Barbara, CA		600	1.5 days per week	Any mental illness or SA disorder		Misdemeanors & some Felonies	most pre-plea	Occasionally	Team, probation, MH staff	
Clark County, WA	2000		3 times per week	Axis I diagnosis of schizophrenia, bipolar, or major depression. No Axis II of development disabilities.		Misdemeanors	pre & post-plea	With violent charges	Community Tx providers	

MHC	Year Began	Average Active Caseload	Team Meeting Schedule	Degree of Mental Illness	Length of MHC	Types of Cases Accepted	Type of Adjudication Model	Use of Sanctions	Type of Supervision	Tx Approach
Seattle, WA	1999	781 (in 2004)	weekly	Axis I diagnosis of schizophrenia, bipolar, or major depression	2 year max	Misdemeanors	most pre-plea	Rarely	Probation	Court Monitor arranges for services, including housing & tx
Marion County, IN	1996		weekly	Axis I diagnosis of schizophrenia, bipolar, or major depression		Misdemeanors	pre-plea	Rarely	Community tx providers	
Santa Clara County, CA				Dual-diagnosis of mental illness & SA disorder		Felonies	post-plea	With discretion only	Team	Various SA and MH services
Orange County, NC	2000	65	2 times per month	Any mental illness (priority given to severe mental illness diagnosis)	6 months	Misdemeanors & Felonies	pre-plea	With discretion only	Tx Staff	ACT & other MH services
Allegheny County, PA	2001	36	weekly	Any mental illness or SA disorder		Misdemeanors & Property Felonies	post-plea	Rarely	Probation	
Washoe County, NV	2001	37	weekly	Major mental illness, developmentally disabled, & individuals w/ an aging disorder or an organic brain injury	2 years max	Misdemeanors & Felonies	post-plea	With discretion only	Team	

MHC	Year Began	Average Active Caseload	Team Meeting Schedule	Degree of Mental Illness	Length of MHC	Types of Cases Accepted	Type of Adjudication Model	Use of Sanctions	Type of Supervision	Tx Approach
Brooklyn, NY	2002	40-50 (since inception)	weekly	Axis I diagnosis of schizophrenia, bipolar disorder, major depression, or schizoaffective disorder	12 months for misdemeanors, 12-24 months for felonies	Nonviolent Felonies & some Misdemeanors	post-plea	Rarely	Court Case managers	Community-based services: ACT & services for co-occurring SA & MH disorders
Bonneville County, ID	2002	13 (max 20 at one time)	weekly	Axis I diagnosis of schizophrenia, bipolar disorder, major depression, or schizoaffective disorder		Misdemeanors & Felonies	post-plea	With discretion only	ACT team & Probation	ACT
Orange County, CA		47		Dual-diagnosis of mental illness & SA disorder		Felonies	post-plea	With discretion only	Probation	Various SA and MH services
Akron, OH	2001	100 (per year)	weekly (judge is only present every 6 weeks)	DSM diagnosis of bi-polar disorder, schizoaffective disorder, or schizophrenia	1 year min, average 1.5 years	Misdemeanor	pre-plea	No protocol for sanctions or incentives	Tx team	Residential program, assistance w/ benefits, linkage to SA and MH services

UTAH THIRD DISTRICT COURT
SALT LAKE COUNTY

MENTAL HEALTH COURT
PARTICIPANT HANDBOOK

2008

This document was compiled by Utah Criminal Justice Center researchers during a program evaluation of the Salt Lake County Mental Health Court in an attempt to provide an example participant handbook, based on examples from other MHCs nationwide.

TABLE OF CONTENTS

BACKGROUND

MISSION

The mission of the Mental Health court is to address the needs of the offender who has a mental illness in the criminal justice system.

PURPOSE

The purpose of the Mental Health Court is to provide a structured link for the offender who has a mental illness with: treatment, rehabilitation, social support services, and the criminal justice system to enhance the functioning of the participant, protect the public and more effectively utilize public resources.

PROGRAM GOALS

Program Goal #1

Reduce criminal recidivism of offenders with an identified mental illness by providing a psychological evaluation and three phases of Mental Health Court intervention to eligible defendants

Program Goal #2

Expand the capacity of Mental Health Court

Program Goal #3

Secure psychiatric medications for all Mental Health Court participants from jail release until funding can be secured so that participant can pay for medications

Program Goal #4

Increase mental health treatment compliance of Mental Health Court participants

Program Goal #5

Continue a forum of providers, prosecutors, defenders, judges, and state correction officials to discuss Mental Health Court issues.

INTAKE INFORMATION

ELIGIBILITY

Mental Health Criteria

1. Axis I Diagnosis (such as Schizophrenia, Bipolar Disorder, or Schizoaffective Disorder)

Legal Criteria

2. Legally Competent
3. Misdemeanor or Felony charge
4. No weapons offenses
5. No sexual offenses
6. No active DUI offenses.
7. Offenses involving violence are reviewed on a case by case basis

Other Criteria

8. Salt Lake County residence
9. Voluntarily choose to participate rather than remain in the traditional court system

MHC PARTICIPANTS ACCEPTED CRIMINAL CHARGES – MISDEAMENORS

Property Crimes

1. Criminal Mischief
2. Trespass
3. Retail theft
4. Theft

Substance Crimes

5. Public intoxication
6. Illegal possession
7. Unlawful open container/possession of alcohol in a public place

Person Crimes

8. Disturbing the peace
9. Disorderly conduct
10. Assault
11. Domestic violence
12. Sex solicitation
13. Telephone harassment
14. Assault on a police officer
15. Interfering with an arrest
16. False information to the police
17. Mischievous conduct
18. Battery

MHC PARTICIPANTS ACCEPTED CRIMINAL CHARGES – FELONIES

Property Crimes

1. Forgery
2. Burglary
3. Possession, forgery writing device
4. Joy riding
5. Theft by deception
6. Reckless burning

Substance Crimes

7. Illegal possession
8. Operation of clandestine laboratory
9. Possession with intent to manufacture

Person Crimes

10. Protective order violation
11. Aggravated assault
12. Threat of use of a dangerous weapon

REFERRAL

Referral into the MHC program may be made by your attorney, the prosecuting attorney, the judge, probation officer, the jail, or a mental health professional. An Intake/Screening Form, Inter-Agency Release of Information, and Authority to Release Records form must be completed to begin the screening process.

Legal Defender Referral

1. Refers client to the legal defender social workers
2. Sends referral to MHC case manager
3. MHC case manager screens client on JEMS
4. Case manager informs MHC Clinician of problems such as DUIs, aggravated crimes, etc. Also if client self-reports a mental illness
5. MHC Clinician checks to see if client is already involved in treatment with Valley Mental Health and decides if client is clinically eligible for MHC
6. If eligible, MHC Clinician informs the District Attorney and City Prosecutor who will decide if client is legally eligible
7. Client is put on court docket and told to report to MHC for orientation
8. If client decides he/she wants to participate in MHC, he/she will plea into the court.
9. Client will be court ordered to report to MHC case manager for intake

Private Referral

1. Lawyer will make telephone call to MHC case manager
2. MHC case manager will fax referral forms
3. When referral forms are received, screening process above (#3, etc.) will take place
4. When screened, MHC Clinician will check on clinical appropriateness and inform the attorney of the result
5. If found eligible clinically, lawyer must get approval of District Attorney
6. Client is put on court docket and told to report to MHC for orientation
7. If client decides he/she wants to participate in MHC, he/she will plea into the court.

8. Client will be court ordered to report to MHC case manager for intake

SCREENING AND ACCEPTANCE

Following legal, clinical, and probation screening, your application for acceptance into the MHC program will be submitted to the staffing team for acceptance or denial. If accepted into the MHC program, you will be represented by the MHC public defender in a non-adversarial manner during your participation in the program.

GUILTY PLEA AND SENTENCING

If you have been charged with a new crime, you will be required to enter a guilty plea to the charge before participating in the MHC program. If you are terminated or voluntarily withdraw from the MHC program, you will be sentenced based on your guilty plea to the charge. If you successfully complete the MHC program, you may potentially be offered a 402 reduction of charge (ex: Class A to Class B Misdemeanor) or a dismissal of a charge through a plea in abeyance. These conditions will be specified in writing upon admission into the program. Successful completion of the program may also include a 3-6 month reduction of your probation period.

Formal entrance into the MHC will begin when you sign the Mental Health Court Agreement and enter a plea before the court. An example MHC Agreement is provided at the end of this handbook.

CONFIDENTIALITY

The MHC makes an effort to protect the confidentiality of its participants. However, participants must sign an Inter-Agency Release of Information form as a condition of participation in the court. Your records will not be released or shared with the MHC team unless a specific release of information has been signed by you to provide that type of information (ex: legal issues/records, mental health diagnosis) to the MHC program.

PARTICIPATION

GENERAL TERMS OF PARTICIPATION

The length of participation in the MHC is determined by the maximum probation sentence for the presenting charge severity, but is typically 12 to 36 months. The specific length of your MHC participation is specified on the MHC Agreement. Non-compliance can result in revocation and reinstatement (extension) of probation.

Successful discharge criteria include:

- a stabilized psychiatric condition
- abstinence from drugs and alcohol for at least a [*insert number*] month period
- successful completion of the treatment program
- compliance with court orders, probation agreement, and MHC agreement
- successful transitioning from treatment to independent living

Your individualized MHC requirements will be specified in your MHC Agreement and treatment plan.

Participants may be expelled from the program if no community-based treatment is likely to restore them to stability, the likelihood of serious physical harm to self or others becomes unmanageable in the community setting, the participant refuses to comply with program requirements, a treatment placement cannot be found, or the client withdraws or is rearrested.

COURT APPEARANCES

Status hearings are held weekly on Monday afternoons at 3 p.m., except on holidays. Each participant generally attends court once a week, but the frequency of these hearings can be reduced to twice a month based on participant progress and the decision of the MHC team. Prior to the hearings the MHC team staffs the cases and discusses participant progress. During the court hearing, clients are called before the judge and given an opportunity to report on progress and discuss issues with the Court. Incentives for compliance and sanctions for non-compliance may be issued during status hearings. The most successful clients are placed on the "Rocket Docket" and are allowed to appear before the Judge at the beginning of court.

INCENTIVES

Incentives are provided for clients that are compliant with the MHC requirements and making progress in their treatment plan. Incentives may include, but are not limited to the following:

1. Verbal Praise
2. Being on the "Rocket Docket"
3. Reduction in frequency of status hearings to twice a month
4. Reduction in treatment or supervision requirements

Sustained successful participation may result in a 3 to 6 month reduction in your probation period. In addition, upon successful completion of the program you may be offered a 402 reduction of charges or a dismissal of charges as outlined in your MHC agreement and plea at intake.

SANCTIONS

The MHC employs graduated sanctions for non-compliance with MHC program requirements. Examples of non-compliance include not adhering to medication and treatment regimens, using alcohol and non-prescribed drugs, or committing new offenses. Sanctions for non-compliance may include, but are not limited to the following:

1. Removal from the "Rocket Docket"
2. Assignments
3. Increased classes
4. Increased drug testing
5. Community service
6. Jail

PROGRAM FEES

[*Insert Salt Lake County MHC Program Fee requirements here*]

PHASES

Phase One - Pre-screening / Arraignment
If incarcerated, the jail mental health unit will assess defendants for competency, suitability, mental health diagnosis, and residence prior to referral to Mental Health Court. Defendants can also be referred from arraignment or pre-trail court appearances.

Phase Two - Entry – 1 Week

During the first week of participation in Mental Health Court the client will make their initial appearance in court. The Valley Mental Health Clinic Coordinator will arrange services between Criminal Justice Services (CJS) and Valley Mental Health (VMH) or Veteran Administration (VA). If the client is currently under the care of a private provider, steps will be taken to coordinate with that provider.

Phase Three – Stabilization – 2-8 Weeks

During this two to eight week phase clients will enter a plea, sign the Mental Health Court agreement, and make weekly appearances in court. The client will be referred to CJS and VMH or VA to do an intake. VMH or VA will provide each client with an individualized treatment plan and medication management. The client will maintain weekly contact with the CJS case manager and attend counseling and other services deemed appropriate by CJS and VMH or VA. Clients with a substance abuse problem may also be required to attend substance abuse treatment and to submit to drug testing.

Phase Four – Maintenance – Remainder of Probation Period

Client will continue treatment as determined by the treatment plan, addressing issues such as education

and employment. Client will continue making court appearances as deemed necessary by the judge. Program completion is determined by a minimum of twelve months to three years of successful participation in Mental Health Court. Upon completion of the program the client will participate in a graduation ceremony at which time charges will be reduced or dismissed, if appropriate.

TREATMENT AND RELEASE PLAN

[*Insert Salt Lake County MHC Treatment and Release Plan here – this is a suggested plan from other MHCs*]

During Phase Four, MHC participants will receive case management services. The case manager works with the defendant and defense counsel to determine whether the individual is eligible for community treatment services, identifies an individualized community treatment plan, and determines if the defendant is willing and able to participate in the plan. The case manager will appear with the defendant and present a formal Treatment & Release Plan to the court to be approved prior to graduation. Elements of this individualized plan may include, but are not limited to:

- Crisis intervention and stabilization
- Safe and affordable housing
- Mental health and substance abuse treatment services
- Initial and/or ongoing psychological assessment
- Intensive case management
- Medication management
- Anger management
- Group therapy
- Individualized therapy
- Family therapy
- Parenting classes
- Individualized “wraparound” services
- Supportive, transitional, or independent housing
- Assistance with entitlements
- Protective payeeship, conservatorship, and guardianship
- Employment, training, and vocational services
- Transportation services
- Linkages to other support services

MENTAL HEALTH COURT CONTACTS

MHC Case Manager
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Case Manager
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Probation Officer
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Probation Officer
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Public Defender
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Housing Specialist
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

Community Treatment Program (CTP)
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Drug Testing Hotline
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

Utah Chapter of National Alliance on Mental Illness (NAMI)
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MENTAL HEALTH COURT PARTNERS

1. Salt Lake Third District Court

2. Valley Mental Health, including
    - Forensic Unit
    - Supported Employment
    - Community Treatment Program (CTP)
    - Jail Diversion Outreach Team (JDOT)

3. Veterans Administration

4. Salt Lake County Criminal Justice Services

5. Utah Commission on Criminal and Juvenile Justice (UCCJJ)

6. Mental Health Management Services at the Jail

7. Salt Lake County District Attorney

8. Salt Lake City Prosecutors

9. Legal Defenders Association

10. Salt Lake City Police Crisis Intervention Team (CIT)

11. Adult Probation and Parole

12. Utah Chapter of the National Alliance on Mental Illness (NAMI)
    - NAMI Bridges Program

13. Supported Housing, including
    - Veteran's Administration Valor House
    - Orange Street
    - Fremont
    - First Step House: Fisher House
    - Volunteers of America (VOA)
    - Valley Mental Health Housing: Timmins House
    - HACSL Housing: RIO, HARP

THIRD DISTRICT MENTAL HEALTH COURT
PARTICIPANT AGREEMENT

NAME: _____
First Middle Last

ADDRESS: _____
Street Apt.# City State Zip

PHONE: _____ DATE OF BIRTH:_____

CASE NUMBER: _____ SSN: _____

I have chosen to pursue treatment in the Mental Health Court program. To assure my full participation in this program, for a period of_____ months, I agree to the following:

1. Immediately report to a caseworker/case manager to be identified by the Court for an intake interview.

2. Maintain residence of record within Salt Lake County and get approval of the caseworker/case manager before changing residence. Notify caseworker/case manager of any change in phone number (or contact phone number) within 24 hours of change.

3. Follow all rules and regulations of his/her residence.

4. Attend all Court hearings as directed by the Court and all appointments as scheduled by caseworker/case manager.

5. Take all medications as prescribed.

6. Refrain from use of alcohol and non-prescribed drugs and comply with random urinalysis as ordered by the Court and/or requested by the caseworker/case manager.

7. Commit no criminal law violations and possess no dangerous weapons. If/when contacted by law enforcement, I shall report such contact to my caseworker/case manager within 48 hours regarding any potential charges and the receipt of any new citations.

8. Sanctions may include but are not limited to modification or treatment, administrative sanctions, community service, fines or a specific jail term.

9. I understand I have been accepted into the Mental Health Program as a condition of probation. This will require an entrance of a plea(s) of guilty and a subsequent sentence being imposed by the Court. If I am in compliance with the other conditions of my probation, I will be successfully discharged and terminated fro probation. If I fail to satisfactorily complete the Mental Health Court Treatment Program, the Court will remove me from the program, revoke my probation and sentence me in accordance with the provisions of the law.

10. Other conditions _____

11. If it is claimed that I have failed to comply with the rules, policies, or requirements of the Mental Health court, I give up the right to a hearing or an attorney and agree to proceed with imposition of any sanction except removal from Mental Health Court. Before I can be terminated from Mental Health Court I am entitled to a full hearing with counsel.

DATED this _____ day of _____, 20_____

_____ _____

Defendant Signature Attorney for Defendant Signature